## ATTENDING DOCTOR'S REPORT AND CARRIER/EMPLOYER BILLING FORM

# STATE OF NEW YORK WORKERS' COMPENSATION BOARD

SERVICES PROVIDED UNDER WCB PREFERRED YES PROVIDER ORGANIZATION PROGRAM (PPO)?

		8 HR.		15 L			PROGR		SEE ITEM 1 ON F FILING INSTRUC		OR			PHYSICIAN		PODIATRIS	ST	(	CHIROP	RACTOR			
	WCB	CASE N	0.	CAR	RIER C	ASE NO	). (IF KNO	OWN)	DATE OF INJUR	Y & TIME	ADDRE	ESS WHE	RE IN	JURY OCCURR	ED (CIT	Y, TOWN OR	VILLAG	E)	soci	NJURED PE AL SECURI	RSON'S TY NUM	BER	
INJURE! PERSON		1							(Last Name	ADDRE	SS (Includ	de Apt	t. No.)						TELEPHONE NO.				
EMPLOYER		•																	PATIENT'S	DATE OF E	BIRTH		
	URANCE ARRIER																			Indicate d & times (A when you	\M or Pl		
PH	UPER- ISING YSICIAN if any)																			available		/.	
_		l ient wa	s unde	the V	FBL o	r VAW	BL sho	w as "E	Employer" the I	cal subc	division a	and c	heck one:	VFBL VAWE				/BL	BL				
If you have filed a previous report, setting forth a history of the injury, enter its date													complete Item			•							
HISTO	<ol> <li>How did injury occur? Give source of information. If an occupational disease, include occupational history and date of onset of related symptoms.</li> </ol>																						
R	2. If there is any history or evidence of pre-existing injury, disease or physical impairment, describe specifically.																						
T R E			caminat report is											eached maximum medical improvement? If patient be seen again?						YES	NO		
A T M E	A Loscribe treatment rendered and planned future treatment. If X-ravs were taken, so indicate, If patient was hospitalized give name/location of																		st.				
N T	5 May	the ini	ur roo	ılt in n	ormon	ont ro	striction	total	YES NO	∃: If "yes"	describ	ь.											
I M P A	or p	artial lo ermane	ss of fu ent facia	nction al, hea	of a p	art or i	membe figurem	r, nent?					.a 1										
RM	due to impairment, if known: working?								to perform regular duties or work?							degree of impairment is: TOTAL PARTIAL							
E N T		COMPLETE ITEMS 9 AND 10 AFTER MAXIMUM MEDICAL IMPROVEMENT HAS BEEN REACHED.  FOR SCHEDULE LOSS TO EXTREMITY Enter percentage loss or loss of use and Part of Body. Use NYS WCB Medical Guidelines. Do not use AMA Guidelines.  10. Can patient do any type of work?  YES  NO  If "yes" describe wo capacity:														ork							
C R	you										S N	О											
CA	12. Dia	agnosis	or natu	ire of o	diseas	e or inj	jury (Re	elate Ite	ems 1,2,3 or 4	to Item 13I	e.) Ente	Enter code and describe nature of injury.											
A R R	2.										4.												
E	13. A							С	,	CODES) E			E	F G			Н						
R / E	From MM		Dates o	f Service To MM DD		YY	Place of YY Service			s, Services or Jusual Circum S MO			Diagnosis Code		\$ Charges		Days or Units COB		B Zip	Zip Code Where Service wa Rendered			
MPLO																							
YER																							
В																							
$\sqcup$ $\sqcup$ $\sqcup$											· · · · ·												
N G					:																		
F O R											<u>:                                      </u>												
M S	14. Federal Tax I.D. Number SSN EIN 15.							15. Pa	tient's Account No	<u> </u>	<u> </u>			I - I			17. Amt. Pd. (Carrier Us Only)		18. Bal. I Only	Due (Carrier )	r Use		
I G N	19. WCB Rating Code								THE INJURED WORKER						SHOULD NOT PAY THIS BILL.								
A T	20. WCB Authorization No.							22. Do	22. Doctor's Name, Address & Phone Number						Doctor's	Billing Name	, Addres	s & P	hone Nu	ımber			
U R	Affirmed Under Penalty of Perjury																						
Е	21. Signature of Doctor Date																						

## MEDICAL REPORTING

### IMPORTANT- TO THE ATTENDING DOCTOR

- This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:
  - 48 HOUR INITIAL REPORT File this form, complete in all details, within 48 hours after you first render treatment.

  - 15 DAY INITIAL REPORT File this form within 17 days after you first render treatment.
    45 DAY PROGRESS REPORT Following the filing of the 15 Day Initial Report, file this form at intervals of 45 days during continuing treatment, unless change of condition necessitates additional reporting.

All reports are to be filed with the Workers' Compensation Board, the workers' compensation insurance carrier, self-insured employer, and if the patient is represented by an attorney or licensed representative, with such representative. If the claimant is not represented, a copy must be sent to the claimant.

#### OPHTHALMOLOGISTS ARE TO USE FORM C-5 FOR FILING REPORTS.

- Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.
- This form must be signed by the attending doctor and must contain her/his authorization certificate number and code letters. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital. **AUTHORIZATION FOR SPECIAL SERVICES** - Services for which authorization must be requested are as follows:
- - PHYSICIANS To engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than \$1,000.
  - PODIATRISTS In treating the foot, to provide physiotherapeutic procedures, X-ray examinations, or special diagnostic laboratory tests costing more than \$1,000. CHIROPRACTORS - In treating a condition as provided in Section 6551 of the Education Law, to engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than \$1,000. AUTHORIZATION MUST BE REQUESTED AS FOLLOWS:
- - Telephone the self-insured employer or insurance carrier, explain the need for the special services, and request the necessary authorization.
  - Confirm the request in writing, setting forth the medical necessity for the special services in item 4 of this form. Attach copy of request, if necessary
  - The self-insured employer or insurance carrier may have the patient examined within 4 working days of the request for authorization, if the patient is hospitalized, or C. within 30 calendar days if the patient is not hospitalized.
  - If authorization or denial is not forthcoming within the 4 working days if the patient is hospitalized, or within the 30 calendar days if the patient is not hospitalized, notify the nearest office of the Workers' Compensation Board.

#### SUCH AUTHORIZATION IS NOT REQUIRED IN AN EMERGENCY

In cases where the <u>physician</u> prescribes a surgical appliance or dental treatment or denture, or where the <u>podiatrist</u> prescribes a surgical appliance, or where the <u>chiropractor</u> prescribes a back belt or support, the attending doctor shall notify the self-insured employer or carrier of the need for such appliance or dental aid, and direct the claimant to the self-insured employer or carrier for the purpose of securing authorization for their purchase before they are furnished to the claimant.

- LIMITATION OF PODIATRY TREATMENT Podiatry treatment is limited as defined in Section 7001 of the Education Law and Section 13-k(2) of the Workers' Compensation Law
- LIMITATION OF CHIROPRACTIC TREATMENT Chiropractic treatment is limited as defined in Section 6551 of the Education Law and the Chair's Rules Relative to Chiropractic Practice Under Section 13-I of the Workers' Compensation Law.
  - A CHIROPRACTOR OR PODIATRIST FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY LAWFULLY BE TREATED AS DEFINED IN THE EDUCATION LAW AND, WHERE IT DOES NOT, HAS ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS/HER CHOICE.
- HIPAA NOTICE In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

## **BILLING INFORMATION**

Complete all billing information contained on the front of this form. Whenever possible, utilize this form for 2 or more treatments. Use continuation Form C-4.1, if necessary. The workers' compensation carrier has 45 days to pay your bill or to file an objection to it. Contact the workers' compensation carrier if you receive neither payment nor an objection within this time period. After contacting the carrier, you may, if necessary, contact the Board's Disputed Bill Unit, at the Albany address indicated below, for information/assistance.

## IMPORTANT TO THE PATIENT

YOUR DOCTORS' BILLS (AND BILLS FOR HOSPITALS AND OTHER SERVICES OF A MEDICAL NATURE) WILL BE PAID BY YOUR EMPLOYER, THE LIABLE POLITICAL SUBDIVISION OR ITS INSURANCE COMPANY OR THE UNAFFILIATED VOLUNTEER AMBULANCE SERVICE IF YOUR CLAIM IS ALLOWED. DO NOT PAY THESE BILLS YOURSELF, UNLESS YOUR CASE IS DISALLOWED OR CLOSED FOR FAILURE TO PROSECUTE.

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OF THIS NOTICE, OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO COMMUNICATE WITH THE BOARD OR THE CARRIER. ALSO, MENTION YOUR SOCIAL SECURITY NUMBER IF YOU WRITE OR CALL THE BOARD.

## **IMPORTANTE PARA EL PACIENTE**

LAS FACTURAS POR SERVICIOS MEDICOS INCLUYENDO HÓSPITALES Y TODO SERVICIO DE NATURALEZA MEDICA SERA PAGADO POR EL PATRONO O POR LA ENTIDAD RESPONSABLE O SU COMPANIA DE SEGUROS SEGUN SEA EL CASO; SI SU RECLAMACION ES APROBADA. NO PAGUE ESTAS FACTURAS A MENOS QUE SU CASO SEA DESESTIMADO EN SU FONDO O ARCHIVADO POR NO REALIZAR LOS TRAMITES CORRESPONDIENTES.

SI USTED TIENE ALGUNA PREGUNTA, EN RELACION A ESTA NOTIFICACION O A SU CASO O EN RELACION A SUS DERECHOS BAJO LA LEY DE COMPENSACION OBRERA O LA LEY DE BOMBEROS VOLUNTARIOS O LA LEY DE SERVICIOS DE AMBULANCIAS VOLUNTARIOS DEBE COMUNICARSE CON LA OFICINA MAS CERCANA DE LA JUNTA PARA ORIENTACION. SIEMPRE USE EL NUMERO DEL CASO QUE APARECE EN LA PARTE DEL FRENTE DE ESTA NOTIFICACION, O EN OTROS DOCUMENTOS RECIBIDOS POR USTED. SI LE ES NECESARIO COMUNICARSE CON LA JUNTA O CON EL "CARRIER." TAMBIEN MENCIONE EN SU COMUNICACION ORAL O ESCRITA SU NUMERO DE SEGURO SOCIAL

## WORKERS' COMPENSATIONBOARD DISTRICTOFFICES

ALBANY 12241 - 100 Broadway, Menands. (866) 750-5157 For all accidents in following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington.

BINGHAMTON 13901 - State Office Building, 44 Hawley Street. (866) 802-3604 For all accidents in following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins.

BUFFALO 14202 - Statler Towers, 107 Delaware Ave. (866) 211-0645 For all accidents in following counties: Cattaraugus, Chautauqua, Erie, Niagara. ROCHESTER 14614 - 130 Main Street West. (866) 211-0644 For all accidents in following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates.

SYRACUSE 13203 - 935 James Street. (866) 802-3730 For all accidents in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.

DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill district offices) - PO Box 5205, Binghamton, NY 13902-5205. NYC (800) 877-1373 Hemp. (866) 805-3630 Haup. (866) 681-5354 Peek. (866) 746-0552 For all accidents in following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester.