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

Arjiga Dib u Furidda Sheegashada
Taasoo ugu Wacan Xaaladda oo ka sii Dartay

Macluumaadka Shaqaalaha
Si buuxda u dhamaystir qeybtaada si dhakhso looga shaqeeyo.

Nambarka sheegashada

Isticmaal oo keliya foomkaan haddii xaaladaada caafimaadka ka sii dartay, iyo la xeray sheegashadaada in ka badan 60 maalin. Haddii ay shaqada kaa soo gaartay dhaawac cusub, buuxi foomka cusub ee ku saabsan Warbixinta Dhaawaca Warshadda ama Xanuunka Shaqada (Report of Industrial Injury or Occupational Disease)

Haddii la bixiyo manaafacaadka waqtiga lumay ka hor inta aan la gaarin go'aanka dib u furidda kaddibna aan sheegashadaada dib loo furin, waxaa lagaa rabaa in aad dib u bixisid manaafacaadkaas. Waxaad heli doontaa macluumaad ku saabsan dib u furidda arjigaada muddo 90 maalin gudahooda kaddib marka Waaxda hesho arjiga dib u furidda.

Magaca (kowaad, dhexe, dambe)	Magacaada ma isbaddalay kaddib marka sheegashadaada la xeray? ☐ Maya ☐ Haa Haddii ay haa tahay, qor magacii hore:
Nambarka telefoonka guriga.	Nambarka Soshal Sekuritiga (xagga Aqoonsiga ID keliya)
Cinwaanka guriga aad iminka daggan tahay	Cinwaanka dirista boostada (haddii uu ka duwan yahay cinwaanka guriga)
Magaalada Gobolka Zip Code	Magaalada Gobolka Zip Code
☐ Waxaan jeclahay in warqadaheyga loo diro Wakiilkeyga (sii magaca iyo cinwaanka wakiilka si loogu diro warqadaha)	

Taariikhda dhaawaca asalka	Waa la xeray taariikhda sheegashada
Loo shaqeeyaha waqtiga dhaawaca asalka	Magaca buuxa takhtarka ku daweeyay waqtiga la xero sheegashada
Maxay yahiin qeybaha jirkaada ay waxyeelada ka soo gaartay dhaawacaan/xanuunkaan?	Taariikhda xaaladda ka sii dartay kaddib marka la xeray sheegashada

Maxay yahiin ashtakooyinka jirka aad iminka qabtid?	Ma la kullantay dhaawacyo cusub/xanuun laga bilaabo marka sheegashada la xeray? ☐ Maya ☐ Haa Haddii ay haa tahay, sharax
Xaaladaada ma ka sii dartay taasoo ugu wacan dhaawac kale/shil kugu dhacay inta aad ku sugan tahay shaqada ama dibadda ka tahay? ☐ Maya ☐ Haa Haddii ay haa tahay, sharax	Ma lagaa daweeyay xaaladaan laga bilaabo marka la xeray sheegashada? ☐ Maya ☐ Haa Haddii ay haa tahay, qor magaca (magacyada) iyo cinwaanka (cinwaanada) takhtarka (takhaatiirta) ku daweeyay.
Magaca Takhtarka Nambarka telefoonka	Magaca Takhtarka Nambarka telefoonka
Magaalada Gobolka Zip Code	Magaalada Gobolka Zip Code

Ma shaqeysaa?
☐ Haa ☐ Maya Haddii ay maya tahay, maxay tahay sababta? ☐ Hawl gab ☐ Awood uma lihid in aad shaqeeysid ☐ Waa lagaa fadhiisiyay shaqada ☐ Waad ka tagtay shaqada Taariikhda ugu dambeysay aad shaqeysay:

Ma dalbatay ama ma qaadataa manaafacaadka hoos ku qoran?
☐ Shaqo La'aanta ☐ Fasaxa jirrada ☐ Kaalmada dadweynaha ☐ Manaafacaadka hawlgabnimada ☐ Ceymiska itaal darrida
☐ Ma jiraan magdhaw kale oo la xariira warshadaha? (sida Shaqaalaha Longshore iyo Dakadda, Sharciga Jones, Treenka)

Loo-shaqeeyaha aad iminka u shaqeysid ama midkii ugu dambeeyay	
Cinwaanka Nambarka telefoonka	
Magaalada Gobolka Zip Code	
Nooca ganacsiga	Ilaa intee ayaad u shaqeysay loo-shaqeeyehaan?
Mansabka shaqadaada iyo waajibaadka ku saarnaa	

Maxay ahayeen loo-shaqeeyeyaasha kale iyo mansabyada shaqada aad haaysay laga bilaabo marka sheegashadaada la xeray?

Xasuuso: Dadka sheega warar been ah si ay u helaan manaafacaadka ceymiska warshadaha waxaa lagu qaadi doonaa ciqaabta madaniga iyo dambiga. Aniga waxaan ku dhawaaqaa in wararkaan yahiin run ilaa inta aan ogahay iyo rumaysanahay. Marka aan

saxiixo foomkaan, waa Aniga oo ogolaaday in takhaatiirta, isbitaalada, kliinikada ama kuwa kale ee haysta macluumaadka caafimaadka in ay diiwaankeyga caafimaadka siiyaan Waaxda Shaqada iyo Warshadaha iyo/ama Loo-Shaqeeyaha Naftiisa Ceymiya.

Saxiixa sheegtaha

Taariikhda

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.