The undersigned moves to reopen this coal workers pneumoconiosis claim. The order or award being reopened was:

___ An Order or Award for retraining incentive benefits.

___ An Order or Award for other benefits under KRS 342.732.

___ Dismissed due to a finding of no coal workers pneumoconiosis on x-ray or failure to meet medical eligibility standards.

This Order or Award was issued __________/________/________.
The undersigned states that the grounds for reopening are stated below:

___ Progression of occupational disease resulting from coal workers pneumoconiosis.

___ Development or progression of respiratory impairment due to occupational pneumoconiosis.

___ Review of university x-ray in compliance with reconsideration procedures of KRS 342.732, effective 7-15-02. Last exposure prior to 12-12-96.

___ Review of dismissal or award under KRS 342.732 as effective 7-15-02. Last exposure between 12-12-96 and 7-14-02.

___ Medical fee dispute. Medical bills in question are attached.

___ Other:

__________________________________________________
__________________________________________________
__________________________________________________.

The undersigned further states that the following information is correct:

1. The employee’s last date of exposure to coal dust was ____________________.

2. The employee was awarded ____________ and received ________________ under the prior award or settlement for coal workers pneumoconiosis.

3. The employee /plaintiff states that the employee/plaintiff has _______ or has not _________ had two additional years of exposure to coal dust in the Commonwealth of Kentucky. This additional exposure was with ____________________________ at _______________________.

4. __ No previous motion to reopen has been filed.

___ Previous motion to reopen was filed ____________/__________/_______.

5. On medical fee disputes:

___ Utilization review was done on ___________________. A copy of the decision is attached.

___ Utilization review is not required because

__________________________________________________.
The motion to reopen is supported by the following attached documents:

(INCLUDE IF NEEDED)

1. Affidavit(s) of ________________________________________________.

2. Medical report of ___________________________________________ showing progression of the disease by x-ray and/or pulmonary function studies (FVC, FEV1) showing development or progression of pulmonary impairment attributable to coal workers’ pneumoconiosis.

3. A current medical release (Form 106) which has been signed and witnessed.

4. A copy of the Opinion and Award, Settlement, Agreed Order or Order of Dismissal sought to be reopened.

5. Updated work history (Form 104) and medical history (Form 105).

The undersigned, being duly sworn, states the foregoing statements in this motion and Forms 104, 105, & 106 are true and accurate to the best of my knowledge and belief.

__________________________________________
(MOVANTS SIGNATURE)

Subscribed and sworn to before me this ______ day of _____________ 20____.

__________________________________________
NOTARY PUBLIC

My Commission expires: __________________________ County:______________________

Respectfully submitted,

__________________________________________
(MOVANTS SIGNATURE)

__________________________________________
(MOVANTS STREET ADDRESS)

__________________________________________
(MOVANTS CITY/STATE/ZIP CODE)
Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact commits a fraudulent insurance act, which is a crime.

CERTIFICATE OF SERVICE

I certify that the original was mailed to the Commissioner at the Department of Workers’ Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 and copies of this motion and attachments were mailed to the names and addresses of the parties given below:

Attorney for Employer or Insurance Carrier if applicable: ____________________________________________

(Associated Attorney Name or Law Firm)

________________________________________

(Associated Attorney Address or Law Firm Street Address)

________________________________________

(Associated Attorney Address, City/State/Zip)

Employer or Insurance Carrier: ____________________________

(Company Name or Employer Name)

________________________________________

(Company or Employer Street Address)

________________________________________

(Company or Employer City/State/Zip)

Other Parties, if applicable: ____________________________

(Name of Party)

________________________________________

(Party Street Address)

________________________________________

(Party City/State/Zip)

This ________ day of ________________, 20____.