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

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

索偿案重新开案申请书
由于病情恶化

索偿编号

工人信息
请完整填写需要您填写的内容以便及时办理。

在您的病情已经恶化且您的索偿案结案时间已经超过 60 天的情况下才应使用此表格。如果您在工作中出现***新的***工伤，请填妥新的"工伤或职业病报告"表格。

若在做出重新开案决定之前已经支付工时损失补偿福利，而且您的索偿案尚未重新开案办理，将要求您偿还这些福利金。于本部接获您的重新开案申请后 90 天内，您将收到关于重新开案申请的处理通知。

姓名（名，中间名，姓）	自索偿案结案以来，您的姓名是否曾更改？ ☐ 否 ☐是 若是如此，请列出曾用名：
家庭电话号码	社会安全号码（仅用于身份识别）
目前的家庭住址	邮寄地址（若与家庭住址不同，则请填写）
市 州 邮政编码	市 州 邮政编码
☐ 我希望将我的往来信件邮寄给本人的代表（提供代表的姓名和邮寄地址）	

最初受伤的日期	索偿案结案日期
于最初受伤时您的雇主姓名或名称	于索偿案结案时您的治疗医生之完整姓名
您的哪些身体部位受到此伤害/疾病的影响？	于索偿案结案后症状恶化的日期为

您目前有哪些身体不适症状？	从索偿案结案日期起，您是否有任何新的伤症或病症？ ☐否 ☐是 若是如此，请解释
您的病症是否因另一在岗或不在岗受伤事件/事故而恶化？ ☐否 ☐是 若是如此，请解释	从索偿案结案以来，您是否曾接受过对此病症的任何治疗？ ☐否 ☐是 若是如此，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
市 州 邮政编码	市 州 邮政编码

您目前是否有工作？
☐是 ☐ 否 如果没有，原因是？☐已退休 ☐无法工作 ☐被解雇 ☐辞职 最后一天上班的日期：

您是否已申请或正获得以下某些福利？
☐失业金 ☐病假 ☐公共援助 ☐退休福利 ☐残障保险
☐ 是否有任何其他的工业保险补偿？（即"码头、港口工人补偿"、Jones 法案雇员补偿、铁路工人补偿）

目前或上一个雇主	
住址	电话号码
市	州 邮政编码
企业类型	您为此位雇主工作已有多久？
您的工作职称及工作职责	

自索偿案结案以来，您是否还有其他雇主以及工作职称？

请注意：凡编造虚假陈述以图获得工业服务福利者都将受到民事和刑事处罚。本人声明，据我所知且本人确信，以上声明均属实。签署此表格则表示我允许医生、医院、诊所和保存本人医疗信息的其他人员向劳工与工业部和/或自办保险雇主披露我的医疗记录。

索偿者签名 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.

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.