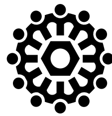


Montana Department of
LABOR & INDUSTRY

DATE STAMP *For Department Use Only*

Petition To Reopen Closed Medical Benefits

Please see instructions on page 2.

1. Injured Worker's Name:	
Address:	Phone:
	Email *(optional)*:
	Date of Birth:
2. Your Worker's Compensation Claim Number: *(optional)*	
Date of Injury:	Body Part:
3. Attorney's Name: *(if applicable)*	
Address:	Phone:
	Email *(optional)*:

4. Preferred review process:	**5. What is your current work status?**	**6. Has there been a settlement approved for medical benefits?**
Medical Director only	Working at my time of injury job	Yes
Panel Review (including medical director)	Working at modified or different job	No
	Not Working	

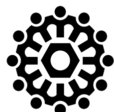
7. Describe how the reopening of medical benefits will keep you at work or return you to work.
Attach additional pages and supporting medical documents as needed.

8. Describe your current job or modified job including the number of hours you are working. If you are not working describe your attempts to return to work and the barriers you encountered. Attach additional pages and supporting medical documents as needed.

By signing below, I authorize the release of all of my health care information in the possession of the insurer or a medical provider, whether generated by the health care provider or any other source, to the Montana Department of Labor and Industry (DLI) and/or its agents for the purpose of evaluating my petition for reopening of workers' compensation medical benefits pursuant to § 39-71-717, Mont. Code Ann. This release is subject to my revocation at any time. This release is effective only as long as I am claiming workers' compensation medical benefits.

Injured Worker's Signature:

Date:


Montana Department of
LABOR & INDUSTRY

Instructions

Petition To Reopen Closed Medical Benefits

Only the injured worker or their legal representative is eligible to complete this form.

The purpose of this form is to:

1. Allow the injured worker the opportunity to reopen medical benefits which could allow him/her to stay at work or return to work.
2. Obtain the necessary information for the Department to review the request and when appropriate approve the petition.

Field 1: Fill in the injured worker's name, current mailing address, telephone number or contact telephone number and date of birth are required. If there is neither a telephone number nor a contact number indicate by using "NONE". Email address is optional.

Field 2: The date of injury and the body part injured is required field. The Worker's Compensation Claim Number is optional.

Field 3: If the injured worker has an attorney representing him/her, the attorney's name, address, phone number are required. Email is optional. If no attorney is being retained indicate by N/A.

Field 4: The injured worker must indicate his/her preferred form of review by checking the appropriate box and is required.

If choosing the Medical Director only, your review will be performed by the department's Medical Director. The doctor will review your medical files and will make a decision based on the documentation received in conjunction with the Utilization and Treatment Guidelines.

If you choose a panel review, the Medical Director and two other doctors will review the medical files submitted for the review. Each doctor and the Medical Director will review your file independently and make their decision. The Medical Director will compile the reviews and the majority will make the decision to reopen or not to reopen you medical benefits in conjunction with the Utilization and Treatment Guidelines.

Field 5: The injured worker must indicate his/her work status by checking the appropriate box and is required.

Field 6: Check the appropriate answer to the question regarding medical settlements only and is required.

Field 7: Explain how the reopening of medical benefits will keep you at work or return you to work. When your petition is accepted, the department will request your medical records from your insurer. However, you are encouraged to include any additional supporting medical documentation, letters, etc. Any medical records or other information submitted by either party which have not previously been provided to the other party, must be sent to the other party at the same time the records or other information are delivered to the department. Add additional pages to this petition if you need more space. This is required.

Field 8: Explain the type of job that you currently have and your current/modified job duties. Include how many hours a week you are working in your current position. If you are not currently working, explain your attempts to return to work and the barriers that you encountered. This is required.

Read the disclosure near the bottom of the page. If you have questions contact the Employment Relations Division (ERD) of the Montana Department of Labor & Industry at (406) 444-6543.

Signature Field:
The injured worker must sign and date the box on bottom of the page. The signature and date is required to reopen the medical benefits.

Send the petition and any supporting documentation to:

MONTANA DEPARTMENT OF LABOR & INDUSTRY
PETITION TO REOPEN CLOSED MEDICAL BENEFITS
P O BOX 8011
HELENA, MONTANA 59604

Or email to: DLIERDReopenWCMedBenefits@mt.gov