

# Joint Agreement and Petition to Reopen Closed Medical Benefits

Date Stamp

For Department Use Only

<p><b>1. Injured Worker's Name:</b></p> <p>Address:</p> <p>Telephone Number:</p> <p>Email (optional):</p> <p>Date of Birth:</p>	<p><b>3. Insurer:</b></p> <p>Contact:</p> <p>Address:</p> <p>Telephone Number:</p> <p>Email (optional):</p>
<p><b>2. What is your current work status?</b></p> <p><input checked="" type="radio"/> Working at my time of injury job</p> <p><input type="radio"/> Working at modified or different job</p> <p><input type="radio"/> Not Working</p>	<p><b>4. MT Agency Claim Number:</b> (optional)</p> <p>Date of Injury:</p> <p>Body Part:</p>
<p><b>5. Has there been a settlement approved for medical benefits?</b></p> <p>Yes <input checked="" type="radio"/> No <input checked="" type="radio"/></p>	

**6. Describe medical benefits you are petitioning to be reopened, including limitations and restrictions.**

**Please include appropriate medical records or letters to support your above position**

The Injured worker and the insurer jointly petition the Department of Labor and Industry to reopen the medical benefits in the workers' compensation or occupational disease claim identified as the MT Agency Claim Number above.

The worker and the insurer jointly petition that the medical benefits described above be reopened, that those medical benefits will remain open for two years or until maximum medical improvement is achieved following surgery or the recommended medical treatment, whichever comes first, and that those medical benefits are subject to the limitation or restrictions described above.

The worker and the insurer each agree that the medical benefits being requested in this petition are necessary and appropriate, and will allow the worker to return to work or continue to work.

The worker and the insurer each understand that **only those medical benefits identified in this Joint Petition, and no other medical benefits**, are being reopened.

The worker and the insurer each agree that this Joint Petition may be reviewed solely by the Department of Labor and Industry's Medical Director and will not be reviewed by a three-physician panel.

By signing all health care information in the possession of the insurer or medical provider, whether generated by the health care provider or any other source, may be released 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 revocation at any time. The revocation is effective from the time it is received in writing to DLI. Authorization is effective only as long as the claimant is claiming workers compensation medical benefits.

Injured Worker's Signature:	Insurer's Signature:
Date:	Date:

Medical Benefits Reopened	date box	Medical Benefits Will Be Reviewed	date box
<p><b>Reviewed by the Medical Director.</b></p> <p>Medical Director's Signature:</p> <p>Date:</p>		<input checked="" type="radio"/> Approved <input type="radio"/> Denied	

## INSTRUCTIONS

The purpose of this form is to:

1. Facilitate a fast and easy way for medical benefits to be reopened that both the injured worker and the insurer agree to and will help the injured worker stay at work or return the injured worker 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 injured worker must indicate his/her work status by checking the appropriate box and is required.

**Field 3:** The insurer's name, contact person (adjustor), mailing address and telephone number are required. The email address is optional.

**Field 4:** The date of Injury and body part injured are required fields. The Montana Agency Number is optional.

**Field 5:** Check the appropriate answer to the question regarding medical settlements only and is required.

**Field 6:** Describe the medical benefits that both parties are petitioning to be reopened. Include any limitations or restrictions that could affect the outcome of the joint petition. Also include how the medical services will allow the injured worker to stay at work or return them to work. This information is required.

**Read the information presented in the middle of the petition carefully.**

**Signature Fields:**

1. The injured worker must sign and date the box on the left hand side of the page. This signifies their agreement with the insurer for reopening the medical benefits. The signature and date is required to reopen the medical benefits listed.
2. The Insurer must sign and date the box on the right hand side of the page. This signifies their agreement with the injured worker for reopening the medical benefits. The signature and date is required to reopen the medical benefits listed.

The boxes below the dark line at the bottom of the page are for the Medical Director's use and are not to be filled out by either the injured worker or the insurer.

Send the petition and any supporting documentation to:

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