

# Claim Re-Opening Application for Permanent Partial Disability

## Section I

**Claimant** – Complete Section I of this form and submit it to your doctor. He or she must then complete Section II of this form in detail, and must attach a narrative report if necessary.

After completion, please forward this application for benefits and any supporting evidence to your private carrier/self-insured/TPA administering your Workers' Compensation claim.

**PLEASE PRINT OR TYPE**

1. Claimant's Name (First, Middle, Last)	2. Social Security Number	3. Date (mm/dd/yyyy)
4. Mailing Address (Street or P.O. Box, City, State, Zip)	5. Telephone Number (include area code)	6. Claim Number
<p>7. The claimant hereby petitions to re-open the above-captioned claim for the following reasons:</p> <p style="margin-left: 20px;">7a. To be examined by permanent partial disability/impairment rating due to:</p> <p style="margin-left: 40px;"> <input type="checkbox"/> Aggravation and/or progression of condition or disability resulting from the compensable injury or occupational disease.  <input type="checkbox"/> Fact or factors pertaining to the disability or condition not previously considered by the OIC in previous findings.         </p>		
<p>8. Have you suffered from any other illness and/or injuries since the injury upon which this claim is based?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p style="margin-left: 20px;">If yes, specify the nature of the illness and/or injuries, the dates of the illnesses, and/or injuries, and list the name(s) and address(s) of the physician(s) who treated you.</p>		
<p>9. Have you filed any other claim(s) for Workers' Compensation?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, please list all claim numbers and/or dates of injuries or occupational disease.</p>		
<p>10. Have you drawn unemployment or wage replacement benefits since the injury or occupational disease covered by this claim?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p style="margin-left: 20px;">If yes, for what period?    Dates:    From:    /    /    To:    /    /</p>		
<p>11. Do you continue to work for the employer for whom you were working at the time of the injury or occupational disease?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p style="margin-left: 20px;">If no, please provide the name and address of current employer.</p>		
<p>12. Have you retired?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, please list the employer's name and any benefits (e.g. Social Security, pension, etc.) you are receiving.</p>		
13. Claimant's Signature	Date:	

**SECTION I – TO BE COMPLETED BY CLAIMANT**

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## Section II

1. Physician's Name, Address, and Telephone Number	2. Physician's FEIN or Vendor Number
3. Were you the treating physician for this claim, or are you a new treating physician? <input type="checkbox"/> Treating Physician for claim <input type="checkbox"/> New Treating Physician	4. Date of examination upon which these findings are based
5. List the current diagnosis for which you are performing the impairment rating (include specific ICD10-CM codes and description), and indicate whether or not you are requesting a rating on a different body part.	
6. List the claimant's complaints as they relate to the compensable injury or occupational disease.	
7. Has there been an aggravation or progression of the claimant's disability since being released to resume employment or being certified as having reached the maximum degree of medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, list the physical findings that relate to the aggravation/progression of the injury or occupational disease. (Please provide a short narrative.) Please submit the results:	
8. Can the claimant work at his or her regular job, or can he or she be returned to light duty? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, will the injured worker benefit from rehabilitation services?	
9. Has the injured worker reached the maximum degree of medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Using the Range-of-Motion model, provide tables and charts used to arrive at the degree of permanent partial disability in terms of whole person percentage. Please apply Title 85 Rule 20 to the exam.	
11. Please list any previous percentages given for the same body part, and indicate whether or not it should be subtracted from the impairment rating.	
12. Physician's Signature	Date

**SECTION II – TO BE COMPLETED BY THE PHYSICIAN IN DETAIL AND A NARRATIVE REPORT ATTACHED IF NECESSARY**