

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check One Only:     PETITION     AUTHORIZATION     CONTROVERT

ADVANCE AUTHORIZATION 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
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**A. CLAIM INFORMATION**

<b>EMPLOYEE</b>	Birthdate	Body Part Injured	Mailing Address		Phone Number
Employee E-mail			City	State	Zip Code
<b>EMPLOYER</b>	Name		<b>INSURER/ SELF-INSURER</b>	Name	
Mailing Address			<b>CLAIMS OFFICE</b>	Name	
			Mailing Address		
City		State	Zip Code	City	State
Employer E-mail		Phone Number	Claims Office E-mail		Phone Number
<b>ATTORNEY FOR EMPLOYEE/CLAIMANT</b>		Name		<b>ATTORNEY FOR EMPLOYER/INSURER</b>	
Mailing Address		Mailing Address			
City		State	Zip Code	City	State
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 authentication with the Board and service upon all parties, and the authorized medical provider, the scheduled Telephonic Conference is cancelled. The undersigned represents full authority to bind the employer/insurer, and certifies that all parties, and the authorized medical provider, have been served with this authorization. Authorized provided by:

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

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov> WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

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<input type="checkbox"/>		<b>D. CONTROVERT IN LIEU OF TELEPHONIC CONFERENCE</b>	
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			

<input type="checkbox"/>		<b>E. CERTIFICATE OF SERVICE</b>	
<b>This section must be completed.</b>			
I hereby certify that today I have served a copy of:			
<input type="checkbox"/> PETITION <input type="checkbox"/> AUTHORIZATION <input type="checkbox"/> CONTROVERT			
to all of the parties and the authorized medical provider, as appropriate, and have filed this form with the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.			
Print Name		Signature	Date
Phone Number	E-mail Address		