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

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

Codsiga in Dib loo furo Sheegashada
Ay sababtay Xaalada Ka sii draysa

Lambarka Sheegashada

Macluumaadka Shaqaalaha

Dhammaystir qaybtaada si buuxda oo u gudbi adeeg bixiyaha ku dawaynaha 30 maalmood gudahood ee adeegyada caafimaadka ay lama huraan ka dhigeen xaalada ka sii daraysa ee caafimadkaaga. Codsigan waxaa dhammaystiray adiga iyo adeeg bixiuayaahaga **waa in** ay heshaa Waaxda ama iskeed u caymiyha 60 maalmood gudahooda adeegyo kasta oo caafimaadka oo uu lama huraan ka dhigay ka sii darkaagu.

Isticmaal foomkan keliya haddii xaaladaada caafimaad ay ka sii dartay oo sheegashadaada la xidhay in ka badan 60 maalmiid. Haddii uu kugu dhacay dhaawac ***cusub*** xaga shaqada,buuxi Warbixinta cusub ee Dhaawaca Warshada iyo foomka Cudurka Shaqada.

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. Waxaad heli doontaa macluumaadka ku saabsan dib u furida codsiga gudaha 90 maalmood ee helitaanka did u furida codsiga ay Waaxdu heshay.

Magaca (Koowaad,Dhexe, Ka dambe)	Miyuu magacaagu isbeddelay ilaa markii sheegashadaada la xidhay> ☐ Maya ☐ Haa Haddii haa, qor magacii hore:
Lambarka telefoonka guriga	Lambarka Sooshalka siykuyuuratiga (ee Aqoonsiga oo keliya)
Ciwaanka guriga hadda	Cinwaanka boosta (haddii ay ka duwan tahay cinwaanka guriga)
Magaalada Gobolka Sibka Lambarka	Magaalada Gobolka Sibka Lambarka
☐ Waxaan door bidyaa wada xidhiidhkayaga inay u tagaan wakiilkayga (magac sii iyo wakiilka cinwaankiisa boosta)	

Taarikhda dhaawaca asalka ah	Taariikhda sheegashada la xidhay
Loo shaqeeyaha wakhtiga dhaawaca asalka ah	Magaca buuxa ee dakhtarka ku dawaynayay wakhtiga xidhitaanka sheegashada.
Qaybtee jidhkaaga ah ayay saamaysay dhaawacan/cudurkan?	Taariikhda xaaladu ka sii dartay ka dib xidhitaanka sheegashada

Waa maxay cabashooyinkaaga jidhka ee hadda?	Ma lahayd wa dhaawacyo cusub/jirooyin ilaa taariikhda xidhitaanka sheegashada? ☐ Maya ☐ Haa Haddii haa, sharax
Miyay xaaladaadu ka sii dartay iyaddoo ay sababtay dhaawac kale/shil miduun jooga ama ka maqan shaqada? ☐ Maya ☐ Haa Haddii haa, sharax	Miyaad heshay wax daawayn caaafimaad ah xaaladan ilaa xidhitaanka sheegashadaada? ☐ Maya ☐ Haa haddii haa, qor magaca(yada) iyo cinwaanka(nada) ee dhakhtarka(da) dawaynaya.
Magaca dhakhtarka Lambarka tekefoonka	Magaca dhakhtarka Lambarka tekefoonka
Magaalada Gobolka Sibka Lambarka	Magaalada Gobolka Sibka Lambarka

Ma shaqaynaysaa?
☐ Haa ☐ Maya Haddii maya, sababtee? ☐ Hawl gabay ☐ Aan shaqayn karin ☐ Shaqada laga dhimay ☐ Tegay
Maalinta u dambaysay ee la shaqeeyay:

Miyaad codsatay ama ma helaysaa wax dheefaha hoos ku qoran ah?
☐ Shaqo la'aanta ☐ Fasaxa shaqada ☐ Kaalmada dad waynaha ☐ Dheefaha hawl gabka ☐ Caymiska naafada
☐ Wax kale oo magdhowga caymiska warshada ah? (waxaa loola jeedaa Longshore iyo Shaqaalaha Dekada, Jones Act, Railroad)

Loo shaqeeyaya hadda iyo kii hore	
Cinwaanka	Lambarka telefoonka
Magaalada	Gobolka Lambarka Sibka
Nooca ganacsiga	Intee in leeg ayaad u shaqaysay loo shaqeeyahan?
Cinwaankaaga shaqada waajibaadka	

Loo shaqeeyayaashee kale iyo cinwaanadee shaqada ayaa lahayd ilaa intii sheegashadaada la xidhay?

Fiiro: Qofka samaynaya warbixin been ah si uu u helo dheefaha adeega warshada waxaa la marin doonaa ciqaabaha madaniga ah ama falka dembiyeed. 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 Loo shaqeeyaha Iskiis caymiska u leh.

Saxeexa dacwoodaha ama 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.

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.