

THE INDUSTRIAL COMMISSION OF ARIZONA CLAIMS DIVISION



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Claims Division: (602) 542 4661
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LAURA L. MCGRORY, DIRECTOR
TERESA HILTON, SECRETARY

RE: PETITION TO REOPEN

Before consideration can be given to reopening your file, it will be necessary for you to submit a Petition to Reopen based on **new, additional or previously undiscovered disability or condition**, along with a statement from your physician setting forth the relationship of your present condition to the industrial injury.

We are enclosing the Petition to Reopen form. It must be filed with the Industrial Commission of Arizona, P.O. Box 19070, Phoenix, Arizona 85005-9070.

The payment of such reasonable and necessary medical expenses will be paid for if the claim is reopened as provided by law and if such expenses are incurred within FIFTEEN (15) DAYS of the filing of the Petition to Reopen.

No surgical benefits or monetary compensation shall be payable for any period prior to the date of filing of the Petition.

Industrial Commission of Arizona
Claims Department
Compliance Section

PETITION TO REOPEN LTR.DOC

INDUSTRIAL COMMISSION OF ARIZONA

IMPORTANT: This completed form must be filed at an Industrial Commission of Arizona (ICA) office. (See addresses below.) The form must be accompanied by a current medical report supporting the reopening of the claim.

PETITION TO REOPEN BASED ON NEW, ADDITIONAL OR PREVIOUSLY UNDISCOVERED DISABILITY OR CONDITION

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the ICA claims and hearing process are available at the ICA offices and through the ICA web-site located at: www.ica.state.az.us

Injured Worker	Social Security No. * _____
Defendant Employer	Date of Injury: _____
Defendant Insurance Carrier	ICA Claim No.: _____
	Ins. Carrier Claim No.: _____

Reopening is requested based on the new, additional or previously undiscovered disability or condition listed below related to this claim:

1. Check one of the following:

- Attached is a medical report to support this Petition to Reopen.
 or
 Dr. _____ will submit a report to support this Petition to Reopen.

2. The following physicians have examined or treated me within the past two years for the conditions listed:

DOCTOR'S NAME	ADDRESS	CONDITION AND DATE OF TREATMENT
A.		
B.		

3. I have worked for the following employers within the past two years.

NAME	ADDRESS	JOB DESCRIPTION
A.		
B.		

I have read this Petition to Reopen and the information contained is true and correct to the best of my knowledge.

Signature of person or the person's authorized representative requesting reopening is REQUIRED.

Date

Address

Telephone No.

City State Zip

Phoenix: Mailing address: Industrial Commission of Arizona P.O. Box 19070 Phoenix, Arizona 85005-9070	Street Address: 800 W. Washington Street Phoenix, Arizona 85007-2922	Tucson: Office: Industrial Commission of Arizona 2675 E. Broadway Tucson, Arizona 85716-5342
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* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

MEDICAL AUTHORIZATION

By this medical authorization or reproduction, I authorize and request each physician and person in the medical or related fields and each hospital, clinic, establishment or place rendering me any medical or related service to allow The Industrial Commission of Arizona or its authorized representative, my employer or its insurance carrier and each person and physician appointed by them to have, examine and/or copy any and all information, records and X-rays, regarding my physical condition and treatment.

Signature of person or the person's authorized representative requesting reopening.

Date

Address

Telephone No.

City State Zip