General Instructions for Completion of the BI-125 Claim Re-opening Application for Temporary Total Disability / Wage Replacement or Medical Treatment Benefits

Please Read Carefully

TO THE PHYSICIAN

A reopening cannot be initiated until the re-opening form, BI-125, has been completed in its entirety and submitted to BrickStreet Mutual Insurance.

SECTION I: EMPLOYEE SECTION

7a – Check box if you are requesting medical treatment only.

7b – Check first box if you are requesting temporary total disability/wage replacement benefits and you are missing time from work. Check the second box if **new** facts pertaining to the disability or condition have not previously been considered by BrickStreet. Once completed, go to line 13 and sign and date.

7b – Check this box if there is an aggravation/progression of the condition or disability that resulted from the compensable injury. Check the second box if **new** facts pertaining to the disability or condition were not previously considered by BrickStreet. Once completed, go to line 13 and sign and date.

SECTION II: EMPLOYER SECTION (OPTIONAL)

This section is optional, complete as needed.

This section should be completed by the employer for whom the claimant was working at the time of the injury or occupational disease covered by this claim. Although this section is optional, its completing may expedite the consideration of the petition.

4 – As the employer, you can expedite the re-opening of the claim by waiving the 10-day notice.

SECTION III: PHYSICIAN SECTION

If re-opening for medical treatment only, complete questions 1 to 8. Skip question 9 and 10, and sign and date line 11.

10 – Specify dates that the claimant may be absent from work.

11 – Physician must sign and date form on the date of the examination.

BI-125

Claim Re-opening Application for Temporary Total Disability/Wage Replacement or Medical Treatment Benefits

01/06

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 III 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 (Optional) Claimant – Take this form to the employer for whom you worked at the time of your injury to complete Section II.
Step 4 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.

SECTION I – TO BE COMPLETED BY CLAIMANT

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. Please check the appropriate boxes:

7a. I am requesting medical benefits due to:
- ☐ Aggravation and/or progression of my condition resulting from the compensable injury or occupational disease.
- ☐ Fact or factors pertaining to my condition not previously considered by BrickStreet Insurance in previous findings.

7b. I am requesting additional Temporary Total Disability (TTD)/Wage Replacement benefits due to:
- ☐ Aggravation and/or progression of condition or disability resulting from the compensable injury or occupational disease.
- ☐ 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? ☐ Yes ☐ No
If yes, specify the nature of the illness and/or injuries, the dates of the illnesses and / or injuries. Please list the names and address of the physicians who treated you.

9. Have you filed any other claims with BrickStreet Insurance? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No
If no, please give name and address of current employer.

12. Have you retired? ☐ Yes ☐ 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 II – EMPLOYER (OPTIONAL)

1. Employer's Name, Address and Telephone Number (include area code)	2. Do you disagree with any of the information contained in Section I or III of this form? ☐ Yes ☐ No If yes, explain the information with which you disagree. Be specific.
3. The claimant began missing work again on / /	4. The employer waives the 10-day notice period and does not object to BrickStreet's immediate ruling on the claimant's petition. ☐ Yes ☐ No

5. Employer's Signature	Title	Date

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? ☐ Treating Physician in Claim ☐ New Treating Physician	4. Date of examination upon which these findings are based

5. List the current diagnosis (include specific ICD9-CM codes and description), and indicate if you are requesting that a new body part be added.

6. List the claimant's complaints as it relates 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? ☐ Yes ☐ No

If yes, list the physical findings that relate to the aggravation/progression of the injury or occupational disease.
Please indicate the date and location for any diagnostic testing that was administered, as well as the results.

8. List any requests for authorizations as it relates to the compensable injury or occupational disease. Please attach any office notes or medical reports.

9. Can the claimant work at his or her regular job, or can he or she be returned to light duty? ☐ Yes ☐ No

If yes, list any work restrictions on the patient's functional abilities.

10. Please list exact periods of Temporary Total Disability/Wage Replacement: From / / To / /

11. Physician's Signature	Date