



WTC Health Program Nationwide Provider Network

WTC HEALTH PROGRAM NATIONWIDE PROVIDER NETWORK

Program Information

- The World Trade Center Health Program was established by Public Law 111-347, the “James Zadroga 9/11 Health and Compensation Act of 2010”. The Program includes a Nationwide Provider Network that is third party administered by MCA/Sedgwick.
- The Program provides health **monitoring** benefits, **diagnostic** benefits for further evaluation of potential WTC-Related Health Conditions, and **treatment** benefits for Program certified World Trade Center (WTC)-Related and Associated Health Conditions.

Exam Details

- Monitoring exams provide for a routine health assessment including preventive medicine coverage for influenza vaccination and cancer screening (USPSTF grade A/B recommendations for the **4 cancers** listed in the chart below).
- Abnormal health findings or symptoms should be documented on the exam form and any recommended referrals.
- If abnormal health findings may be WTC-related and meet the Program’s policies and procedures, then further diagnostic evaluation will be arranged by the NPN, based on recommended referrals.
- If the findings are not WTC-related and covered by the Program, then the member will be made aware of the findings and advised to follow-up with their personal healthcare provider.
- All exam components identified in the grid below are offered to the WTC member. The member may choose to refuse certain components and screening.
- If a member refuses any components, document the refusal on the exam form.
- The Medical Health Questionnaire (MHQ) Summary will be provided to you via fax 3-5 days prior to the member’s appointment and should be reviewed prior to the appointment.
- Completed forms should be returned within 48 hours via secure fax or a direct upload to the Provider Portal.
 - Fax Number: **866.728.7860**
 - Provider Portal: www.sedgwickwtc.com
- MHQ summaries, the exam form, and other provider education can also be located on the Provider Portal.

Monitoring Exam Components



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Component	Notes	Initial Health Examination	Annual Monitoring Examination
Medical History Questionnaire (MHQ) Summary	To be faxed to provider for review prior to exam		
Spirometry/Pulmonary Function Testing	Initial spirometry to include pre/post bronchodilation with clinical indication		
Laboratory Testing	Including CBC, CMP or BMP, lipids (fasting or non-fasting) and UA		
Chest X-ray			Every 2 years with clinical indication
EKG	≥ 40 yrs. old with clinical indication		
Influenza Vaccine			
Physical Examination			
Offer Cancer Screening	Colorectal, Lung, Breast, & Cervical		



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Physical Exam Form

General information

Provider name (last, first) <input type="text"/>	Exam location
Member name (last, first) <input type="text"/>	Exam date (MM/DD/YY)
Member DOB (MM/DD/YY) <input type="text"/>	WTC Member ID

Member concerns/subjective:



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MHQ summary reviewed

☐ Yes ☐ No

Comments:

Vital signs

BP / Pulse Pulse irregular ☐ (describe)

Respirations: Height (inches): Weight (lbs.): BMI:

General appearance

☐ Normal ☐ Abnormal

If abnormal, please describe:

Ears

☐ Normal ☐ Abnormal

If abnormal, please describe:

Eyes

☐ Normal ☐ Abnormal

If abnormal, please describe:

Nose☐ Normal ☐ Abnormal

If abnormal, please describe:

Sinuses☐ Normal ☐ Abnormal

If abnormal, please describe:

Mouth/throat☐ Normal ☐ Abnormal

If abnormal, please describe:

Neck☐ Normal ☐ Abnormal

If abnormal, please describe:

Chest☐ Normal ☐ Abnormal

If abnormal (barrel chest, kyphosis, scoliosis, asymmetrical, etc.), please describe:

Coughing during exam?

☐ Yes ☐ No

If yes, please indicate the following:

☐ Rare ☐ Occasional ☐ Frequent ☐ Productive ☐ Non-productive

Auscultation

☐ Normal ☐ Abnormal

Rales	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	
Rhonchi	<input type="checkbox"/>	
Diminished breath sounds	<input type="checkbox"/>	

Heart

☐ Normal ☐ Abnormal

If abnormal, please describe:

Abdomen

☐ Normal ☐ Abnormal

If abnormal, please describe:

Skin

☐ Normal ☐ Abnormal

If abnormal, please describe:

Musculoskeletal

☐ Normal ☐ Abnormal

If abnormal, please describe:

Neurological

☐ Normal ☐ Abnormal

If abnormal, please describe:

Testing results

Labs (CBC, BMP or CMP, non-fasting or fasting lipids, and UA)

☐ Normal ☐ Abnormal

Provider's comments:

EKG (only if indicated)

☐ Normal ☐ Abnormal

Provider's comments:

Spirometry

☐ Normal ☐ Abnormal

Provider's comments:

Spirometry quality test grade

☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

Chest x-ray (Initial exam and then every two years)

☐ Normal ☐ Abnormal

Provider's comments:

Potential WTC-related health conditions

Potential WTC-related medical conditions will be evaluated to determine if they meet the certification policy requirements by the Administrator of the WTC Health Program. These conditions are substantially likely to be caused or aggravated by or contributed to by 9/11 terrorist attack events and exposures (<https://www.cdc.gov/wtc/regulations2.html>).

Upper airway conditions

ICD code	Description
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Referral type

☐ None
 ☐ ENT
 ☐ Internal medicine
 ☐ Pulmonary
 ☐ Sleep medicine
☐ Smoking cessation
 ☐ Other

Recommended diagnostic procedures:

Symptom(s):

Symptom onset:

Symptom management/treatment summary:

Additional comments:

Lower airway conditions

ICD Code	Description
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Referral type

☐ None
 ☐ ENT
 ☐ Internal medicine
 ☐ Pulmonary
 ☐ Sleep medicine
☐ Smoking cessation
 ☐ Other

Recommended diagnostic procedures:

Symptom(s):

Symptom onset:

**Symptom management/
treatment summary:**

Date of last influenza vaccine:

☐ Administered

☐ Refused

☐ Recommended

Additional comments:

Gastrointestinal conditions

ICD code	Description
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Referral type

☐ None

☐ GI

☐ Internal medicine

☐ Other

Recommended diagnostic procedures:

Symptom(s):

Symptom onset:

**Symptom management/
treatment summary:**

Additional comments:

Mental health conditions

ICD Code	Description

Referral type

☐ None
 ☐ Psychology
 ☐ Psychiatry
 ☐ Social Work
 ☐ Smoking cessation
 ☐ Other

Recommended diagnostic procedures:

Symptom(s):

Symptom onset:

Symptom management/
treatment summary:

Additional comments:

Musculoskeletal disorder(s) (Only potentially certifiable for WTC responders with supporting medical documentation from 9/11/01 to 9/11/03)

Acute traumatic injury (Only potentially certifiable with supporting medical documentation from 9/11/01-9/11/03)

ICD code	Description

Referral type

☐ None
 ☐ Other

Recommended diagnostic procedures:

Symptom(s):

Symptom onset:
Symptom management/
treatment summary:

Additional comments:

FINDINGS REQUIRING FURTHER DIAGNOSTIC EVALUATION

Abnormal findings

ICD code	Description
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Referral type

- ☐ ENT
 ☐ Pulmonology
 ☐ Gastroenterology
 ☐ OB/GYN
 ☐ Oncology
 ☐ Hematology
 ☐ Other

Recommended diagnostic procedures:

Symptom(s):

Symptom onset:

Symptom management/
treatment summary:

Additional comments:

USPSTF recommended cancer screening(s)

Lung cancer screening indicated:

☐ Yes ☐ No ☐ Member declined

If yes, please explain:

Referral type

☐ Radiology for low dose CT

Other:

Breast cancer screening indicated:

☐ Yes ☐ No ☐ Member declined

If yes, please explain:

Referral type

☐ Mammogram*

*The program covers mammograms every other year.

Other:

Cervical cancer screening indicated:

☐ Yes ☐ No ☐ Member declined

If yes, please explain:

Referral type

- ☐ Age 21-29, cytology/PAP smear every three years
- ☐ Age 30-65, cytology/PAP smear every three years
- ☐ Age 30-65, high-risk HPV testing every five years
- ☐ Age 30-65, cytology/PAP smear and high-risk HPV testing every five years (co-testing)

Other:

Colorectal cancer screening indicated:

☐ Yes ☐ No ☐ Member declined

If yes, please explain:

Referral type

- ☐ Colonoscopy
- ☐ High-Sensitivity Guaiac FOBT or FIT annually
- ☐ sDNA-FIT every 1-3 years

Other screening method:



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Other conditions identified that may NOT be related to 9/11 events

The following findings were abnormal. Follow up with member's personal provider is recommended as WTC Health Program does not provide coverage for these conditions:

Member to follow up with personal provider on this finding:

SIGNATURE

Provider signature	Provider name and credentials: (please print)
<input type="text"/>	<input type="text"/>
Date (MM/DD/YY)	
<input type="text"/>	