Dept. of Labor & Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

Dept of Labor & Industries
Self Insurance
PO Box 44892
Olympia WA 98504-4892

APPLICATION TO REOPEN CLAIM

DUE TO WORSENING OF CONDITION

WORKER INFORMATION
Complete your portion in FULL for prompt action

Claim number

Important: Only use this form if your medical condition has worsened, and your claim has been closed for more than 60 days. If time loss benefits are paid before a decision about reopening is made and your claim is not reopened, you will be required to repay those benefits. Please write your claim number above. You will receive information about your reopening application within 90 days of the Department's receipt of the reopening application. If you have had a **new** injury at work, complete a new Report of Industrial Injury or Occupational Disease form in lieu of this application.

1. Name (first, middle, last)

2. Name changed since claim closed? Yes ☐ No ☐
If yes, list previous name

3. Home phone no.

4. Soc. Sec. No. *(for ID only)*

5. Present home address

6. Mailing address(if different than home address)

7. City State ZIP

8. City State ZIP

8a. I prefer my correspondence go to my Representative.
Name: Address State ZIP

9. Date of original injury / /

10. Employer at time of original injury

11. What are your present physical complaints?

12. Date claim closed / /

13. Date condition became worse after claim closure? / /

15. Full name of doctor treating you at time of claim closure

14. What parts of your body are affected by this injury/disease?

16. Have you had any new injuries or illnesses since the date of claim closure? If yes, explain.

17. Did your condition worsen due to another injury or accident either on or off the job? Yes ☐ No ☐ If yes, explain.

18. Have you received any medical treatment for this condition since claim closure? Yes ☐ No ☐
If yes, list name and address of treating doctor(s).

19. Doctor Phone number
Address
City State ZIP+4

20. Doctor Phone number
Address
City State ZIP+4

21. Have you applied for or are you receiving ? (check correct box(es))
Unemployment ☐ Public assistance ☐
Sick leave ☐ Retirement benefits ☐
Disability insurance ☐

22. Are you working? Yes ☐ No ☐ If no, Why? Retired ☐ Laid off ☐ Unable to work ☐ Quit ☐

23. Last date worked / /

Any other Industrial Insurance compensation? ☐ If checked, explain.
(i.e., Longshore harbor workers, Jones Act, Railroad)

24. Present or last employer
Address Phone number
City State ZIP+4

28. What other employers & job titles have you had since your claim was closed?

25. Your job title and duties

26. Type of business

27. How long have you worked for this employer?

NOTE: Persons making false statements in obtaining industrial insurance benefits are subject to civil and criminal penalties. I declare that these statement are true to the best of my knowledge and belief. In signing this form, I permit doctors, hospitals, clinics or others with medical information to release my medical records to the Department of Labor & Industries and/or the Self Insured Employer.

Dept. use only

Today's date / /

Claimant's signature
X

CONTINUE FOR DOCTOR'S INFORMATION

Claim number

DOCTOR'S INFORMATION (complete form in FULL)

Please complete this form and send it to the Department of Labor & Industries. It will enable us to determine if the current medical condition is due to a worsening of a previous work-related 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. 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.

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 this industrial injury or occupational disease? Yes ☐ No ☐

4a. 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**

4b. Upon what information did you rely to make the comparison to substantiate worsening of the industrial injury or occupational disease.

☐ Doctor at the time of claim closure ☐ Contacted the previous doctor
☐ 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

10. Diagnosis of condition found by examination.

ICD Diagnosis Codes

☐☐☐.☐☐
☐☐☐.☐☐
☐☐☐.☐☐

Doctor's name (type or print) | Phone no.

Address | City | State ZIP + 4

Today's date / / | L&I provider no. | Doctor'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