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

Application to Reopen Claim
Due to Worsening of Condition

Claim Number

Worker Information

Complete your portion in full and submit it to your treating provider within 30 days of any medical services made necessary by a worsening of your medical condition. The application completed by you and your provided **must** be received by the Department or self-insurer within 60 days of any medical services made necessary by your worsening.

Use this form only if your medical condition has worsened and your claim has been closed for more than 60 days. If you have had a ***new*** injury at work, complete a new Report of Industrial Injury or Occupational Disease form.

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. You will receive information about your reopening application within 90 days of the Department's receipt of the reopening application.

Name (First, Middle, Last)	Has your name changed since your claim closed? ☐ No ☐ Yes If yes, list previous name:
Home phone number	Social Security Number (for ID only)
Current home address	Mailing address (if different from home address)
City State Zip Code	City State Zip Code
☐ I prefer my correspondence go to my representative (give name and mailing address of representative)	

Date of original injury	Date claim closed
Employer at the time of the original injury	Full name of doctor treating you at time of claim closure
What parts of your body are affected by this injury/disease?	Date condition became worse after claim closure

What are your present physical complaints?	Have you had any new injuries/illnesses since the date of claim closure? ☐ No ☐ Yes If yes, explain
Did your condition worsen due to another injury/accident either on or off the job? ☐ No ☐ Yes If yes, explain	Have you received any medical treatment for this condition since claim closure? ☐ No ☐ Yes If yes, list name(s) and address(es) of treating doctor(s).
Doctor name Phone number	Doctor name Phone number
City State Zip Code	City State Zip Code

Are you working?
☐ Yes ☐ No If no, why? ☐ Retired ☐ Unable to work ☐ Laid off ☐ Quit Last date worked:

Have you applied for or are you receiving any of the benefits listed below?
☐ Unemployment ☐ Sick leave ☐ Public assistance ☐ Retirement benefits ☐ Disability insurance
☐ Any other industrial insurance compensation? (i.e. Longshore and Harbor Workers, Jones Act, Railroad)

Present or last employer	
Address	Phone number
City State Zip Code	
Type of business	How long have you worked for this employer?
Your job title and duties	

What other employers and job titles have you had since your claim was closed?

Note: Person making false statement in obtaining industrial service benefits are subject to civil and criminal penalties. I declare that these statements 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 and Industries and/or the Self-Insured Employer.

Claimant's signature Date

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.

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