GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check One Only: ☐ **PETITION** ☐ **AUTHORIZATION** ☐ **CONTROVERT**

ADVANCE AUTHORIZTION FOR THE MEDICAL TREATMENT OF TESTING OF AN INJURED EMPLOYEE IS NOT REQUIRED.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	Body Part Injured	Mailing Address	Phone Number
Employee E-mail			City / State / Zip Code	

EMPLOYER	Name		**INSURER/ SELF-INSURER** Name	SBWC# (five digit #)
Mailing Address			**CLAIMS OFFICE** Name	
			Mailing Address	
City	State	Zip Code	City / State / Zip Code	
Employer E-mail	Phone Number		Claims Office E-mail / Phone Number	

ATTORNEY FOR EMPLOYEE/CLAIMANT	Name	**ATTORNEY FOR EMPLOYER/INSURER**	Name
Mailing Address		Mailing Address	
City / State / Zip Code		City / State / Zip Code	
GA Bar Number	Phone Number	GA Bar Number	Phone Number
Attorney E-mail		Attorney E-mail	

☐ B. PETITION TO SHOW CAUSE REGARDING MEDICAL TREATMENT/ TESTING RECOMMENDED BY AUTHORIZED MEDICAL PROVIDER

Authorized Medical Provider _____ has recommended the following treatment or testing:
(Name of Authorized Medical Provider)

_____
(Describe the treatment or testing requested)

Supporting documentation regarding the treatment/testing is attached.

The undersigned affirms that an authorized medical provider has recommended treatment or testing as detailed in the attached documentation, and the undersigned further affirms that the attached documentation was supplied to the employer/insurer at least **5 business days** before the date of this petition along with a request for authorization, but as of the date of this petition, no authorization has been provided. Petitioner requests the Board to issue a notice of a telephonic conference during which the employer/insurer shall be directed to show cause as the reason the medical treatment/testing has not been authorized.

Authorized Medical Provider's Address	City	State	Zip Code
Authorized Medical Provider's E-mail Address	Authorized Medical Provider's Telephone Number		

☐ C. AUTHORIZATION

The medical treatment/testing authorized by the employer/insurer is: _____
(Description of medical treatment/testing authorized)

The treatment or testing in the Petition to Show Cause filed on _____is hereby authorized by the undersigned, Upon filing the authorization with the Board and service upon all parties, the authorized medical provider and the treatment or testing provider, the scheduled telephonic Conference is cancelled. The undersigned represents full authority to bind the employer/insurer, and certifies that all parties, the authorized medical provider, and the treatment or testing provider, have been served with this authorization. Authorized provided by:

Name		Signature
Date	Company/Firm Name	
E-mail Address		Phone Number

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

☐ **D. CONTROVERT IN LIEU OF TELEPHONIC CONFERENCE**

The medical treatment/testing is controverted by the employer/insurer. Reason for controvert:

Name	Title
Signature	Date
Company/Firm Name	Phone Number
E-mail Address	

☐ **E. CERTIFICATE OF SERVICE**

This section must be completed.

I hereby certify that today I have served a copy of:

☐ PETITION ☐ AUTHORIZATION ☐ CONTROVERT

to all of the parties, the authorized medical provider and the treatment or testing provider, as appropriate, and have filed this from with the State Board of Workers Compensation, 270 Peachtree St., NW Atlanta, Georgia 30303-1299.

Print Name	Signature	Date
Phone Number	E-mail Address	