

## Appendix S

### WTC-3 Request for Certification



Form Approved  
OMB No. 0920-0891  
Exp. Date XXXXXX

### Determinations for WTC Certification

**Instructions to WTC Health Program Determining Physician:** This form is to be used to request, for an individual WTC Health Program (WTCHP) member, that the WTC Program Administrator certify the WTC-related or medically associated conditions covered by the WTC Health Program. An "Authorization to Release Medical Records" signed by the WTC Health Program member and the determining physician's attestation statement must accompany this certification request for the process to be valid. Please use the appropriate medical records release form for your institution to grant such a release of information. Please provide the information requested on the required documentation below, complete the other required documentation forms as applicable to this member's health condition(s) certification request and submit the signed/completed forms and the member's authorization to your Clinical Center of Excellence (CCE) or Nationwide Provider Network (NPN). The CCE/NPN should fax the completed WTC-3 package (applicable WTC-3 forms, and member authorization form) to the WTCHP using the secure server 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/NPN 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.

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#### 1. Identifying Member Information:

Date and Time of WTC-3 Certification Request: \_\_\_\_\_

WTC Member Name: \_\_\_\_\_

Responder or  Survivor    WTCHP ID Number (911#): \_\_\_\_\_

Public reporting burden of this collection of information is estimated to average 30 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/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

## 2. Determining Physician Information:

Physician Name (printed): \_\_\_\_\_ Specialty: \_\_\_\_\_

Degree: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

CCE/NPN affiliation: \_\_\_\_\_

## 3. WTC-Related Condition

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., 2015 ICD-10-CM). Qualifying WTC-related health condition(s):

WTC-Related Condition Name	ICD Code	Requesting authorization for time-limited treatment? Y/N

### Justification of WTC-Related Health Condition

Using narrative or suggested templates document that exposure to airborne toxins, other hazards, or adverse conditions resulting from the September 11, 2001, terrorist attacks were determined substantially likely to be a significant factor in aggravating, contributing to, or causing the condition(s). Justification should contain pertinent information about 9/11 exposure and time-linked emergence of symptoms. Please refer to the "WTCHP Policy and Procedure Manual" at <http://www.cdc.gov/wtc/ppm.html> and Policy, Procedure Notices at <http://www.cdc.gov/wtc/policies.html> and the WTC Health Program Codebook and the James Zadroga 9/11 Health and Compensation Act of 2010. 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, WTCHP ID, and date. The expected length is less than 1 typewritten page; but not to exceed 2 pages.

## 4. Medically Associated Condition

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. Establish that the medically associated condition "results from" treatment or progression of the underlying WTC-related condition. The underlying WTC-related health condition must first be certified by the WTC Program Administrator before any conditions may be certified as medically associated with the underlying condition.

Medically Associated Condition Name	ICD Code	WTC-Related Condition Name	ICD Code	Requesting authorization for time-limited treatment? Y/N

- a) Is the underlying WTC-related condition already certified?
- Yes
  - No, but included in this request
- b) Is the associated health condition under consideration a direct **result of the medical treatment** of the WTC-related health condition?
- Yes. If yes, demonstrate in the narrative (including medical records when appropriate) that the health condition “results from” **medical treatment** of the underlying certified WTC-related health condition without the influence of an intermediary health condition or event.
  - No
- c) Is the medically associated health condition under consideration a **result of disease progression** of the WTC-related health condition?
- Yes. If yes, demonstrate in the narrative (including medical records when appropriate) that that the health condition “results from” **progression** of the underlying certified WTC-related health condition without the influence of an intermediary health condition or event.
  - No

Medically Associated Condition Narrative

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## 5. Physician Professional Determination and Attestation:

- (a) 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.
- (b) In regard to the request for WTC-related certification(s) on this WTC-3, I have determined that the member’s exposure to airborne toxins, other hazards, or adverse conditions resulting from the September

11, 2001 terrorist attacks is substantially likely to be a significant factor in aggravating, contributing to, or causing this condition(s).

Physician Signature\_\_\_\_\_

Date\_\_\_\_\_