Department of Labor and Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520
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CODSIGA DIB U FURIDA SHEEAGASHA AY SABABTAY XAALADA OO KA SII DARAYSA

MACLUUMAADKA DHIBANAHA
U dhammaystir qaybtaada si BUUXDA Wixii tallabo degdeg ah

Lambarka shegashada

Muuhim

Keliya isticmaal foomkan haddii xaaladaada caafimaad ay ka sii dartay , **iyo** sheegashadaada la xidhay in ka badan 90 maalmiid. Haddii ay tahay dheefaha wakhtiga lumay ee la bixiyay ka hor go'aanka ee ku sabasan dib u furida la sameeyay oo aan sheegashadaada dib loo furin, waxaa lagaaga baahan doonaa inaad dib u bixiso dheefahan. fadlan kor ku qor magacaaga sheegashada Waxaad heli doontaa macluumaadka ku saabsan dib u furida codsiga gudaha 90 maalmood ee helitaanka codsiga ay waaxdu heshay.

1. Magaca (Koowaad,Dhexe, Ka dambe)	2. Beddelka magaca ilaa sheegashada la xidhay? Haa ☐ Maya ☐ haddii haa, qor magacii hore	3. lambarka telefoonka guriga	4. Sosh Sek,Lam (*ee aqoonsiga keliya*)

5. Ciwaanka guriga hadda	6. Cinwaanka boostada (haddii u ka duwanyahay cinwaanka guriga)
7. Magaalada Gobolka Sibka	8. Magaalada Gobolka Sibka

8a. Waxaan door bidaa la xidhiidhkayga inay u tagaan Wakiilkayga Magaca: Cinwaanka Gobolka Sibka

9. Taarikhda dhaawaca asalka ah	10. Loo shaqeeyaha wakhtiga dhaawaca asalka ah

11. Waa maxay cabashooyinkaaga jidhka ee hadda?	12. Taariikhda sheegashada la xidhay	13. Taariikhda xaaladu ka sii dartay ka dib xidhitaanka sheegashada?

14. Magaca buuxa ee adeeg bixiyha ku dawaynayay wakhtiga xidhitaanka sheegashada.	15. Qaybtee jidhkaaga ah ayay saamaysay?
16. Ma lahayd wa dhaawacyo cusub ama jirooyin ilaa taariikhda xidhitaanka sheegashada? Haa ☐ Maya ☐ haddii haa, sharax.	17. Miyay xaaladaadu ka sii dartay iyaddoo ay sababtay dhaawac kale ama shil? Haa ☐☐ Maya haddii haa, sharax.

18. Miyaad heshay wax daawayn caaafimaad ah xaaladan ilaa xidhitaanka sheegashadaada? Haa ☐ Maya ☐
Haddii haa, qor magaca iyo cinwaanka cidda dawaynaysa.

19. Adeeg bixiye Lambarka telefoonka	20. Adeeg bixiye Lambarka telefoonka
Cinwaanka	Cinwaanka
Magaalada Gobolka Sibka +4	Magaalada Gobolka Sibka +4

21. Miyaad codsatay ama ma helaysaa wax dheefo ah? (Sax dhammaan inta ku habboon)

Shaqo la'aanta ☐ Caawimada dad waynaha ☐
Faxasa jirrada ☐ Dheefaha hawlgabka ☐
SSI/SSA ☐ Caymiska Naafanimada ☐
Medicare ☐ Magdhowga shaqaalaha ☐

Wax kale oo magdhowga caymiska warshada ah? (waxaa loola jeedaa Longshore shaqaalaha dekada, Jones Act, Railroad)
☐ Haddii la saxo, sharax

22. Ma shaqaynaysaa? Haa ☐ Maya ☐ Haddii maya, Sababtee? Hawl gab ah Aan shaqayn karin ☐ La dhimay Ka tegay ☐

23. Maalinta u dabaysa ee uu shaqeeyay

24. Loo shaqeeyaya hadda iyo kii hore Lambarka telefoonka

Cinwaanka Magaalada Gobolka Sibka +4

25. Nooca ganacsiga

26. Cinwaankaaga shaqada waajibaadka

27. Intee in leeg ayaad u shaqaysay loo shaqeeyahan?

FIIRO: Dadka samaynaya warbixinaha beenta ah ee helida dheefaha Magdhowga Dhibanayaasha dembiga waxaa la hoos gaynayaa ciqaabta madaniga ah iyo dembiga. Waxaan ku dhawaaqayaa in warbixinahan ay run yihiin ilaa inta aqoontayda ugu fiican iyo rumayntayda. Saxeexida foomka, waxaan u oggolaanayaa dhakhtarada, cusbitaalada, rugaha caafimaadka ama kuwa kale ee wata macluumaadka caafimaadka inay shaaciyaan diiwanadayda caafimaad iyo.ama Barnaamijka Magdhowga Dhibaha Dembiga.

Waaxda isticmaalka oo keliya

Taariikhda maanta	Saxeexa dhibanaha **X**

SII WAD MACLUUMAADKA ADEEG BIXIYAHA

PROVIDER'S INFORMATION (complete form in FULL)	Claim number

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

Provider's name (type or print)			Phone no.
Address	City	State	ZIP+4
Today's date	CVCP provider no. / NPI#	Provider's signature **X**	

Benefits may be delayed if this form is not filled out completely

Please retain a copy of this reopening application for your records