LWC FORM 1010A - FIRST REQUEST PLEASE PRINT OR TYPE

SECTION 1. IDENTIFYING INFORMATION			
P A T	Last Name: First: Middle:	Social Security Number:	
ENT	Employers Name:	Claim Number (if known):	
	SECTION 2. CARRIER/SELF INSURED EMPLOYER'S FIRST REQUEST FOR REQUIRED MINIMUM INFORMATION		
C A R R I E R	COMMENTS (Please provide a detailed explanation in support of your First Request) R I E		
SECTION 3. HEALTH CARE PROVIDER RESPONSE TO FIRST REQUEST			
	Additional information has been provided - Attach Supporting	Documentation	
	Additional information has not been provided - Provide expla	nation below	
	EXPLANATION		
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