



# CARRIER'S REQUEST FOR OCCUPATIONAL LUNG CENTER EXAMINATION

Claims Services Division  
PO Box 50541  
Charleston, WV 25305

Only medical information received by the Insurance Commission at least 10 days prior to the examination date will be considered during the examination.

## CLAIMANT INFORMATION

- 1. **Claimant Name:** \_\_\_\_\_  
First Name
Middle Name or Initial
Last Name
Generation
- 2. **Claimant Address:** \_\_\_\_\_  
Street, City, State, Zip
- 3. **Claimant Phone #:** (\_\_\_\_) \_\_\_\_\_ **4. Claimant SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Include Area Code
- 5. **Carrier's Claim ID #:** \_\_\_\_\_ **6. Date of Last Exposure with Most Recent Employer:** \_\_\_\_\_  
**Jurisdiction Claim #:** \_\_\_\_\_

## REASON FOR LUNG CENTER EXAMINATION

7. Please mark application reason stated below:

**PRESUMPTIVE**

**NON-PRESUMPTIVE**

**New Claim Filing**

**Date of Application:** \_\_\_\_\_

Submit the following information for every claim on file under the claimant's SSN:

- (1) Non-medical Decision (Required)
- (2) Employee's Report of Occupational Pneumoconiosis (Required)
- (3) Physician's Report of Occupational Pneumoconiosis (Required)
- (4) Physician's International Labor Organization (ILO) Form (Required)
- (5) Employer's Report of Occupational Pneumoconiosis (When Available)
- (6) Adjudicated Awards and Compensability Decisions (if applicable)(Final Order) (Required)
- (7) Previous Occupational Pneumoconiosis Board Findings (Required)

**Claim Reopening**

**Date of Application:** \_\_\_\_\_

Submit the following information for every claim on file under the claimant's SSN:

- (1) Request for Reopening (Required)
- (2) Reopening Decision (Required)
- (3) Medical Evidence Provided with Reopening Request (Required)
- (4) Adjudicated Awards and Compensability Decisions(if applicable) (Final Order) (Required)
- (5) Previous Occupational Pneumoconiosis Board Findings (if applicable) (Required)

**Requested Due to Outcome of Litigation**

Submit the following information for every claim on file under the claimant's SSN :

- (1) Copy of Litigation Decision from Office of Judges, Board of Review or Supreme Court (Required)
- (2) Adjudicated awards and Compensability Decisions (if applicable) (Final Order) (Required)
- (3) Previous Occupational Pneumoconiosis Board Findings (if applicable) (Required)

**Fatal Dependent Benefits**

**Date of Death:** \_\_\_\_\_

Submit the following information for every claim on file under the claimant's SSN:

- (1) Non-Medical Decision (Required)
- (2) Application for Dependent Benefits (Required)
- (3) Death Certificate (Required)
- (4) Autopsy Report (If Autopsy Performed)
- (5) Pathology Reports (When Available)
- (6) Other Medical Information - X-Rays and X-Ray Reports (Required) **Do Not Send Digital X-Ray Recorded on CD**
- (7) Adjudicated awards and Compensability Decisions (if applicable) (Final Order) (Required)
- (8) Previous Occupational Pneumoconiosis Board Findings (if applicable) (Required)

## CARRIER AND CONTACT INFORMATION

- 8. **Carrier Name:** \_\_\_\_\_
- 9. **Contact Person's Name:** \_\_\_\_\_
- 10. **Contact Person's Phone Number:** \_\_\_\_\_
- 11. **Contact Person's Email Address:** \_\_\_\_\_
- 12. **Contact Person's USPS Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 13. **Contact Persons' Signature:** \_\_\_\_\_
- 14. **Date Signed:** \_\_\_\_\_

RETURN COMPLETED DOCUMENT AND ATTACHMENTS TO ADDRESS AT TOP OF FORM. Incomplete requests will be