Department of Labor and Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520
Fax 360-902-5333

APPLICATION TO REOPEN CLAIM

DUE TO WORSENING OF CONDITION

VICTIM 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 90 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 request within 90 days of the department's receipt of the 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?
14. Full name of provider treating you at time of claim closure
15. What parts of your body are affected?
16. Have you had any new injuries or illnesses since the date of claim closure? Yes ☐ No ☐ If yes, explain.
17. Did your condition worsen due to another injury or accident? 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 provider(s).
19. Provider Phone number
    Address
    City State ZIP+4
20. Provider Phone number
    Address
    City State ZIP+4
21. Have you applied for or are you receiving any of these benefits? (check all that apply)
    Unemployment ☐ Public assistance ☐
    Sick leave ☐ Retirement benefits ☐
    SSI/SSA ☐ Disability insurance ☐
    Medicare ☐ Worker compensation ☐

    Are any other Industrial Insurance compensation? (i.e., Longshore harbor workers, Jones Act, Railroad)
    ☐ If checked, explain
22. Are you working? Yes ☐ No ☐ If no, Why? Retired ☐ Laid off ☐ Unable to work ☐ Quit ☐
23. Last date worked
24. Present or last employer Phone number
    Address City State ZIP+4
25. Type of business
26. Your job title and duties
27. How long have you worked for this employer?

NOTE: Persons making false statements in obtaining Crime Victims Compensation 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 Crime Victims Compensation Program.

Dept. use only

Today's date

Victim's signature
X

CONTINUE FOR PROVIDER'S INFORMATION

PROVIDER'S INFORMATION (complete form in FULL)	Claim number

A claim can **only** be reopened if there is 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 this form. Payment for any additional services 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 address on the application. Bills should be sent separately.

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 the covered injury? ☐ Yes ☐ No

4a. List physical or psychological examination in detail, including all objective findings referable to complaints and areas involved in your claim. If evaluating a mental condition, please give relationship of all symptoms to the covered injury. Is there a preexisting physical or psychological condition that will retard recovery?

4b. Upon what information did you rely to make the comparison to substantiate worsening? (check box)

☐ Provider at the time of claim closure ☐ Contacted the previous provider
☐ 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 some form of work.

10. Diagnosis of condition found by examination.

ICD Diagnosis Codes

Provider's name (type or print)			Phone no.
Address	City	State	ZIP+4
Today's date	CVCP provider no. / NPI#	Provider'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