



Claim Re-opening Application for Permanent Partial Disability

Return completed form to:
BrickStreet Mutual Insurance
P.O. Box 3151
Charleston, WV 25332-3151

PLEASE PRINT OR TYPE

- Step 1 Claimant** – Complete Section I and take this form to your doctor.
- Step 2 Physician** – Complete Section II and return this form to the claimant for delivery to employer at time of injury, or send to BrickStreet Mutual Insurance at P.O. Box 3151, Charleston, WV 25332-3151.
- Step 3 Claimant** – Send completed form to BrickStreet Mutual Insurance at P.O. Box 3151, Charleston, WV 25332-3151. It is your responsibility to see that BrickStreet Insurance receives the completed form.

1. Claimant's Name (First, Middle, Last)	2. Social Security Number	3. Date of Injury / /
4. Mailing Address (Street or P.O. Box, City, State, Zip)	5. Telephone Number (include area code)	6. Claim Number
7. The claimant hereby petitions BrickStreet Insurance to re-open the above-captioned claim for the following reasons: 7a. To be examined for permanent partial disability/impairment rating due to: <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 BrickStreet Insurance in previous findings.		
8. Have you suffered any other illness and / or injuries since the injury upon which this claim is based? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify the nature of the illness and/or injuries, the dates of the illnesses and / or injuries and list the names and address of the physicians who treated you.		
9. Have you filed any other claims with BrickStreet Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all claim numbers and/or dates of injuries or occupational disease.		
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 If yes, for what period? Dates: From / / To / /		
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 If no, please give name and address of current employer.		
12. Have you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list employer's name and any benefits (i.e. Social Security, pension, etc.) you are receiving.		
13. Claimant's Signature	Date	

SECTION I – TO BE COMPLETED BY CLAIMANT

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

1. Physician's Name, Address and Telephone Number	2. Physician's FEIN or Vendor Number
3. Were you the treating physician in this claim or are you a new treating physician? <input type="checkbox"/> Treating Physician in 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 ICD9-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 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, give tables and charts used to arrive at the degree of permanent partial disability in terms of whole person percentages. 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