Physician's/Medical Officer's Statement

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

The information on this form will be used to determine whether a representative payee should be appointed for the patient. While you are not required to respond, your cooperation will help us decide whether it would be in the patient's best interest to have his/her funds managed by another party. Your cooperation in completing and returning this statement will be appreciated. Please answer all items on this form. Include additional information under "Remarks".

OMB No. 1240-0020
Expires: 05/31/2024

Patient's (Beneficiaries) Name

Identifying Information (DOL ONLY)

Miner's Name:

Patient's Date of Birth:

Patient's Address (Number and Street, City, State, and Zip Code)

DOL's Case ID Number:

1. In your opinion, is the patient able to manage benefit payments in the patient's own interest?

☐ Yes (if "YES" or "UNDETERMINED," answer ONLY items 2 and 3 - then SIGN and DATE the form.)
☐ No (If "No," answer items 2 through 5 - then Sign and Date the form.)
☐ Undetermined

2. a. Describe the findings that led to this conclusion.

c. What type of impairment is this?
☐ Mental ☐ Physical

b. What is the diagnosis?

d. Date of Onset

3. What date did you last examine the patient?

Date of Examination

4. a. Do you expect this inability to manage funds to continue indefinitely?
☐ Yes ☐ No (if "No," answer 4b.) ☐ Undetermined

b. When do you expect the patient's ability to be restored?

5. If you know who has assumed responsibility for the patient, or who displays an active interest in the patient's welfare, please give that person's name, address, telephone number and relationship to the patient.

Name of person | Telephone Number (include Area Code) | Relationship to Patient

Address (Number and street, City, State, and Zip Code)

Any person who willfully makes any false or misleading statement or representation to obtain benefits or payments under the Black Lung Benefits Act shall be guilty of a misdemeanor under 30 USC 941 and, on conviction, subject to a fine of up to $1000, or imprisonment for up to one year, or both.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS AND ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Name of Physician/Medical Officer (Please print.)

Title

Address (Number and street, City, State, and Zip Code)

Telephone Number (include Area Code)

Signature of Physician/Medical Officer

Date Signed

TWO FILING OPTIONS:

1. To file electronically, submit completed form to the COAL Mine Portal: https://eclaimant.dol.gov/portal/?program_name=BL
2. To file by mail, submit completed form to: U.S. Department of Labor OWCP/DCMWC, P.O. Box 8307, London, KY 40742-8307
   Please return the form as soon as possible to DOL in the envelope provided.

For further information call TOLL-FREE 1-800-638-7072.

Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gatherng and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room N-3464, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

6. Remarks

INSTRUCTIONS: PLEASE READ BEFORE COMPLETING FORM

The information you give us will be used to determine whether your patient (or former patient), identified on the front of the form, has a mental or physical impairment which prevents the management of Black Lung benefits in that patient's best interests. If the patient is determined to be incapable of managing benefits, DOL will normally appoint a representative payee to receive and use benefits on behalf of the individual.

For DOL purposes, incapability means a beneficiary age 18 or older who is dependent on others to provide protection of interests and daily needs -such as food, clothing and shelter. Examples of impairments causing incapability include severe mental retardation that has made the beneficiary dependent on others since birth, senility or forgetfulness resulting from advancing age, schizophrenia and other mental health problems and severe physical impairments that prevent the beneficiary from not only managing funds, but also directing others to manage them.

The completed form should show the nature of the patient's impairment, if any, and, based on an examination conducted within the 1-year period prior to the date you complete this form, your opinion as to the patient's capability to manage monthly Black Lung benefit payments. If you have not examined the patient within the past year and if the patient has not made an appointment for an examination, please complete as many questions on the form as you deem advisable. We will use such information, along with other evidence we receive, to determine whether direct or representative payment will serve the patient's best interests.

Please sign and date the form before filing it.

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

PRIVACY ACT NOTICE

The following information is provided in accordance with the Privacy Act of 1974, 5 USC 552a. (1) This report is authorized by the Black Lung Benefits Act, as amended (30 USC 932(b)) and its implementing regulations (20 CFR 725.506, 725.510). (2) The information will be used to determine whether a representative payee should be appointed. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, including potentially liable coal mine operators and their insurance carriers; medical professionals in obtaining medical services or evaluations; contractors providing automated data processing services to the Department of Labor; representatives of the parties to the claim; and federal, state or local agencies in obtaining information about eligibility for benefits. (4) Furnishing all requested information will facilitate the representative payee process; and the effects of not providing all or any part of the requested information may delay the process. (5) This information is included in a System of Records, DOL/ OWCP-2, published at 81 Federal Register 25765, 25858 (April 29, 2016), or as updated and republished.

NOTICE

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims staff to ask about this assistance.