



Claim number

PROVIDER'S INFORMATION (complete form in FULL)

A claim can **only** be reopened if there is an objective worsening of the allowed condition since the date of closure **and** that worsening is not due to an unrelated or preexisting condition or a new injury. You will be paid for the office call and diagnostic studies necessary to complete this form. Payment for any additional services will depend on our decision on the reopening request. If the claim is reopened, benefits cannot be paid for services provided more than 60 days prior to our receipt of the form. Answer all questions completely to ensure timely action on this reopening application. Please mail to the address on the application. Bills should be sent separately.

1. Please describe patient's current symptoms.

2. What was the FIRST date you saw the patient for these symptoms after claim closure? 3. Are the symptoms the result of the covered injury?  Yes  No

4a. List physical or psychological examination in detail, including all objective findings referable to complaints and areas involved in your claim. If evaluating a mental condition, please give relationship of all symptoms to the covered injury. Is there a preexisting physical or psychological condition that will retard recovery?

4b. Upon what information did you rely to make the comparison to substantiate worsening? (check box)
 Provider at the time of claim closure  Contacted the previous provider
 Reviewed the previous medical file  Other:

5. Does the current condition prevent the patient from working? Yes  No  If yes, estimate number of days off work: 6. Beginning date of current disability

7a. Describe the physical limitations and/or restrictions preventing the patient from working. Please provide the basis for your opinion.

7b. Could the patient return to work with modified or different duties (light, sedentary work or transitional part time work)?

8. List all medical factors that might impede or influence the patient's recovery.

9. What is your specific curative treatment plan? Please include expected time for recovery and indicate when the patient may return to some form of work.

10. Diagnosis of condition found by examination.

ICD Diagnosis Codes

Form with fields: Provider's name (type or print), Phone no., Address, City, State, ZIP+4, Today's date, CVCP provider no. / NPI#, Provider's signature

Benefits may be delayed if this form is not filled out completely
Please retain a copy of this reopening application for your records