



Authorization for Payment of Autopsy

National Institute for Occupational Safety and Health

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 ABNORMALITIES CONSISTENT WITH PNEUMOCONIOSIS (IF KNOWN)

Small Opacities	Profusion 0/- 0/0 0/1	Areas			Large Opacities Yes No	Pneumoconiosis determination based upon (Select all that apply): X-ray CT
		Zones	Right	Left		
Yes		Upper				
No	1/0 1/1 1/2	Middle				
	2/1 2/2 2/3	Lower				
	3/2 3/3 3/+					

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

FOR NIOSH USE ONLY

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

¹Social 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).
Public reporting burden of this collection of information is estimated to average 10 minutes 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, Reports Clearance Officer, 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30329; ATTN: PRA (0920-0020). Do not send completed form to this address.