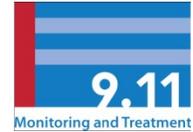

Attachment J

WTC Health Condition Certification Request



New Determinations for WTC Certification

Instructions to WTC Health Program Physician or Licensed Mental Health Professional: This form is to be used to request, for an individual WTC Health Program (WTCHP) member, that the WTC Program Administrator certify the listed WTC-related or medically associated conditions covered under the Zadroga Act. Please indicate if you are also requesting a time-limited authorization to provide medically necessary treatment for one (or more) of these qualifying medical conditions. The time limitation will be indicated upon approval by the WTC Program Administrator. An "Authorization to Release Medical Records" signed by the WTC Health Program member must accompany this certification request for the process to be valid. Please utilize the appropriate medical records release form for your institution to grant such a release of information. Please provide the information requested below, sign the form and submit the signed/completed form and the member's authorization to your Clinical Center of Excellence (CCE). The CCE should fax the completed WTC-3 package (WTC-3 form, condition justification, and member authorization form) to the WTCHP using the secure data transfer or via secure fax line: <1-877-646-5308> (with "WTC-3" and number of pages per member written on the cover page). The CCE can call 1.888.WTC.HP4U (1.888.982.4748) on Mondays-Saturdays from 8 a.m. to 8 p.m. Eastern Time, with any problems regarding the certification process.

1. Provide date/time of request, name and WTC Health Program identification # of the responder or survivor being treated.

Date and Time: _____

Name of WTC Responder or Survivor: _____

Circle whether Responder or Survivor and specify WTCHP ID Number: _____

2. Provide name and contact number/email of the examining WTCHP physician or licensed mental health professional making the determination.

Physician/Licensed Mental Health Professional Name: _____

Contact Information: _____

CCE affiliation: _____

Public reporting burden of this collection of information is estimated to average 30minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

3. This section is only necessary if requesting consideration for a WTC-related condition. Provide the WTC-Related Health Condition and the current respective International Classification of Disease [ICD] code - current for the program year (e.g., 2011-ICD9-CM). Qualifying WTC-related health condition(s):

WTC-related condition NAME	WTC-related condition CODE

I. *Justification of a WTC-related health condition.*

Document that exposure to airborne toxins, other hazards, or adverse conditions resulting from the September 11, 2001, terrorist attacks was determined substantially likely to be a significant factor in aggravating, contributing to, or causing the condition. Specific written (typed) justification is required to meet this criterion, and shall be appended to this form for submission. The extra page(s) should have the member’s name, program ID, and date. The expected length is less than 1 typewritten page; but not to exceed 2 pages. Please refer to the “*Guidance for the Directors of Clinical Centers of Excellence: Physician’s Determination that a Condition is WTC-Exposure Related*” (appended) for assistance in completing this narrative.

[ATTACH justification - 1 to 2 typewritten page(s) using font similar to Times Roman, no smaller than 11 point font, and 1.5 line spacing; include member’s name, program ID, and date]

II. Are you requesting a time-limited authorization pending certification by the WTC Program Administrator in order to provide medically necessary treatment for one of the covered WTC-related conditions?

- Yes Specify which (name and ICD code): _____

- No

4. This section is only necessary if requesting consideration of a medically associated condition. Complete the information about the medically associated condition under consideration, using both the name of the condition, the ICD code and the WTC-related health condition with which it is being associated.

Covered medically associated condition(s) and the paired WTC-related health condition:

Medically associated condition	WTC-related health condition involved

Condition NAME	ICD CODE	Condition NAME	ICD CODE

I. **Justification of a health condition medically associated with a WTC-related health condition.** Is the covered WTC-related condition already certified?

- Yes
- No, but included in this request (see # 3, above)
- No, specify situation _____

II. Select one of following categories of medically associated conditions and provide the medical rationale for association of the stated health condition, including the specific diagnoses of both the WTC-related and medically associated conditions:

- a. **Adverse treatment:** (explain how the health condition has resulted from treatment of a previously certified WTC-related health condition)

- b. **Disease progression:** (explain how the health condition has resulted from progression of the certified WTC-related health condition)

III. Are you requesting a time-limited authorization to provide medically necessary treatment for one of the medically associated conditions?

- Yes Specify which (name and ICD code): _____

- No

Physician or Licensed Mental Health Professional Determination:

With the patient's approval, the medical file is incorporated by reference and available to support the information on the form. By signing below, I certify that the information I have provided on this form is true and accurate. I understand that any false statements or concealment of material facts may subject me to criminal penalties under 18 U.S.C. § 1001 and 18 U.S.C. § 1035.

Physician or Licensed Mental Health Professional Signature _____

Date_____

Do Not Write Below this Line

- Approved by, or on behalf of, the WTC Program Administrator
- Not Approved by, or on behalf of, the WTC Program Administrator

WTC Program Administrator's (or designee's) Signature: _____

Date:_____

WTC-3 SEP 2011