File Number:
CA-1008 OD-D-ACC

U S DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 13 SFC
LONDON, KY 40742-8300
Phone: (415) 625-7500

August 13, 2010

Date of Injury:
Employee:

Dear Mr :

This is to notify you that your claim for an occupational disease has been accepted for the following condition(s):

Diagnosed condition(s)	ICD-9 code(s)
RESPIRATORY CONDITIONS DUE TO OTHER SPECIFIED EXTERNAL AGENTS	5088
BRONCHITIS, NOT SPECIFIED AS ACUTE OR CHRONIC	490
EXTRINSIC ASTHMA	4930

Please advise all medical providers who are treating you for this injury of the accepted ICD-9 code(s). Accurate coding facilitates timely bill processing.

If the current accepted condition(s) need to be revised or additional complications related to the current accepted condition(s) need to be added, your physician should explain in writing, with medical rationale, the relationship between any additional condition and the work injury or the current accepted condition(s) noted above.

If you lose time from work due to your work related condition, you may claim compensation using Form CA-7.

Please refer to the attachment entitled "Now That Your Claim Has Been Accepted" for important information pertaining to how to contact us, medical authorizations, payment of bills, and returning to work.

Sincerely,

Brad Mayberry

Brad Mayberry
Senior Claims Examiner

Enclosure: NOW THAT YOUR CLAIM HAS BEEN ACCEPTED