

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check One Only:  PETITION  AUTHORIZATION  CONTROVERT

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

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
<b>A. CLAIM INFORMATION</b>				
<b>EMPLOYEE</b>	Birthdate	Body Part Injured	Address	
Employee E-mail		City	State	Zip Code
<b>EMPLOYER</b>	Name	<b>INSURER/ SELF-INSURER</b>	Name	SBWC# (five digit #)
Address		<b>CLAIMS OFFICE</b>	Name	
City	State	Zip Code	Address	
Phone Number		City	State	Zip Code
Employer E-mail		Claims Office E-mail		
<b>ATTORNEY FOR EMPLOYEE/CLAIMANT</b>	Name		<b>ATTORNEY FOR EMPLOYER/INSURER</b>	Name
Address		Address		
City	State	Zip Code	City	State
GA Bar Number	Phone Number		GA Bar Number	Phone Number
Attorney E-mail		Attorney E-mail		

<input type="checkbox"/> <b>B. PETITION TO SHOW CAUSE REGARDING MEDICAL TREATMENT/ TESTING RECOMMENDED BY AUTHORIZED MEDICAL PROVIDER</b>			
Authorized Medical Provider _____ has recommended the following treatment or testing: <small>(Name of Authorized Medical Provider)</small>			
_____ <small>(Describe the treatment or testing requested)</small>			
<b>Supporting documentation regarding the treatment/testing is attached.</b>			
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 <b>5 business days</b> 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 to 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		

<input type="checkbox"/> <b>C. AUTHORIZATION</b>	
The medical treatment/testing authorized by the employer/insurer is: _____ <small>(Description of medical treatment/testing authorized)</small>	
The treatment or testing in the Petition to Show Cause filed on _____ is hereby authorized by the undersigned. Upon filing this authorization 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. Authorization 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	Telephone 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	Date
Phone Number	E-mail

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