FOR NIOSH USE ONLY

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Authorization for Payment of Autopsy

National Institute for Occupational Safety and Health

Form Approved—CDC/NIOSH
OMB Control No. 0920-0020
Exp

Deceased Miner's Name (Last, First, Middle) _____ **Social Security Number**[1] (Last 4 digits are required) _____

Sex _____ **Date of Birth** (MM/DD/YYYY) ____ / ____ / _____ **Date of Death** (MM/DD/YYYY) ____ / ____ / _____ **Place of Death** (City, State) _____

Miner's next of kin (Last, First) _____ **Relationship** _____

City _____ **State** _____ **Zip Code** _____ **Telephone Number** _____

PARENCHYMAL ABNOMALITIES CONSISTENT WITH PNEUMOCONIOSIS (IF KNOWN)

Small Opacities
Yes ◯
No ◯

Profusion

0/- ◯	0/0 ◯	0/1 ◯
1/0 ◯	1/1 ◯	1/2 ◯
2/1 ◯	2/2 ◯	2/3 ◯
3/2 ◯	3/3 ◯	3/+ ◯

Areas

Zones	Right	Left
Upper	☐	☐
Middle	☐	☐
Lower	☐	☐

Large Opacities
Yes ◯
No ◯

Pneumoconiosis determination based upon *(Select all that apply)*: ☐ X-ray ☐ CT

Was miner the victim of a coal mine disaster?
Yes ◯ No ◯

REQUESTING PATHOLOGIST INFORMATION

Physician's name (Last, First, Middle) _____ **FEIN or SSN**[2] _____ **Date of Birth** (MM/DD/YYYY) ____ / ____ / _____

Hospital or Department _____ **Street Address** _____

City _____ **State** _____ **Zip Code** _____

Telephone Number _____ **Email Address** _____

Active State License(s) Specialty

State: _____ License# _____ Primary _____ Board Certified? Yes ◯ No ◯

State: _____ License# _____ Secondary _____ Board Certified? Yes ◯ No ◯

I am requesting prior authorization and have proposed a payment amount to perform an autopsy on the above listed miner in accordance with 42 CFR 37 SUBPART–Autopsies.

Physician Signature (required for processing) _____ **Date** (MM/DD/YYYY) ____ / ____ / _____

PAYMENT INFORMATION

Proposed Payment Amount for Autopsy _____ **Make payable to** (First, MI, Last Name or Facility) _____

Mail payment to (Hospital or Department) _____ **Street Address** _____

City _____ **State** _____ **Zip Code** _____

Return completed form by secured track-able mail or fax:
Mail to: NIOSH Coal Workers' Health Surveillance Program, 1000 Frederick Lane, Morgantown, WV 26508 Fax: 1-304-285-6058

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NIOSH Official Authorizing Payment (First, Last) _____ **Title** _____ **Signature** _____ **Date** (MM/DD/YYYY) ____ / ____ / _____

[1]Social Security Number (SSN) is requested solely for identification and for payment. It will be treated as confidential information and released only with permission of the requesting pathologist.
[2] Federal Employer Identification Number (FEIN) or Social Security Number (SSN).

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