



Authorization for Payment of Autopsy

National Institute for Occupational Safety and Health

Deceased Miner's Name (Last, First, Middle) _____ Social Security Number¹ (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	Areas	Large Opacities	Pneumoconiosis determination based upon
Yes	0/- 0/0 0/1	<u>Zones</u> <u>Right</u> <u>Left</u>	Yes	(Select all that apply): X-ray CT
No	1/0 1/1 1/2	Upper	No	
	2/1 2/2 2/3	Middle		Was miner the victim of a coal mine disaster?
	3/2 3/3 3/+	Lower		Yes No

REQUESTING PATHOLOGIST INFORMATION

Physician's name (Last, First, Middle) _____ FEIN or SSN² _____ 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. I attest that no other specific payment, fee, or reimbursement has been or will be received in connection with the autopsy from the miner's widow/widower, his/her family, his/her estate, or any other Federal agency.

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) ____/____/____

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).

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/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS H21-8, Atlanta, Georgia 30329; ATTN: PRA (0920-0020). Do not send completed form to this address.