Print Form

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 #:** (____) _____ (Include Area Code)
4. **Claimant SSN:** _____ - ___ - _____
5. **Carrier's Claim ID #:** _____
   Jurisdiction Claim #: _____
6. **Date of Last Exposure with Most Recent Employer:** _____

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 - digital x-rays, x-rays, and x-ray reports. (Required)
(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 returned to the carrier/responsible administrator.

(Rev. 8/2007)