Dept of Labor & Industries
State Fund
PO Box 44291
Olympia WA 98504-4291
传真：360-902-6100

Dept of Labor & Industries
Self-Insurance
PO Box 44892
Olympia WA 98504-4892
传真：360-902-6900

因病情恶化而重启索赔之申请

索赔编号

工人信息

在您因病情恶化而需任何医疗服务后的30天内，完整填写您的部分并提交给您的治疗服务提供者。您填写的申请表和您提供的申请表，**必须**在您病情恶化而需任何医疗服务后的60天内交给本部门或自我保险公司。

只有在您的病情恶化且您的索赔已关闭60天以上时，才使用此表格。如果您在工作中遭受***新***伤，请填写新的工伤或职业病报告表。

如果在做出重启的决定之前支付了工时损失福利，而您的索赔没有重启，您将被要求偿还这些福利。您将在本部门收到重启申请后的90天内收到有关您重启申请的信息。

姓名（名，中间名，姓）	自索赔关闭后，您的姓名是否更改？ ☐ 否 ☐ 是 若选择是，请列出之前的姓名：
住宅电话号码	社保号（仅针对ID）
现住址	邮寄地址（若与住址不同）
城市 州 邮政编码	城市 州 邮政编码
☐ 我希望我的信件寄到我的代表处（提供代表的姓名和邮寄地址）	

初次受伤的日期	索赔关闭的日期
初次受伤时的雇主	索赔关闭时为您提供治疗服务的医生的全名
您身体的哪些部位受到此伤害/疾病的影响？	索赔关闭后病情恶化的日期

您目前的身体问题是什么？	自索赔关闭之日起，您是否遭受到任何新的伤害/疾病？ ☐ 否 ☐ 是 若选择是，请说明
您的病情是否因工作期间或下班时的另一次受伤/事故而恶化？ ☐ 否 ☐ 是 若选择是，请说明	自索赔关闭以来，您是否为此病情接受过任何治疗？ ☐ 否 ☐ 是 若选择是，请列出治疗医生的姓名和地址。
医生姓名 电话号码	医生姓名 电话号码
城市 州 邮政编码	城市 州 邮政编码

您目前是否有工作？
☐ 是 ☐ 否 若选择否，请说明原因 ☐ 退休 ☐ 无法工作 ☐ 遭解雇 ☐ 辞职 最后工作的日期：

您是否曾申请或正在获得下列任何福利？
☐ 失业补助 ☐ 病假 ☐ 公共援助 ☐ 退休福利金 ☐ 残疾保险
☐ 是否有任何其他工伤保险赔偿？（即码头和港口工人、琼斯法案、铁路工伤赔偿）

现任或前任雇主	
地址	电话号码
城市 州 邮政编码	
企业类型	您为此雇主工作了多久？
您的职位和职责	

自索赔关闭以来，您还有过哪些其他雇主和职位？

注意：在获取工业服务福利时做出虚假陈述的人将会受到民事和刑事处罚。本人声明，据本人所知且本人确信，这些陈述均属实。在签署本表格时，本人允许医生、医院、诊所或其他拥有医疗信息的人将本人的医疗记录披露给劳工与工商保险服务部和/或自我保险雇主。

索赔人签名 日期

Provider Information

Claim number

Please complete this form and send it to the State Fund Program or the Self Insurance Program. It will enable us to determine if the current medical condition is due to a worsening of a previous injury. A claim can **only** be reopened if there has been 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.

The completed application ***must*** be received by the Department or self-insurer within 60 days of any medical services made necessary by a worsening of the worker's condition.

You will be paid for the office call and diagnostic studies necessary to complete the form, however, payment for any additional services not authorized by the department will depend on our decision on the reopening request. **You must be participating in the L&I Medical Provider Network (MPN) to be designated as attending provider, administer treatment, or certify physical restrictions resulting in workers' compensation benefits (exception: out-of-state providers don't need to be in the MPN).** 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 appropriate address on the reverse side. Do ***not*** attach a bill to this form.

Please describe patient's current symptoms.	
What was the FIRST date you saw the patient for these symptoms after claim closure?	Are the symptoms the result of the covered injury? ☐ Yes ☐ No

List all the elements of your current medical findings including history, examination, and test results that would support a **measurable (objective) worsening** of the industrial injury or occupational disease since claim closure or the last reopening denial. **Attach test results and findings.**

Upon what information did you rely to make comparison to substantiate worsening? Check appropriate box.

☐ Provider at the time of claim closure ☐ Reviewed the previous medical file ☐ Contacted the previous provider

☐ Other:

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

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

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

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

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

Diagnosis of condition found by examination.

ICD Codes.

Provider name (please print)			Provider number
Provider address			Provider phone number
City	State	Zip Code	Provider's signature and date

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

Please retain a copy of this reopening application for your records.