

## **CATEGORY A – SAMPLE CLAIMS**

## **SAMPLE CLAIM #1 – CONNIE RICARDO**

**Claim #1 – Connie Ricardo/ CC# 00000001-001/ DOA: 8/28/14**

General Claim Information: The Claimant is a female Teacher who suffered a compensable work related injury when she caught her hand in a door. Accident, Notice and Causal Relationship (ANCR) has been established to the left hand and left middle finger. Six (6) weeks of lost time from work resulted. It is likely that this claim will result in a Schedule Loss of Use (SLU) award.

The following services are required for this claim:

- 1) Legal Representation at WCB Hearing: Hearing Type: Basic; Issue: ANCR finger vs. hand. (Left hand conceded by carrier w/ out further litigation of issue); Location: Garden City, NY 11530; Time: 1 hour, inclusive of preparation, hearing and report
- 2) Legal Representation at WCB Hearing: Hearing Type: Basic; Issue: Finalize agreed upon SLU Award for unrepresented Claimant; Location: Garden City, NY 11530; Time: 1 hour, inclusive of preparation, hearing and report
- 3) Independent Medical Exam for an opinion on permanency/ SLU w/ Orthopedic Doctor in Wantagh, NY 11793
- 4) Review/Adjustment of Emergency Room Bill (attached)
- 5) Review/Adjustment of Doctor's Initial Report/ C-4 (attached)
- 6) Review/Adjustment of Doctor's Progress Report/ C-4.2 (attached)
- 7) Review/Adjustment of Doctor's Report of MMI/Permanent Impairment/ C-4.3 (attached)

On tab #1 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Indemnity)

Legal Representation (2 basic hearings)

Independent Medical Exam (1 exam)

Medical Bill Review/ Adjustment (4 bills)

**Note:** For the medical bill review, provide the service fees attributable to the review/ adjustment of the bill, **not** the payment due the medical provider. For the purposes of this exercise, assume that each medical bill has the supporting medical documentation necessary to process payment as billed by provider.



# Doctor's Initial Report

**C-4**

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

## A. Patient's Information

1. Name: Ricardo Connie 2. Social Security #: - -  
Last First MI
3. Home phone #: ( ) 4. WCB Case # (if known): 5. Carrier Case #: 00000001-001
6. Mailing address: Number and Street City State Zip Code
7. Date of injury/onset of illness: 08 / 28 / 2014 8. Date of Birth: / / 9. Gender: ☐ Male ☒ Female
10. On the date of injury/illness what was the patient's job title or description:
11. On the date of injury/illness what were the patient's usual work activities:
12. Patient's Account #:

## B. Employer Information

1. Employer when injury occurred: Company/Agency Name 2. Phone #: ( )
3. Employer Address: WANTAGH Number and Street City State Zip Code

## C. Doctor's Information

1. Your name: Last First MI 2. WCB Authorization #:
3. WCB Rating Code: 4. Federal Tax ID #:  The Tax ID # is the (check one): ☐ SSN ☐ EIN
5. Office address: Number and Street City State Zip Code
6. Billing group or practice name:
7. Billing address: Number and Street City State Zip Code
8. Office phone #: ( ) 9. Billing phone #: ( ) 10. Treating Provider's NPI #:
11. You are a (check one): ☒ Physician ☐ Podiatrist ☐ Chiropractor

## D. Billing Information

1. Employer's insurance carrier: 2. Carrier Code #: W
3. Insurance carrier's address: Number and Street City State Zip Code
4. Diagnosis or nature of disease or injury:  
Enter ICD9 Code: ICD9 Descriptor:  
(1) 818.02 CLOSED FRACTURE OF DIGITAL PHALANX OR PHALANGES OF HAND  
(2)   
(3)   
(4)

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: Ricardo Connie  
Last First MI

Date of injury/onset of illness: 08 / 28 / 2014

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
10	07	14	10	07	14	11		99024		1	0.00	1		11563-2460
10	07	14	10	07	14	11		73140	LT	1	53.43	1		11563-2460

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$	\$	\$

## E. History

- Based on the patient's history, where and how did the injury/illness happen: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- How did you learn about the injury/illness (check one): ☐ Patient ☐ Medical Records ☐ Other(specify): \_\_\_\_\_
- Did another health provider treat this injury/illness including hospitalization and/or surgery? ☐ Yes ☐ No If yes, give details: \_\_\_\_\_  
 \_\_\_\_\_
- Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☐ No If yes, when: \_\_\_\_\_

## F. Exam Information

- Date(s) of Examination: \_\_\_\_\_
- Patient's subjective complaints: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Numbness/Tingling _____	<input type="checkbox"/> Swelling _____
<input type="checkbox"/> Pain _____	<input type="checkbox"/> Weakness _____
<input type="checkbox"/> Stiffness _____	<input type="checkbox"/> Other (specify) _____
- Type/nature of injury: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Abrasion _____	<input type="checkbox"/> Infectious Disease _____
<input type="checkbox"/> Amputation _____	<input type="checkbox"/> Inhalation Exposure _____
<input type="checkbox"/> Avulsion _____	<input type="checkbox"/> Laceration _____
<input type="checkbox"/> Bite _____	<input type="checkbox"/> Needle Stick _____
<input type="checkbox"/> Burn _____	<input type="checkbox"/> Poisoning/Toxic Effects _____
<input type="checkbox"/> Contusion/Hematoma _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Crush Injury _____	<input type="checkbox"/> Puncture Wound _____
<input type="checkbox"/> Dermatitis _____	<input type="checkbox"/> Repetitive Strain Injury _____
<input type="checkbox"/> Dislocation _____	<input type="checkbox"/> Spinal Cord Injury _____
<input type="checkbox"/> Fracture _____	<input type="checkbox"/> Sprain/Strain _____
<input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Torn Ligament, Tendon or Muscle _____
<input type="checkbox"/> Hernia _____	<input type="checkbox"/> Vision Loss _____
<input type="checkbox"/> Other (specify) _____	

Patient's Name: Ricardo Connie Date of injury/onset of illness: 08 / 28 / 2014  
Last First MI

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- |   |   |
|---|---|
| <input type="checkbox"/> None at present              | <input type="checkbox"/> Neuromuscular Findings:      |
| <input type="checkbox"/> Bruising _____               | <input type="checkbox"/> Abnormal/Restricted ROM      |
| <input type="checkbox"/> Burns _____                  | <input type="checkbox"/> Active ROM _____             |
| <input type="checkbox"/> Crepitation _____            | <input type="checkbox"/> Passive ROM _____            |
| <input type="checkbox"/> Deformity _____              | <input type="checkbox"/> Gait _____                   |
| <input type="checkbox"/> Edema _____                  | <input type="checkbox"/> Palpable Muscle Spasm _____  |
| <input type="checkbox"/> Hematoma/Lump/Swelling _____ | <input type="checkbox"/> Reflexes _____               |
| <input type="checkbox"/> Joint Effusion _____         | <input type="checkbox"/> Sensation _____              |
| <input type="checkbox"/> Laceration/Sutures _____     | <input type="checkbox"/> Strength (Weakness) _____    |
| <input type="checkbox"/> Pain/Tenderness _____        | <input type="checkbox"/> Wasting/Muscle Atrophy _____ |
| <input type="checkbox"/> Scar _____                   |   |
| <input type="checkbox"/> Other findings: _____        |   |

5. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

6. Describe any treatment(s) rendered at this visit: \_\_\_\_\_

7. Describe prognosis for recovery: \_\_\_\_\_

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No

If yes, list and describe: \_\_\_\_\_

## G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? \_\_\_\_\_ %
5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

## H. Plan of Care

1. What is your proposed treatment? \_\_\_\_\_

2. Medication(s): (a) list medications prescribed: \_\_\_\_\_

(b) list over-the-counter medications advised: \_\_\_\_\_

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below: \_\_\_\_\_

Patient's Name: Ricardo Connie  
Last First MI

Date of injury/onset of illness: 08 / 28 / 2014

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan  
☐ EMG/NCS  
☐ MRI (Specify): \_\_\_\_\_  
☐ Labs (Specify): \_\_\_\_\_  
☐ X-rays (Specify): \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor  
☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair  
☐ Other (specify): \_\_\_\_\_

**Important:** Form C-4 AUTH should be used to request any special medical service costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

5. When is the patient's next follow-up appointment?

☐ Within a week ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ \_\_\_\_\_ months ☐ Return as needed

## I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☐ No If yes, date patient first missed work: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Is the patient currently working? ☐ Yes ☐ No If yes, did the patient return to: ☐ usual work activities ☐ limited work activities

2. Can the patient return to work? (check only one):

- a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_
- b. ☐ The patient can return to work without limitations on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- c. ☐ The patient can return to work with the following limitations (check all that apply) on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bending/twisting         | <input type="checkbox"/> Lifting                       | <input type="checkbox"/> Sitting                      |
| <input type="checkbox"/> Climbing stairs/ladders  | <input type="checkbox"/> Operating heavy equipment     | <input type="checkbox"/> Standing                     |
| <input type="checkbox"/> Environmental conditions | <input type="checkbox"/> Operation of motor vehicles   | <input type="checkbox"/> Use of public transportation |
| <input type="checkbox"/> Kneeling                 | <input type="checkbox"/> Personal protective equipment | <input type="checkbox"/> Use of upper extremities     |
| <input type="checkbox"/> Other(explain): _____    |  |   |

Describe/quantify the limitations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

**This form is signed under penalty of perjury.**

**Board Authorized** Health Care Provider - Check one:

- ☒ I provided the services listed above.  
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

**Board Authorized** Health Care Provider signature:

Name	Signature	ORTHOPEDIC SURGEON	/ /
		Specialty	Date

**MEDICAL REPORTING****IMPORTANT-TO THE ATTENDING DOCTOR**

1. 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** - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.  
If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future 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 use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.
2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
5. **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.
6. **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-l 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.
7. **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 this form. 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 Customer Service toll-free number listed 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 HOSPITALES 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.

Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

**NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

**Customer Service Toll-Free Line: 877-632-4996**

**Statewide Fax Line: 877-533-0337**



# Doctor's Progress Report

State of New York - Workers' Compensation Board

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

Date(s) of Examination: 10/20/2014-10/27/2014

WCB Case Number (if known): \_\_\_\_\_ Carrier Case Number (if known): 00000001-001

## A. Patient's Information

Ricardo Connie 2. Date of injury/illness: 08/28/2014 3. Soc. Sec. #: - -  
Last First MI

4. Address (if changed from previous report): \_\_\_\_\_  
Number and Street City State Zip Code

5. Patient's Account #: \_\_\_\_\_

## B. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI

3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN

5. Office address: \_\_\_\_\_  
Number and Street City State Zip Code

6. Billing Group or Practice Name: \_\_\_\_\_

7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code

8. Office phone #: (\_\_\_\_\_) 9. Billing phone #: (\_\_\_\_\_) 10. Treating Provider's NPI #: \_\_\_\_\_

## C. Billing Information

1. Employer's insurance carrier: \_\_\_\_\_ 2. Carrier Code #: **W**

3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code

4. Diagnosis or nature of disease or injury:

Enter ICD9 Code:

ICD9 Descriptor:

(1) 816.02 CLOSED FRACTURE OF DISTAL PHALANX OR PHALANGES OF HAND

(2) 729.5 PAIN IN SOFT TISSUES OF LIMB

(3) \_\_\_\_\_

(4) \_\_\_\_\_

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
10	20	14	10	20	14	11		97110		1,2	67.10	2		11758-2391
10	20	14	10	20	14	11		97010		1,2	20.03	1		11758-2391
10	24	14	10	24	14	11		97110		1,2	67.10	2		11758-2391
10	24	14	10	24	14	11		97010		1,2	20.03	1		11758-2391
10	27	14	10	27	14	11		97110		1,2	67.10	2		11758-2391
10	27	14	10	27	14	11		97010		1,2	20.03	1		11758-2391

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 261.39	\$	\$

## D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

Patient's Name: RICARDO CONNIE  
Last First MI

Date of injury/onset of illness: 08/28/2014

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: \_\_\_\_\_

3. List additional body parts affected by this injury, if any: \_\_\_\_\_

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: \_\_\_\_\_

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan ☐ EMG/NCS  
☐ MRI (specify): \_\_\_\_\_  
☐ Labs (specify): \_\_\_\_\_  
☐ X-rays (specify): \_\_\_\_\_  
☐ Other (specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor ☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in: \_\_\_\_\_  
☐ Other (specify): \_\_\_\_\_

**Important: Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.**

6. Describe treatment rendered today: \_\_\_\_\_

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ \_\_\_\_ months ☐ as needed

**E. Doctor's Opinion (based on this examination)**

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No  
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No  
3. Is the patient's history of the injury/illness consistent with your objective findings? ☐ Yes ☐ No ☐ N/A (no findings at this time)  
4. What is the percentage (0-100%) of temporary impairment? \_\_\_\_\_ %  
5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

**F. Return to Work**

1. Is patient working now? ☐ Yes ☐ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: \_\_\_\_\_

How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (check only one):

- a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_  
b. ☐ The patient can return to work without limitations on: \_\_\_\_/\_\_\_\_/\_\_\_\_  
c. ☐ The patient can return to work with the following limitations (check all that apply) on: \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Bending/twisting ☐ Lifting ☐ Sitting  
☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing  
☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation  
☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities  
☐ Other (explain): \_\_\_\_\_

Describe/quantify the limitations: \_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

**This form is signed under penalty of perjury.**

**Board Authorized Health Care Provider - Check one:**

- ☐ I provided the services listed above.  
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

**Board Authorized Health Care Provider signature:**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL REPORTING****IMPORTANT - TO THE ATTENDING DOCTOR**

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:

**PROGRESS REPORTS** - Following the filing of Form C-4, Doctor's Initial Report, file this form within 15 days after initial report and thereafter during continuing treatment without further request, when a follow-up visit is necessary, except the intervals between reports shall be no more than 90 days.

When reporting on MMI and/or Permanent Impairment, use Form C-4.3.

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 use Form C-5, Occupational/Physical Therapists use Form OT/PT-4 and Psychologists use Form PS-4 for filing reports.

2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service(s) costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee or shoulder.

***AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY***

5. **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.
6. **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-l 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.**
7. **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 this form. 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 HOSPITALES 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' COMPENSATION BOARD**

Reports should be filed by sending directly to the Workers' Compensation Board at the address below with a copy sent to the insurance carrier:

NYS Workers' Compensation Board  
Centralized Mailing  
PO Box 5205  
Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Use this form: 1. When rendering an opinion on MMI and/or permanent impairment; or 2. In response to a request by the Workers' Compensation Board to render a decision on MMI and/or permanent impairment.

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

Date(s) of Examination: 08 / 28 / 2014 WCB Case # (if known): \_\_\_\_\_ Carrier Case #: 00000001-001

## A. Patient's Information

1. Name: Ricardo Connie  2. Date of Birth:  /  /  3. SSN: - - -  
Last First MI

4. Address (if changed from previous report) : \_\_\_\_\_  
Number and Street City State Zip Code

5. Home phone #: (\_\_\_\_) \_\_\_\_\_ 6. Date of injury/illness:  /  /  7. Patient's Account #: \_\_\_\_\_

## B. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
First Last MI

3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN

5. Office address: \_\_\_\_\_  
Number and Street City State Zip Code

6. Billing Group or Practice Name: \_\_\_\_\_

7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code

8. Office phone #: (\_\_\_\_) \_\_\_\_\_ 9. Billing phone #: (\_\_\_\_) \_\_\_\_\_ 10. Treating Provider's NPI #: \_\_\_\_\_

## C. Billing Information

1. Employer's insurance carrier: \_\_\_\_\_ 2. Carrier Code #: W

3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code

4. Diagnosis or nature of disease or injury:  
Enter ICD9 Code: ICD9 Descriptor:  
(1) 715.14 PRIMARY LOCALIZED OSTEOARTHRISIS, HAND  
(2) 816.02 CLOSED FRACTURE OF DISTAL PHALANX OR PHALANGES OF HAND  
(3) \_\_\_\_\_  
(4) \_\_\_\_\_

Relate ICD9 codes in (1), (2), (3) or (4) to Diagnosis Code column below by line.

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			Procedures, Services or Supplies CPT/HCPCS	MODIFIER					
07	03	15	07	03	11	11		99455		1,2	500.00	1		11563-2460

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge <b>\$500.00</b>	Amount Paid (Carrier Use Only) <b>\$</b>	Balance Due (Carrier Use Only) <b>\$</b>
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## D. Maximum Medical Improvement

1. Has the patient reached Maximum Medical Improvement? ☐ Yes ☐ No If yes, provide the date patient reached MMI: \_\_\_\_/\_\_\_\_/\_\_\_\_  
If No, describe why the patient has not reached MMI and the proposed treatment plan (attach additional documentation, if necessary).

## E. Permanent Impairment/Work Status

1. Is there permanent impairment? ☐ Yes ☐ No

Complete either **1a. or 1b.** based on the patient's current condition, if you believe there is MMI and a permanent impairment or if directed by the Workers' Compensation Board.

If this is for Scheduled loss, please complete section **1a.** below, sign Board Authorization at the bottom of this page, and return.

☐ **a. Schedule loss of use of member or facial disfigurement:**

(Identify impairment rating according to the latest NY Guidelines and attach separate sheet for additional body parts.)

Body Part: \_\_\_\_\_ Impairment %: \_\_\_\_\_

Body Part: \_\_\_\_\_ Impairment %: \_\_\_\_\_

Body Part: \_\_\_\_\_ Impairment %: \_\_\_\_\_

Describe findings and relevant diagnostic test results: \_\_\_\_\_

☐ Facial Disfigurement: (Describe findings) \_\_\_\_\_

If this is for Non-Scheduled loss, please complete section **1b.** below, complete page 3, Section F, sign Board Authorization at the bottom of page 3, and return.

☐ **b. Non-Schedule losses:**

(Identify impairment class according to the latest NY Guidelines. Attach separate sheet for additional body parts.)

Body Part: \_\_\_\_\_ Impairment Table: \_\_\_\_\_ Severity Ranking: \_\_\_\_\_

Body Part: \_\_\_\_\_ Impairment Table: \_\_\_\_\_ Severity Ranking: \_\_\_\_\_

Body Part: \_\_\_\_\_ Impairment Table: \_\_\_\_\_ Severity Ranking: \_\_\_\_\_

State the basis for the impairment classification (attach additional narrative, if necessary):

History: \_\_\_\_\_

Physical Findings: \_\_\_\_\_

Diagnostic Test Results: \_\_\_\_\_

2. Patient's work status:

a. Is the patient working now? ☐ Yes, at the pre-injury job ☐ Yes, at other employment ☐ No, Not Working

b. Could this patient perform his/her at-injury work activities without restrictions? ☐ Yes ☐ No

If this is a Scheduled loss (1a.), Section F should NOT be completed. Please sign Board Authorization below and return.

If this is a Non-Scheduled loss (1b), please complete page 3, Section F, sign Board Authorization at the bottom of page 3, and return.

**This form is signed under penalty of perjury.**

**Board Authorized** Health Care Provider signature: \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## F. Functional Capabilities/Exertional Abilities

1. Please describe patient's residual functional capacities for any work at this time (not limited to the at-injury job activities):

	Never	Occasionally	Frequently	Constantly
Lifting/carrying	<input type="checkbox"/>	<input type="checkbox"/> lbs.	<input type="checkbox"/> lbs.	<input type="checkbox"/> lbs.
Pulling/pushing	<input type="checkbox"/>	<input type="checkbox"/> lbs.	<input type="checkbox"/> lbs.	<input type="checkbox"/> lbs.
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/stooping/squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simple grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching at/or below shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operating machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temp extremes/high humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Patient's Residual Functional Capacities

- **Occasionally:** can perform activity up to 1/3 of the time.
- **Frequently:** can perform activity from 1/3 to 2/3 of the time.
- **Constantly:** can perform activity more than 2/3 of the time.

Specify: \_\_\_\_\_

Psychiatric/neuro-behavioral (attach documentation describing functional limitations)

2. Please check the applicable category for the patient's exertional ability:

- ☐ **Very Heavy Work** - Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Heavy Work.
- ☐ **Heavy Work** - Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Medium Work.
- ☐ **Medium Work** - Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Light Work.
- ☐ **Light Work** - Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may only be a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.
- ☐ **Sedentary Work** - Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.
- ☐ **Less than Sedentary Work** - Unable to meet the requirement of Sedentary Work.

3. Other medical considerations which arise from this work related injury (including the use of pain medication such as narcotics): \_\_\_\_\_

4. Could this patient perform his/her at-injury work activities with restrictions? ☐ Yes ☐ No If Yes, specify \_\_\_\_\_

5. Has the patient had an injury/illness since the date of injury which impacts residual functional capacity?

☐ Yes ☐ No If YES, please attach a detailed explanation.

6. Have you discussed the patient's return to work and/or limitations with any of the following: ☐ patient ☐ patient's employer ☐ N/A

7. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No If Yes, explain \_\_\_\_\_

***This form is signed under penalty of perjury.***

**Board Authorized** Health Care Provider signature: \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date    /    /

## **IMPORTANT - TO THE ATTENDING DOCTOR**

The C-4.3 has been modified to accommodate the 2012 Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefits cases as follows: 1. When rendering an opinion on MMI and/or permanent impairment; or 2. In response to a request by the Workers' Compensation Board to render a decision on MMI and/or permanent impairment.

### **MEDICAL REPORTING**

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 his/her authorization certificate number, code letters and NPI number.

**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.

### **Instructions for Completing Section D, E and F**

#### **Section D. Maximum Medical Improvement**

Section D includes questions regarding maximum medical improvement (MMI). For the definition of MMI, see Chapter 1.2 of the 2012 Guidelines. A provider who finds that the patient has met MMI should so indicate and provide the approximate date of such finding (Question 1). A provider who determines that the patient has not yet reached MMI should so indicate (Question 1) and provide an explanation as to why additional improvement is expected and the proposed treatment plan.

#### **Section E. Permanent Impairment/Work Status**

Section E includes questions regarding permanent impairment/work status. A provider who finds that there is no permanent impairment (Question 1) should not file this form and use Form C-4.2 (Dr's. Progress Report). For more information on evaluating impairment, see Chapter 9.2 of the 2012 Guidelines.

A provider should complete either 1a. (Schedule loss of use of member or facial disfigurement) or 1b. (Non-Schedule losses). A provider should complete Question 2 pertaining to the patient's work status.

1a. Schedule loss of use of member or facial disfigurement. A provider should determine impairment % using the impairment guidelines in Chapters 2-8. If this is a Scheduled loss, Section F., Functional Capabilities/Exertional Abilities, should not be completed. A provider should sign the Board Authorization at the bottom of page 2 and return to the Workers' Compensation Board.

1b. Non-Schedule loss. If this is a Non-schedule loss, a provider should record the body part, impairment table and severity letter grade for each body part or system. A provider should also state the history, physical findings, and diagnostic test results that support the impairment finding. If the patient has a non-schedule impairment of a body part or system that is not covered by an impairment guideline, the provider should follow Chapter 17 and include the relevant history, physical findings, and diagnostic test results, but no severity letter grade.

In addition, if this is a Non-schedule loss, a provider should complete Section F, Functional Capabilities/Exertional Abilities. A provider should complete Section F based on the patient's current condition if they believe there is MMI and/or permanent impairment or in a response to a request by the Board to render a decision on MMI and/or permanent impairment.

#### **Section F. Functional Capabilities/Exertional Abilities**

Section F includes questions applicable to a patient who has reached MMI and has a permanent, non-schedule impairment. For more information on evaluating functional capabilities, see Chapter 9.2 of the 2012 Guidelines. A provider should measure and record the specific functional abilities and losses caused by the work-related medical impairment on Questions 1 through 5 as follows:

Question 1 - The provider should rate whether the patient can perform each of the fifteen functional abilities never, occasionally, frequently, or constantly. The provider should note the specific weight tolerances for the categories lifting/carrying and pulling/pushing. There is also room to describe any functional limitations in connection with environmental conditions (e.g., occupational asthma). Attach documentation when describing Psychiatric/neuro-behavioral functional limitations, if applicable to a patient.

Question 2 - The provider should rate the patient's exertional ability according to the federal standards set forth by the Department of Labor.

Question 3 - The provider should note any other medical considerations arising from the permanent injury that are not captured elsewhere in Sections E and F. This includes any restrictions or limitations that may be imposed as a result of medications (e.g., narcotics) taken by the patient or other relevant medical considerations that impact work function.

Question 4 - If Yes, the provider should specifically assess the patient's ability to perform his/her at-injury work activities with restrictions.

Question 5 - If Yes, the provider should attach a detailed explanation if the patient has had an intervening injury or illness that may account for any of the functional restrictions noted in Question 1.

### **BILLING INFORMATION**

Complete all billing information contained on this form. Use continuation Form C-4.1, if necessary. A physician who fully completes an evaluation of permanent impairment, including a full evaluation of functional limitations, on a Form C-4.3 shall be entitled to payment for a Level 5 E&M consultation code (CPT99245). 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 866-750-5157 for information/assistance.

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.

**All reports are to be filed by sending directly to the Workers' Compensation Board at the address below with a copy sent to the insurance carrier:**

**Statewide Fax Line: 877-533-0337**

**OR**

**NYS Workers' Compensation Board - Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997  THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF



**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

## **SAMPLE CLAIM #2 – JOSEPH RIVERS**

**Claim #2 – Joseph Rivers / CC# 000000002-002/ DOA: 3/30/15**

General Claim Information: The Claimant is a male Certified Nursing Assistant who suffered a compensable work related injury while repositioning a patient. Accident, Notice and Causal Relationship (ANCR) is established to the right shoulder. The Claimant did not lose time from work as a result of this accident. This claim is “medical only”.

The following services are required for this claim:

- 1) Review/ Adjustment of Doctor’s Initial Report C-4 (attached)
- 2) Review/ Adjustment of HICF (attached)

On tab #2 of the excel spreadsheet titled “Sample Claims Worksheet”, provide the total fees for the following services and how they were calculated:

“Life of Claim” Administrative fee for this claim (Medical Only)  
Medical Bill Review/ Adjustment (2 bills)

***Note:*** For the medical bill review, provide the service fees attributable to the review/ adjustment of the bill, **not** the payment due the medical provider. For the purposes of this exercise, assume that each medical bill has the supporting medical documentation necessary to process payment as billed by provider.



# Doctor's Initial Report

**C-4**

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

## A. Patient's Information

1. Name: Rivers Joseph 2. Social Security #: - -  
Last First MI

3. Home phone #: ( ) 4. WCB Case # (if known): 5. Carrier Case #: 000000002-002

6. Mailing address: 25 Pine Court Yonkers NY 10703  
Number and Street City State Zip Code

7. Date of injury/onset of illness: 03 / 30 / 2015 8. Date of Birth: 06 / 15 / 1960 9. Gender: ☒ Male ☐ Female

10. On the date of injury/illness what was the patient's job title or description: CNA

11. On the date of injury/illness what were the patient's usual work activities: \_\_\_\_\_

12. Patient's Account #: \_\_\_\_\_

## B. Employer Information

1. Employer when injury occurred: \_\_\_\_\_ 2. Phone #: ( ) \_\_\_\_\_  
Company/Agency Name

3. Employer Address: \_\_\_\_\_  
Number and Street City State Zip Code

## C. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI

3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN

5. Office address: 145 Forrest Avenue New Rochelle NY 10801  
Number and Street City State Zip Code

6. Billing group or practice name: \_\_\_\_\_

7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code

8. Office phone #: ( ) 9. Billing phone #: ( ) 10. Treating Provider's NPI #: \_\_\_\_\_

11. You are a (check one): ☒ Physician ☐ Podiatrist ☐ Chiropractor

## D. Billing Information

1. Employer's insurance carrier: State Insurance Fund 2. Carrier Code #: W

3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code

4. Diagnosis or nature of disease or injury:

Enter ICD9 Code:	ICD9 Descriptor:
(1) <u>719.41</u>	<u>Pain in joint involving shoulder region.</u>
(2) <u>726.10</u>	<u>Disorders of bursae and tendons in shoulder region, unspecified</u>
(3) <u>840.4</u>	<u>Rotator cuff (capsule) sprain</u>
(4) <u>719.43</u>	<u>Pain in joint involving forearm</u>

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: Rivers Joseph   
Last First MI

Date of injury/onset of illness: 03 / 30 / 2015

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
06	08	15	06	08	15	11		99244	25	1, 2, 3, 4	390.00	1		10801
06	08	15	06	08	15	11		20610		1	125.00	1		10801
06	08	15	06	08	15	11		J0702		1	200.00	1		10801

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 715.00	\$	\$

## E. History

1. Based on the patient's history, where and how did the injury/illness happen: \_\_\_\_\_

Injury to his right shoulder while lifting and turning a patient on his side.

2. How did you learn about the injury/illness (check one): ☒ Patient ☐ Medical Records ☐ Other(specify): \_\_\_\_\_

3. Did another health provider treat this injury/illness including hospitalization and/or surgery? ☐ Yes ☒ No If yes, give details: \_\_\_\_\_

4. Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☒ No If yes, when: \_\_\_\_\_

## F. Exam Information

1. Date(s) of Examination: 6/8/2015

2. Patient's subjective complaints: Check all that apply and identify specific affected body part(s).

- |   |   |
|---|---|
| <input type="checkbox"/> Numbness/Tingling _____            | <input type="checkbox"/> Swelling _____                         |
| <input checked="" type="checkbox"/> Pain <u>R. Shoulder</u> | <input checked="" type="checkbox"/> Weakness <u>R. Shoulder</u> |
| <input type="checkbox"/> Stiffness _____                    | <input type="checkbox"/> Other (specify) _____                  |

3. Type/nature of injury: Check all that apply and identify specific affected body part(s).

- |   |  |
|---|--|
| <input type="checkbox"/> Abrasion _____           | <input type="checkbox"/> Infectious Disease _____  |
| <input type="checkbox"/> Amputation _____         | <input type="checkbox"/> Inhalation Exposure _____   |
| <input type="checkbox"/> Avulsion _____           | <input type="checkbox"/> Laceration _____  |
| <input type="checkbox"/> Bite _____               | <input type="checkbox"/> Needle Stick _____  |
| <input type="checkbox"/> Burn _____               | <input type="checkbox"/> Poisoning/Toxic Effects _____                                     |
| <input type="checkbox"/> Contusion/Hematoma _____ | <input type="checkbox"/> Psychological _____   |
| <input type="checkbox"/> Crush Injury _____       | <input type="checkbox"/> Puncture Wound _____  |
| <input type="checkbox"/> Dermatitis _____         | <input type="checkbox"/> Repetitive Strain Injury _____                                    |
| <input type="checkbox"/> Dislocation _____        | <input type="checkbox"/> Spinal Cord Injury _____  |
| <input type="checkbox"/> Fracture _____           | <input checked="" type="checkbox"/> Sprain/Strain <u>R. Shoulder</u>                       |
| <input type="checkbox"/> Hearing Loss _____       | <input checked="" type="checkbox"/> Torn Ligament, Tendon or Muscle <u>R. Rotator Cuff</u> |
| <input type="checkbox"/> Hernia _____             | <input type="checkbox"/> Vision Loss _____   |
| <input type="checkbox"/> Other (specify) _____    |  |

Patient's Name: Rivers Joseph Date of injury/onset of illness: 03 / 30 / 2015  
Last First MI

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- |  |  |
|--|--|
| <input type="checkbox"/> None at present                               | <input type="checkbox"/> Neuromuscular Findings:                           |
| <input type="checkbox"/> Bruising _____                                | <input checked="" type="checkbox"/> Abnormal/Restricted ROM                |
| <input type="checkbox"/> Burns _____                                   | <input checked="" type="checkbox"/> Active ROM _____                       |
| <input type="checkbox"/> Crepitation _____                             | <input checked="" type="checkbox"/> Passive ROM _____                      |
| <input type="checkbox"/> Deformity _____                               | <input type="checkbox"/> Gait _____  |
| <input type="checkbox"/> Edema _____                                   | <input type="checkbox"/> Palpable Muscle Spasm _____                       |
| <input type="checkbox"/> Hematoma/Lump/Swelling _____                  | <input type="checkbox"/> Reflexes _____                                    |
| <input type="checkbox"/> Joint Effusion _____                          | <input type="checkbox"/> Sensation _____                                   |
| <input type="checkbox"/> Laceration/Sutures _____                      | <input checked="" type="checkbox"/> Strength (Weakness) <u>R. Shoulder</u> |
| <input checked="" type="checkbox"/> Pain/Tenderness <u>R. Shoulder</u> | <input type="checkbox"/> Wasting/Muscle Atrophy _____                      |
| <input type="checkbox"/> Scar _____                                    |  |
| <input type="checkbox"/> Other findings: _____                         |  |

5. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

6. Describe any treatment(s) rendered at this visit: \_\_\_\_\_

7. Describe prognosis for recovery: Good

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No

If yes, list and describe: \_\_\_\_\_

### G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 0 %
5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

### H. Plan of Care

1. What is your proposed treatment? Physical Therapy & Cortisone Injection

2. Medication(s): (a) list medications prescribed: Decline

(b) list over-the-counter medications advised: Decline

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

Patient's Name: Rivers Joseph  
Last First MI

Date of injury/onset of illness: 03 / 30 / 2015

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan  
☐ EMG/NCS  
☐ MRI (Specify): \_\_\_\_\_  
☐ Labs (Specify): \_\_\_\_\_  
☐ X-rays (Specify): \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor  
☐ Internist/Family Physician  
☐ Occupational Therapist  
☒ Physical Therapist  
☐ Specialist in \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair

☐ Other (specify): \_\_\_\_\_

**Important:** Form C-4 AUTH should be used to request any special medical service costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

5. When is the patient's next follow-up appointment?

☐ Within a week ☐ 1-2 weeks ☒ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ \_\_\_\_\_ months ☐ Return as needed

## I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☒ No If yes, date patient first missed work: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Is the patient currently working? ☒ Yes ☐ No If yes, did the patient return to: ☒ usual work activities ☐ limited work activities

2. Can the patient return to work? (check only one):

a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_

b. ☐ The patient can return to work without limitations on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

c. ☐ The patient can return to work with the following limitations (check all that apply) on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bending/twisting         | <input type="checkbox"/> Lifting                       | <input type="checkbox"/> Sitting                      |
| <input type="checkbox"/> Climbing stairs/ladders  | <input type="checkbox"/> Operating heavy equipment     | <input type="checkbox"/> Standing                     |
| <input type="checkbox"/> Environmental conditions | <input type="checkbox"/> Operation of motor vehicles   | <input type="checkbox"/> Use of public transportation |
| <input type="checkbox"/> Kneeling                 | <input type="checkbox"/> Personal protective equipment | <input type="checkbox"/> Use of upper extremities     |
| <input type="checkbox"/> Other(explain): _____    |  |   |

Describe/quantify the limitations: \_\_\_\_\_

\_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☒ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☐ with patient ☐ with patient's employer ☒ N/A

**This form is signed under penalty of perjury.**

**Board Authorized** Health Care Provider - Check one:

- ☐ I provided the services listed above.  
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty COS

**Board Authorized** Health Care Provider signature:

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL REPORTING****IMPORTANT-TO THE ATTENDING DOCTOR**

1. 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** - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.  
If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future 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 use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.
2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
5. **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.
6. **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-l 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.
7. **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 this form. 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 Customer Service toll-free number listed 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 HOSPITALES 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.

Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

**NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

**Customer Service Toll-Free Line: 877-632-4996**

**Statewide Fax Line: 877-533-0337**



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

□□□ PICA

PICA

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Medicaid #)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																														
														000000002-002																														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE			4. INSURED'S NAME (Last Name, First Name, Middle Initial)																															
Rivers Joseph										MM DD YY 06/15/1960			M <input checked="" type="checkbox"/> F <input type="checkbox"/>			Rivers Joseph																												
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)																															
25 Pine Court										Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																		
CITY STATE										8. PATIENT STATUS			CITY STATE																															
Yonkers NY										Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																																		
ZIP CODE TELEPHONE (Include Area Code)										Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE TELEPHONE (Include Area Code)																															
10703																																												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (CURRENT OR PREVIOUS)			a. INSURED'S DATE OF BIRTH																															
										<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																															
b. OTHER INSURED'S DATE OF BIRTH SEX										b. AUTO ACCIDENT? PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME																															
MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										<input type="checkbox"/> YES <input type="checkbox"/> NO																																		
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME OR PROGRAM NAME																															
										<input type="checkbox"/> YES <input type="checkbox"/> NO																																		
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																															
NYSIF													<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																													
SIGNED _____ DATE _____															SIGNED _____																													
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																													
MM DD YY 03/30/2015										MM DD YY MM DD YY					FROM MM DD YY TO MM DD YY																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																													
										17b. NPI					FROM MM DD YY TO MM DD YY																													
19. RESERVED FOR LOCAL USE															20. OUTSIDE LAB? \$ CHARGES																													
															<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)															22. MEDICAID RESUBMISSION ORIGINAL REF. NO.																													
1. 840.4 3. 842.00															CODE																													
2. 726.10 4.															23. PRIOR AUTHORIZATION NUMBER																													
24. A. DATE(S) OF SERVICE B. Place of Service C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID QUAL. J. RENDERING PROVIDER ID. #																																												
From To MM DD YY MM DD YY																																												
070115 070115 11 97110 1,2,3 125.00 1																																												
070115 070115 11 97035 1,2,3 45.00 1																																												
070115 070115 11 97014 1,2,3 55.00 1																																												
070115 070115 11 97010 1,2,3 40.00 1																																												
070115 070115 11 97124 1,2,3 100.00 1																																												
25. FEDERAL TAX I.D. NUMBER SSN EIN															26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back)					28. TOTAL CHARGE					29. AMOUNT PAID					30. BALANCE DUE									
00-0000000 <input type="checkbox"/> <input checked="" type="checkbox"/>																				<input type="checkbox"/> YES <input type="checkbox"/> NO					\$ 365.00					\$					\$ 365.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)															32. SERVICE FACILITY LOCATION INFORMATION															33. BILLING PROVIDER INFO & PH #														
															325 Forrest Avenue															325 Forrest Avenue														
															New Rochelle, NY 10801															New Rochelle NY 10801														
SIGNED _____ DATE _____															a. _____ b. _____															a. _____ b. _____														

**Instructions for Completing OWCP-1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)**

**GENERAL INFORMATION-FECA AND EEOICPA CLAIMANTS:** Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for compensable illnesses defined under that Act. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of the disability or illness, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, or osteopathic practitioners within the scope of their practice as defined by State law. However, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

**FEES:** The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

**REPORTS:** A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

**GENERAL INFORMATION-BLBA CLAIMANTS:** The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

**SIGNATURE OF PHYSICIAN OR SUPPLIER:** Your signature in Item 31 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by you or were furnished incident to your professional services by your employee under your immediate personal supervision, except as otherwise expressly permitted by FECA, Black Lung or EEOICPA regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material act, may be prosecuted under applicable Federal or State laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF FECA, BLACK LUNG AND EEOICPA INFORMATION  
(PRIVACY ACT STATEMENT)**

We are authorized by OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. Your response regarding the medical service(s) received or the amount charged is required to receive payment for the claim. See 20 CFR §§ 10.801, 30.701, 725.406, 725.701, and 725.704. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the claim because of incomplete information. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished. You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

**FORM SUBMISSION**

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742-8300, unless otherwise instructed.  
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 8302, London, KY 40742-8302, unless otherwise instructed.  
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304, unless otherwise instructed.

**INSTRUCTIONS FOR COMPLETING THE FORM:** A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

- Item 1. Leave blank.
- Item 1a. Enter the patient's claim number.
- Item 2. Enter the patient's last name, first name, middle initial.
- Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
- Item 4. For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
- Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
- Item 6. Leave blank.
- Item 7. For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
- Item 8. Leave blank.
- Item 9. Leave blank.
- Item 10. Leave blank.
- Item 11. For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.

- Item 11a. Leave blank.  
 Item 11b. Leave blank.  
 Item 11c. Leave blank.  
 Item 11d. Leave blank.  
 Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.  
 Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.  
 Item 14. Leave blank.  
 Item 15. Leave blank.  
 Item 16. Leave blank.  
 Item 17. Leave blank.  
 Item 18. Leave blank.  
 Item 19. Leave blank.  
 Item 20. Leave blank.  
 Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.  
 Item 22. Leave blank.  
 Item 23. Leave blank.  
 Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.  
 Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).  
 Column C: not required.  
 Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.  
 Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.  
 Column F: enter the total charge(s) for each listed service(s).  
 Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.  
 Column H: Leave blank.  
 Column I: Leave blank.  
 Column J: Enter NPI.  
 Item 25: Enter the Federal tax I.D.  
 Item 26: Provider may enter a patient account number that will appear on the remittance voucher.  
 Item 27: Leave blank.  
 Item 28: Enter the total charge for the listed services in Column F.  
 Item 29: If any payment has been made, enter that amount here.  
 Item 30: Enter the balance now due.  
 Item 31: For BLBA and EEOICPA: sign and date the form. For FECA: signature stamp or "signature on file" is acceptable.  
 Item 32: Enter complete name of hospital, facility or physician's office where services were rendered. Item 32a. Enter NPI. Item 32b. Enter taxonomy number.  
 Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.  
 Item 33a. Enter NPI.  
 Item 33b. Enter taxonomy number.

Place of Service (POS) Codes for Item 24B

3	School	34	Hospice
4	Homeless Shelter	41	Ambulance - Land
5	Indian Health Service Free-Standing Facility	42	Ambulance - Air or Water
6	Indian Health Service Provider-Based Facility	50	Federally Qualified Health Center
7	Tribal 638 Free-Standing Facility	51	Inpatient Psychiatric Facility
8	Tribal 638 Provider-Based Facility	52	Psychiatric Facility Partial Hospitalization
11	Office	53	Community Mental Health Center (CMHC)
12	Patient Home	54	Intermediate Care Facility/Mentally Retarded
15	Mobile Unit	55	Residential Substance Abuse Treatment Facility
20	Urgent Care	56	Psychiatric Residential Treatment Center
21	Inpatient Hospital	60	Mass Immunization Center
22	Outpatient Hospital	61	Comprehensive Inpatient Rehabilitation Facility
23	Emergency Room - Hospital	62	Comprehensive Outpatient Rehabilitation Facility
24	Ambulatory Surgical Center	65	End Stage Renal Disease Treatment Facility
25	Birth Center	71	State or Local Public Health Clinic
26	Military Treatment Facility	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other Place of Service
33	Custodial Care Facility		

### Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1240-0044. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1240-0044), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

### 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 your claims examiner to ask about this assistance.

## **SAMPLE CLAIM #3 – DONNA GARLAND**

**Claim #3 – Donna Garland/ CC# 00000003-003/ DOA: 6/7/14**

General Information: The Claimant is a female Bus Driver who suffered a compensable work related injury when she fell exiting her bus. Initially, employer denied knowledge of this injury, but after investigation, claim was accepted. Accident, Notice and Causal Relationship (ANCR) has been established to both the Right and Left Knees and Consequential Depression. The Claimant has not returned to work since the Date of Accident.

The following services are required for this claim:

- 1) Initial Field Investigation with Claimant. Purpose: to obtain details of accident, witnesses, to whom it was reported, related medical treatment and releases, work status, etc.; Location: Massapequa, NY 11758; Time: 1.5 hours, inclusive of travel, interview and report preparation
- 2) Initial Field Investigation with Employer. Purpose: to obtain details of accident, witnesses, to whom it was reported, related medical treatment, work status, etc.; Location: Farmingdale, NY 11735 and takes 1.5 hours, inclusive of travel, interview and report preparation
- 3) Review/Adjustment of Doctor's Initial Report/ C-4 (attached)
- 4) Review/Adjustment of Doctor's Progress Report/ C-4.2 (attached)
- 5) Independent Medical Exam for an opinion causally related depression and degree of disability w/ a Psychologist in Massapequa, NY 11758
- 6) Review of MG-2 (attached)

On tab #3 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Indemnity)

Field Investigations (2)

Medical Bill Review/ Adjustment (2 bills)

Independent Medical Exam (1 exam)

MG-2

**Note:** For the medical bill review, provide the service fees attributable to the review/ adjustment of the bill, **not** the payment due the medical provider. For the purposes of this exercise, assume that each medical bill has the supporting medical documentation necessary to process payment as billed by provider. Also assume that the MG-2 submitted **does not** include medical justification needed to meet the "burden of proof" standard for continuing treatment.



# Doctor's Initial Report

**C-4**

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

## A. Patient's Information

1. Name: GARLAND DONNA 2. Social Security #: - - -  
Last First MI
3. Home phone #: ( ) 4. WCB Case # (if known): 5. Carrier Case #:
6. Mailing address:
7. Date of injury/onset of illness: 06 / 07 / 2011 8. Date of Birth: / / 9. Gender: ☐ Male ☒ Female  
Number and Street City State Zip Code
10. On the date of injury/illness what was the patient's job title or description:
11. On the date of injury/illness what were the patient's usual work activities:
12. Patient's Account #:

## B. Employer Information

1. Employer when injury occurred: 2. Phone #: ( )  
Company/Agency Name
3. Employer Address:   
Number and Street City State Zip Code

## C. Doctor's Information

1. Your name: 2. WCB Authorization #:   
Last First MI
3. WCB Rating Code: 4. Federal Tax ID #: The Tax ID # is the (check one): ☐ SSN ☐ EIN
5. Office address:   
Number and Street City State Zip Code
6. Billing group or practice name:
7. Billing address:   
Number and Street City State Zip Code
8. Office phone #: ( ) 9. Billing phone #: ( ) 10. Treating Provider's NPI #:
11. You are a (check one): ☐ Physician ☐ Podiatrist ☐ Chiropractor

## D. Billing Information

1. Employer's insurance carrier: 2. Carrier Code #: **W**
3. Insurance carrier's address:   
Number and Street City State Zip Code
4. Diagnosis or nature of disease or injury:  

Enter ICD9 Code:	ICD9 Descriptor:
(1) <u>715.16</u>	<u>OSTERARTHROSIS, LOCALIZED, PRIMARY, INVOLVING LOWER LEG</u>
(2) <u>836.0</u>	<u>TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE, CURRENT</u>
(3) <u>836.1</u>	<u>TEAR OF LATERAL CARTILAGE OR MENISCUS OF KNEE, CURRENT</u>
(4) <u></u>	<u></u>

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: GARLAND DONNA   
Last First MI

Date of injury/onset of illness: 06 / 07 / 2011

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
09	06	11	09	06	11	11		99243			20.00	0		11758
09	6	11	09	06	11	11		99243		123	350.00	1		11758

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 370.00	\$	\$

## E. History

1. Based on the patient's history, where and how did the injury/illness happen: PATIENT STATED WHILE AT WORK TRAVEL TRAINING WITH STUDENTS, WALKING FROM THE BUILDING TO A BUS STOP WHEN SHE FELL INJURING BOTH KNEES

2. How did you learn about the injury/illness (check one): ☒ Patient ☐ Medical Records ☐ Other(specify): \_\_\_\_\_

3. Did another health provider treat this injury/illness including hospitalization and/or surgery? ☐ Yes ☒ No If yes, give details: \_\_\_\_\_

4. Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☒ No If yes, when: \_\_\_\_\_

## F. Exam Information

1. Date(s) of Examination: 09/06/2011

2. Patient's subjective complaints: Check all that apply and identify specific affected body part(s).

- |  |  |
|--|--|
| <input type="checkbox"/> Numbness/Tingling _____           | <input type="checkbox"/> Swelling _____        |
| <input checked="" type="checkbox"/> Pain <u>BOTH KNEES</u> | <input type="checkbox"/> Weakness _____        |
| <input type="checkbox"/> Stiffness _____                   | <input type="checkbox"/> Other (specify) _____ |

3. Type/nature of injury: Check all that apply and identify specific affected body part(s).

- |  |  |
|--|--|
| <input type="checkbox"/> Abrasion _____                              | <input type="checkbox"/> Infectious Disease _____              |
| <input type="checkbox"/> Amputation _____                            | <input type="checkbox"/> Inhalation Exposure _____             |
| <input type="checkbox"/> Avulsion _____                              | <input type="checkbox"/> Laceration _____                      |
| <input type="checkbox"/> Bite _____                                  | <input type="checkbox"/> Needle Stick _____                    |
| <input type="checkbox"/> Burn _____                                  | <input type="checkbox"/> Poisoning/Toxic Effects _____         |
| <input type="checkbox"/> Contusion/Hematoma _____                    | <input type="checkbox"/> Psychological _____                   |
| <input type="checkbox"/> Crush Injury _____                          | <input type="checkbox"/> Puncture Wound _____                  |
| <input type="checkbox"/> Dermatitis _____                            | <input type="checkbox"/> Repetitive Strain Injury _____        |
| <input type="checkbox"/> Dislocation _____                           | <input type="checkbox"/> Spinal Cord Injury _____              |
| <input type="checkbox"/> Fracture _____                              | <input type="checkbox"/> Sprain/Strain _____                   |
| <input type="checkbox"/> Hearing Loss _____                          | <input type="checkbox"/> Torn Ligament, Tendon or Muscle _____ |
| <input type="checkbox"/> Hernia _____                                | <input type="checkbox"/> Vision Loss _____                     |
| <input checked="" type="checkbox"/> Other (specify) <u>SEE NOTES</u> |  |



Patient's Name: GARLAND DONNA MI Date of injury/onset of illness: 06 / 07 / 2011  
Last First MI

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- |   |   |
|---|---|
| <input type="checkbox"/> None at present                  | <input type="checkbox"/> Neuromuscular Findings:      |
| <input type="checkbox"/> Bruising _____                   | <input type="checkbox"/> Abnormal/Restricted ROM      |
| <input type="checkbox"/> Burns _____                      | <input type="checkbox"/> Active ROM _____             |
| <input type="checkbox"/> Crepitation _____                | <input type="checkbox"/> Passive ROM _____            |
| <input type="checkbox"/> Deformity _____                  | <input type="checkbox"/> Gait _____                   |
| <input type="checkbox"/> Edema _____                      | <input type="checkbox"/> Palpable Muscle Spasm _____  |
| <input type="checkbox"/> Hematoma/Lump/Swelling _____     | <input type="checkbox"/> Reflexes _____               |
| <input type="checkbox"/> Joint Effusion _____             | <input type="checkbox"/> Sensation _____              |
| <input type="checkbox"/> Laceration/Sutures _____         | <input type="checkbox"/> Strength (Weakness) _____    |
| <input checked="" type="checkbox"/> Pain/Tenderness _____ | <input type="checkbox"/> Wasting/Muscle Atrophy _____ |
| <input type="checkbox"/> Scar _____                       |   |
| <input type="checkbox"/> Other findings: _____            |   |

5. Describe any diagnostic test(s) rendered at this visit: X-RAY BOTH KNEES

6. Describe any treatment(s) rendered at this visit: INITIAL OFFICE VISIT

7. Describe prognosis for recovery: \_\_\_\_\_

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☒ Yes ☐ No  
If yes, list and describe: \_\_\_\_\_

### G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 0.00 %
5. Describe findings and relevant diagnostic test results: X-RAY BOTH KNEES - SEE OFFICE NOTES FOR INTERPRETATION

### H. Plan of Care

1. What is your proposed treatment? \_\_\_\_\_

2. Medication(s): (a) list medications prescribed: PERCOCET

(b) list over-the-counter medications advised: \_\_\_\_\_

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

Patient's Name: GARLAND DONNA  
Last First MI

Date of injury/onset of illness: 06 / 07 / 2011

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan  
☐ EMG/NCS  
☒ MRI (Specify): BOTH KNEES  
☐ Labs (Specify): \_\_\_\_\_  
☐ X-rays (Specify): \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor  
☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair  
☐ Other (specify): \_\_\_\_\_

**Important:** Form C-4 AUTH should be used to request any special medical service costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

5. When is the patient's next follow-up appointment?

☐ Within a week ☐ 1-2 weeks ☒ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ \_\_\_\_\_ months ☐ Return as needed

## I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☒ No If yes, date patient first missed work: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Is the patient currently working? ☐ Yes ☐ No If yes, did the patient return to: ☐ usual work activities ☐ limited work activities

2. Can the patient return to work? (check only one):

- a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_
- b. ☐ The patient can return to work without limitations on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- c. ☐ The patient can return to work with the following limitations (check all that apply) on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bending/twisting         | <input type="checkbox"/> Lifting                       | <input type="checkbox"/> Sitting                      |
| <input type="checkbox"/> Climbing stairs/ladders  | <input type="checkbox"/> Operating heavy equipment     | <input type="checkbox"/> Standing                     |
| <input type="checkbox"/> Environmental conditions | <input type="checkbox"/> Operation of motor vehicles   | <input type="checkbox"/> Use of public transportation |
| <input type="checkbox"/> Kneeling                 | <input type="checkbox"/> Personal protective equipment | <input type="checkbox"/> Use of upper extremities     |
| <input type="checkbox"/> Other(explain): _____    |  |   |

Describe/quantify the limitations: \_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☒ with patient ☐ with patient's employer ☐ N/A

**This form is signed under penalty of perjury.**

**Board Authorized** Health Care Provider - Check one:

- ☒ I provided the services listed above.  
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

**Board Authorized** Health Care Provider signature:

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL REPORTING****IMPORTANT-TO THE ATTENDING DOCTOR**

1. 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** - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.  
If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future 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 use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.
2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
5. **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.
6. **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-l 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.
7. **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 this form. 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 Customer Service toll-free number listed 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 HOSPITALES 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.

Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

**NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

**Customer Service Toll-Free Line: 877-632-4996**

**Statewide Fax Line: 877-533-0337**

# Doctor's Progress Report

State of New York - Workers' Compensation Board

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

Date(s) of Examination: 11/08/2011

WCB Case Number (if known): \_\_\_\_\_ Carrier Case Number (if known): \_\_\_\_\_

## A. Patient's Information

1. Name: GARLAND DONNA 2. Date of injury/illness: 06 / 07 / 2011 3. Soc. Sec. #: - - -

4. Address (if changed from previous report): \_\_\_\_\_  
Number and Street City State Zip Code

5. Patient's Account #: \_\_\_\_\_

## B. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI

3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN

5. Office address: \_\_\_\_\_  
Number and Street City State Zip Code

6. Billing Group or Practice Name: \_\_\_\_\_

7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code

8. Office phone #: (\_\_\_\_\_) \_\_\_\_\_ 9. Billing phone #: (\_\_\_\_\_) \_\_\_\_\_ 10. Treating Provider's NPI #: \_\_\_\_\_

## C. Billing Information

1. Employer's insurance carrier: \_\_\_\_\_ 2. Carrier Code #: **W** \_\_\_\_\_

3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code

4. Diagnosis or nature of disease or injury:  
Enter ICD9 Code: ICD9 Descriptor:  
(1) 836.1 TEAT OF LATERAL CARTILLAGES OR MENISCUS OF KNEE, CURRENT  
(2) 836.0 TEAR OF MEDIAL CARTILLAGES OR MENISCUS OF KNEE, CURRENT  
(3) 715.10 OSTEOARTHRITIS, LOCALIZED, PRIMARY, INVOLVING LOWER LEG  
(4) \_\_\_\_\_

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
11	08	11	11	08	11	11		99212		123	120.78	1		11758

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 120.78	\$	\$

## D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

Patient's Name: GARLAND DONNA Date of injury/onset of illness: 06 / 07 / 2011  
Last First MI

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: SEE NOTES

3. List additional body parts affected by this injury, if any: \_\_\_\_\_

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: \_\_\_\_\_

5. Based on this examination, does the patient need diagnostic tests or referrals? ☒ Yes ☐ No If yes, check all that apply:

**Tests:**

☐ CT Scan ☐ EMG/NCS

☐ MRI (specify): \_\_\_\_\_

☐ Labs (specify): \_\_\_\_\_

☐ X-rays (specify): \_\_\_\_\_

☐ Other (specify): \_\_\_\_\_

**Referrals:**

☐ Chiropractor ☐ Internist/Family Physician

☐ Occupational Therapist

☐ Physical Therapist

☐ Specialist in: \_\_\_\_\_

☐ Other (specify): \_\_\_\_\_

**Important: Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.**

6. Describe treatment rendered today: FOLLOW UP OFFICE VISIT

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ \_\_\_\_ months ☐ as needed

**E. Doctor's Opinion (based on this examination)**

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No

2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No

3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)

4. What is the percentage (0-100%) of temporary impairment? 0.00 %

5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

**F. Return to Work**

1. Is patient working now? ☒ Yes ☐ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: \_\_\_\_\_

How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (check only one):

a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_

b. ☐ The patient can return to work without limitations on: \_\_\_\_/\_\_\_\_/\_\_\_\_

c. ☐ The patient can return to work with the following limitations (check all that apply) on: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Bending/twisting

☐ Lifting

☐ Sitting

☐ Climbing stairs/ladders

☐ Operating heavy equipment

☐ Standing

☐ Environmental conditions

☐ Operation of motor vehicles

☐ Use of public transportation

☐ Kneeling

☐ Personal protective equipment

☐ Use of upper extremities

☐ Other (explain): \_\_\_\_\_

Describe/quantify the limitations: \_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☒ with patient ☐ with patient's employer ☐ N/A

4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

**This form is signed under penalty of perjury.**

**Board Authorized Health Care Provider - Check one:**

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

**Board Authorized Health Care Provider signature:**

PHYSICIAN

11 / 15 / 11

Name

Signature

Specialty

Date

**MEDICAL REPORTING****IMPORTANT - TO THE ATTENDING DOCTOR**

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:

**PROGRESS REPORTS** - Following the filing of Form C-4, Doctor's Initial Report, file this form within 15 days after initial report and thereafter during continuing treatment without further request, when a follow-up visit is necessary, except the intervals between reports shall be no more than 90 days.

When reporting on MMI and/or Permanent Impairment, use Form C-4.3.

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 use Form C-5, Occupational/Physical Therapists use Form OT/PT-4 and Psychologists use Form PS-4 for filing reports.

2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service(s) costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee or shoulder.

***AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY***

5. **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.
6. **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-l 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.**
7. **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 this form. 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**

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**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' COMPENSATION BOARD**

Reports should be filed by sending directly to the Workers' Compensation Board at the address below with a copy sent to the insurance carrier:

NYS Workers' Compensation Board  
Centralized Mailing  
PO Box 5205  
Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION



# ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND CARRIER'S RESPONSE

State of New York - Workers' Compensation Board

**MG-2**

For additional variance requests in this case, attach Form MG-2.1.

Answer all questions where information is known.

WCB Case Number: _____	Carrier Case Number: 00000003-003	Date of Injury: 06/07/14
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**A.** Patient's Name: DONNA GARLAND Social Security No.: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Employer's Name & Address: \_\_\_\_\_

Insurance Carrier's Name & Address: \_\_\_\_\_

**B.** Attending Doctor's Name & Address: MASSAPEQUA

Individual Provider's WCB Authorization No.: ☐ ☐ ☐ ☐ ☐ ☐ - ☐ ☐ Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

**C.** The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:

Guideline Reference: ☐ - ☐ ☐ ☐ ☐ (In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)

**Approval Requested for: (one request type per form)**

**PRP INJECTION BILATERAL KNEES**

## STATEMENT OF MEDICAL NECESSITY - See item 4 on instruction page.

Your explanation must provide the following information:

- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:

- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:

- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of service of supporting medical in WCB case file, if not already submitted: \_\_\_\_\_

Date(s) of previously denied variance request for substantially similar treatment, if applicable: \_\_\_\_\_

**PLEASE SEE ATTACHED NOTES**

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care. I ☐ did / ☐ did not contact the carrier by telephone to discuss this variance request before making the request. I contacted the carrier by telephone on (date) \_\_\_\_\_ and spoke to (person spoke to or was not able to speak to anyone) \_\_\_\_\_

☐ A copy of this form was sent to the carrier/employer/self-insured employer/Special Fund (fax number or email address required) \_\_\_\_\_

A copy was sent to the Workers' Compensation Board, and copies were provided to the claimant's legal counsel, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

☐ I am not equipped to send or receive forms by fax or email. This form was mailed to the parties indicated above on \_\_\_\_\_

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: \_\_\_\_\_ Date: 12/20/2013

Patient Name: <u>DONNA</u>	WCB Case Number: _____	Date of Injury: <u>06/07/14</u>
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**D. CARRIER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW**

☐ The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the variance request.

By: (print name) \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**E. CARRIER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST**

Carrier's response to the variance request is indicated in the checkboxes on the right. Carrier denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CARRIER'S / EMPLOYER'S RESPONSE**

If service is denied or granted in part, explain in space provided.

- |  |  |
|--|--|
| <input type="checkbox"/> Granted   | <input type="checkbox"/> Without Prejudice |
| <input type="checkbox"/> Granted in Part                                 |  |
| <input type="checkbox"/> Denied  |  |
| <input type="checkbox"/> Burden of Proof Not Met                         |  |
| <input type="checkbox"/> Substantially Similar Request Pending or Denied |  |

Name of the Medical Professional who reviewed the denial, if applicable: \_\_\_\_\_

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

**(Please complete if request is denied.)** If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ at a WCB Hearing. I understand that if either party, the carrier or the claimant, opts in writing for resolution at a WCB hearing; the decision will be made at a WCB hearing. I understand that if neither party opts for resolution at a hearing, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER**

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name) \_\_\_\_\_ Title: \_\_\_\_\_

Carrier's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S / CARRIER'S DENIAL**

**NOTE to Claimant's / Claimant Licensed Representative's:** The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

**YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE CARRIER'S DENIAL OF THE PROVIDER'S VARIANCE REQUEST.**

☐ I request that the Workers' Compensation Board review the carrier's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ at a WCB Hearing. I understand that if either party, the carrier or the claimant, opts in writing for resolution at a WCB hearing; the decision will be made at a WCB hearing. I understand that if neither party opts for resolution at a hearing, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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.

**NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

**Customer Service Toll-Free Number: 877-632-4996**



## TO THE PROVIDER - REQUEST FOR APPROVAL TO VARY FROM MEDICAL TREATMENT GUIDELINES

1. This form is used for a workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit case as follows:  
To request approval to vary the treatment of the claimant identified on this form from the relevant Medical Treatment Guidelines.
2. Treating Medical Providers, which includes any physician, podiatrist, chiropractor or psychologist who is providing treatment and care to an injured worker pursuant to the Workers' Compensation Law, **must** treat injuries pursuant to the relevant Medical Treatment Guidelines. The Medical Treatment Guidelines are posted on the Board's website. For additional information, please call 1-800-781-2362.
3. The Medical Treatment Guidelines are the standard of care for injured workers.
4. A variance must be requested using this form. All questions on this form must be answered completely. The treating medical provider must prove that it is appropriate and medically necessary to vary from the Board's Medical Treatment Guidelines in the treatment of this claimant. Failure to provide sufficient reasons why a variance is necessary may result in the denial of the variance or may delay its approval. Your explanation must provide the following information:
  - the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
  - an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
  - a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
  - the specific duration or frequency of treatment for which a variance is requested.Variance requests for treatment or testing that is not recommended or not addressed, must include:
  - the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
  - medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.**No variance will be permitted for claimants who exceed the 10 visit annual maximum for on-going maintenance care.**
5. A supporting medical report must be submitted with this request if such report is not already in the Board's case file. No action will be taken on cases without a supporting medical report. A medical report supporting the denial of the variance request is not necessary when the denial is based upon the allegation that (1) the provider did not meet the burden of proof that a variance is appropriate, (2) the medical care for which the variance is requested has already been rendered, (3) the medical care requested is not covered under Section 13(a) of the Workers' Compensation Law, (4) the claimant did not appear for a scheduled independent medical examination, or (5) a new variance request was submitted prior to a substantially similar being granted or denied or a prior identical variance request has been denied, and the resubmitted request does not contain any additional documentation or justification.
6. If approval or denial is not forthcoming within 15 calendar days after the carrier has received the request and an IME or Medical Record Review is not required, the variance is deemed approved and the Board will issue an Order of the Chair stating the request is approved. If the payer decides either an IME or records review is required, the payer must notify the Board and Treating Medical Provider within 5 business days that it will be obtaining an outside opinion. The payer has 30 calendar days to get the IME exam or Medical Records Review and submit Form IME-4. If no notice of an IME or Medical Record Review is submitted, the payer has 15 calendar days from the date of the request to reply to the variance request.
7. If the claim is controverted, the Treating Medical Provider must request approval for the variance from the insurance carrier or Special Fund who would be responsible if the claim is established using this form and process.
8. This form must be signed by the Treating Medical Provider and must contain his/her 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.
9. If the carrier has checked "GRANTED" or "GRANTED IN PART" AND "WITHOUT PREJUDICE" in Section E, the liability for this claim has not yet been determined. This authorization is made pending final determination by the Board. Pursuant to 22NYCRR§325-1.4(b) this authorization is limited to the question of medical necessity only and is not an admission that the condition for which the services are required is compensable. This authorization does not represent an acceptance of this claim by the carrier, self-insured employer, employer or Special Fund or guarantee payment for the services authorized. When a decision is rendered regarding liability, you will receive a Notice of Decision by mail. The carrier, self-insured employer, employer or Special Fund will only provide payment for these services if the claim is established and the carrier, self-insured employer, employer or Special Fund is found to be responsible for the claim.
10. If the carrier has checked "SUBSTANTIALLY SIMILAR REQUEST PENDING OR DENIED" in Section E, the denial is not subject to an Order of the Chair. A substantially similar variance request may not be submitted unless the carrier has denied a previous request. Substantially similar requests that were previously denied may be submitted with additional documentation or justification.
11. Please ask your patient for his/her WCB case number and the carrier's case number and show these numbers on the form. In addition, ask your patient if he/she has retained a representative. If represented, ask for the name and address of the representative.
12. This request **must be sent by fax or email to the Board** and serve a copy by fax or email on the workers' compensation insurance carrier or self-insured employer, the patient and the patient's attorney or licensed representative, if represented. The report must be prepared, signed and submitted within two (2) business days. The request may be mailed if the certification is completed that the Treating Medical Provider is not equipped to send and receive the form by one of the prescribed methods of the same day transmission.
13. 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.

## TO THE CARRIER/EMPLOYER/SELF-INSURED EMPLOYER/SPECIAL FUND

### **Response Time and Notification Required:**

The carrier/employer/self-insured employer/Special Fund must approve or grant each variance request in writing by completing this form and sending it by fax or email to the Treating Medical Provider, claimant's legal counsel, if any, any parties of interest, and the Workers' Compensation Board. The carrier/ employer/self-insured employer/Special Fund may respond orally to the Treating Medical Provider about the variance requested by such provider. If the insurance carrier or Special Fund responds orally, it still must send a written response within the appropriate time period. If the carrier submits a notice of an IME or Medical Records Review within 5 business days of the variance request, the carrier has 30 calendar days to get the IME exam or Medical Records Review and submit Form IME-4. If no notice of an IME or Medical Record Review is submitted, the carrier has 15 calendar days from the date of the request to reply to the variance request.

### **Denial of the Variance Request:**

For a denial of a variance request for medical treatment, the carrier/employer/self-insured employer/Special Fund must explain why it was denied and attach the written report of the medical professional—a physician, registered physician assistant, registered professional nurse, or nurse practitioner licensed by New York State, or the appropriate state where the professional practices, who is employed by an insurance carrier or Special Fund, or has been directly retained by the insurance carrier or Special Fund or is employed by a URAC accredited company retained by the insurance carrier or Special Fund through a contract to review claims and advise the insurance carrier or Special Fund—that reviewed the variance request. Such report shall include a list describing the medical records reviewed by the medical professional when considering the variance request. The carrier has the option to submit citations or copies of relevant literature published in recognized, peer-reviewed medical journals in support of a denial of a variance request. A medical report supporting the denial of the variance request is not necessary when the denial is based upon the allegation that (1) the provider did not meet the burden of proof that a variance is appropriate, (2) the medical care for which the variance is requested has already been rendered, (3) the medical care requested is not covered under Section 13(a) of the Workers' Compensation Law, (4) the claimant did not appear for a scheduled independent medical examination, or (5) a new variance request was submitted prior to a substantially similar request being granted or denied or a substantially similar variance request has been denied, and the resubmitted request does not contain any additional documentation or justification.

### **Controverted Claims:**

If the compensation case is controverted, the carrier/self-insured employer/employer/Special Fund must still respond to the variance request timely and in the same manner as requests in non-controverted claims. If the carrier/employer/self-insured employer/Special Fund approves a variance request when a claim is controverted or the compensability of the body part is controverted, the approval only relates to medical necessity and shall not be construed as an admission that the condition for which variance is requested is compensable. The carrier/employer/self-insured employer/Special Fund shall not be responsible for the payment of medical care which is the subject of the variance request until the question of compensability is resolved.

### **Failure to Timely Respond to Variance Report:**

A valid variance may be deemed approved by an Order of the Chair issued by the Workers' Compensation Board if the carrier/employer/self-insured employer/Special Fund **fails to respond to a properly completed request within the time frames specified above**. The Order of the Chair is the final decision of the Board.

## **SAMPLE CLAIM #4 – BLAKE DENG**

**Claim #4 Blake Deng/ CC# 00000004-004/ DOA: 6/10/14**

General Information: The Claimant is a male Laborer who suffered a compensable work related injury when a heavy object fell on his thumb. Accident, Notice and Causal Relationship (ANCR) has been established to the right thumb. The injury resulted in surgery and the claimant lost 12 weeks from work as a result of this injury. It is likely that this claim will result in a SLU award.

The following services are required for this claim:

- 1) Independent Medical Exam for an opinion degree of disability w/ an Orthopedic Doctor in Latham, NY 12110
- 2) Review/Adjustment of HICF/ ER Physician Bill (attached)
- 3) Review/Adjustment of Pre-Operative Testing Bill (attached)
- 4) Review/Adjustment of DRG – Hospital Bill (attached)
- 5) Review/Adjustment of Surgical/Operative Bill (attached)
- 6) Review/Adjustment of HICF/ Anesthesia Bill (attached)
- 7) Review/Adjustment of HICF/ OT Bill (attached)
- 8) Review/Adjustment of Doctor's Initial Report/ C-4 (attached)

On tab #4 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Indemnity)

Medical Bill Review/ Adjustment (7 bills)

Independent Medical Exam (1 exam)

**Note:** For the medical bill review, provide the service fees attributable to the review/ adjustment of the bill, **not** the payment due the medical provider. For the purposes of this exercise, assume that each medical bill has the supporting medical documentation necessary to process payment as billed by provider.

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997  THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.



# Doctor's Initial Report

**C-4**

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

## A. Patient's Information

1. Name: DENG, BLAKE 2. Social Security #: - -  
Last First MI
3. Home phone #: ( ) 4. WCB Case # (if known): 5. Carrier Case #: 00000004-004
6. Mailing address: \_\_\_\_\_
7. Date of injury/onset of illness: 06 / 09 / 2014 8. Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 9. Gender: ☒ Male ☐ Female  
Number and Street City State Zip Code
10. On the date of injury/illness what was the patient's job title or description: \_\_\_\_\_
11. On the date of injury/illness what were the patient's usual work activities: \_\_\_\_\_
12. Patient's Account #: \_\_\_\_\_

## B. Employer Information

1. Employer when injury occurred: \_\_\_\_\_ 2. Phone #: ( ) \_\_\_\_\_  
Company/Agency Name
3. Employer Address: \_\_\_\_\_  
Number and Street City State Zip Code

## C. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI
3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN
5. Office address: \_\_\_\_\_ ALBANY NY 12206  
Number and Street City State Zip Code
6. Billing group or practice name: \_\_\_\_\_
7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code
8. Office phone #: ( ) 9. Billing phone #: ( ) 10. Treating Provider's NPI #: \_\_\_\_\_
11. You are a (check one): ☒ Physician ☐ Podiatrist ☐ Chiropractor

## D. Billing Information

1. Employer's insurance carrier: \_\_\_\_\_ 2. Carrier Code #: W
3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code
4. Diagnosis or nature of disease or injury:
- |                   |  |
|-------------------|--|
| Enter ICD9 Code:  | ICD9 Descriptor:                             |
| (1) <u>727.63</u> | <u>NONTRAUMAT RUP EXT TEND HND&amp;WRIST</u> |
| (2) _____         | _____  |
| (3) _____         | _____  |
| (4) _____         | _____  |

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: DENG, BLAKE  
Last
First
MI

Date of injury/onset of illness:        /        /       

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
07	07	14	07	07	14	11		99024	.....	1	0.00	1		12206
07	07	14	07	07	14	11		99070	.....	1	4.00	1		12206
									.....					
									.....					
									.....					
									.....					
									.....					

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 4.00	\$	\$

## E. History

- Based on the patient's history, where and how did the injury/illness happen: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- How did you learn about the injury/illness (check one): ☐ Patient ☐ Medical Records ☐ Other(specify): \_\_\_\_\_
- Did another health provider treat this injury/illness including hospitalization and/or surgery? ☐ Yes ☐ No If yes, give details: \_\_\_\_\_  
 \_\_\_\_\_
- Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☐ No If yes, when: \_\_\_\_\_

## F. Exam Information

- Date(s) of Examination: \_\_\_\_\_
- Patient's subjective complaints: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Numbness/Tingling _____	<input type="checkbox"/> Swelling _____
<input type="checkbox"/> Pain _____	<input type="checkbox"/> Weakness _____
<input type="checkbox"/> Stiffness _____	<input type="checkbox"/> Other (specify) _____
- Type/nature of injury: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Abrasion _____	<input type="checkbox"/> Infectious Disease _____
<input type="checkbox"/> Amputation _____	<input type="checkbox"/> Inhalation Exposure _____
<input type="checkbox"/> Avulsion _____	<input type="checkbox"/> Laceration _____
<input type="checkbox"/> Bite _____	<input type="checkbox"/> Needle Stick _____
<input type="checkbox"/> Burn _____	<input type="checkbox"/> Poisoning/Toxic Effects _____
<input type="checkbox"/> Contusion/Hematoma _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Crush Injury _____	<input type="checkbox"/> Puncture Wound _____
<input type="checkbox"/> Dermatitis _____	<input type="checkbox"/> Repetitive Strain Injury _____
<input type="checkbox"/> Dislocation _____	<input type="checkbox"/> Spinal Cord Injury _____
<input type="checkbox"/> Fracture _____	<input type="checkbox"/> Sprain/Strain _____
<input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Torn Ligament, Tendon or Muscle _____
<input type="checkbox"/> Hernia _____	<input type="checkbox"/> Vision Loss _____
<input type="checkbox"/> Other (specify) _____	



Patient's Name: DENG, BLAKE Last First MI Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- |   |   |
|---|---|
| <input type="checkbox"/> None at present              | <input type="checkbox"/> Neuromuscular Findings:      |
| <input type="checkbox"/> Bruising _____               | <input type="checkbox"/> Abnormal/Restricted ROM      |
| <input type="checkbox"/> Burns _____                  | <input type="checkbox"/> Active ROM _____             |
| <input type="checkbox"/> Crepitation _____            | <input type="checkbox"/> Passive ROM _____            |
| <input type="checkbox"/> Deformity _____              | <input type="checkbox"/> Gait _____                   |
| <input type="checkbox"/> Edema _____                  | <input type="checkbox"/> Palpable Muscle Spasm _____  |
| <input type="checkbox"/> Hematoma/Lump/Swelling _____ | <input type="checkbox"/> Reflexes _____               |
| <input type="checkbox"/> Joint Effusion _____         | <input type="checkbox"/> Sensation _____              |
| <input type="checkbox"/> Laceration/Sutures _____     | <input type="checkbox"/> Strength (Weakness) _____    |
| <input type="checkbox"/> Pain/Tenderness _____        | <input type="checkbox"/> Wasting/Muscle Atrophy _____ |
| <input type="checkbox"/> Scar _____                   |   |
| <input type="checkbox"/> Other findings: _____        |   |

5. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

6. Describe any treatment(s) rendered at this visit: \_\_\_\_\_

7. Describe prognosis for recovery: \_\_\_\_\_

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No

If yes, list and describe: \_\_\_\_\_

## G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

## H. Plan of Care

1. What is your proposed treatment? \_\_\_\_\_

2. Medication(s): (a) list medications prescribed: \_\_\_\_\_

(b) list over-the-counter medications advised: \_\_\_\_\_

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan  
☐ EMG/NCS  
☐ MRI (Specify): \_\_\_\_\_  
☐ Labs (Specify): \_\_\_\_\_  
☐ X-rays (Specify): \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor  
☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair  
☐ Other (specify): \_\_\_\_\_

**Important:** Form C-4 AUTH should be used to request any special medical service costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

5. When is the patient's next follow-up appointment?

☐ Within a week ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ \_\_\_\_\_ months ☐ Return as needed

## I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☐ No If yes, date patient first missed work: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the patient currently working? ☐ Yes ☐ No If yes, did the patient return to: ☐ usual work activities ☐ limited work activities

2. Can the patient return to work? (check only one):

- a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_
- b. ☐ The patient can return to work without limitations on \_\_\_\_/\_\_\_\_/\_\_\_\_
- c. ☐ The patient can return to work with the following limitations (check all that apply) on \_\_\_\_/\_\_\_\_/\_\_\_\_
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bending/twisting         | <input type="checkbox"/> Lifting                       | <input type="checkbox"/> Sitting                      |
| <input type="checkbox"/> Climbing stairs/ladders  | <input type="checkbox"/> Operating heavy equipment     | <input type="checkbox"/> Standing                     |
| <input type="checkbox"/> Environmental conditions | <input type="checkbox"/> Operation of motor vehicles   | <input type="checkbox"/> Use of public transportation |
| <input type="checkbox"/> Kneeling                 | <input type="checkbox"/> Personal protective equipment | <input type="checkbox"/> Use of upper extremities     |
| <input type="checkbox"/> Other(explain): _____    |  |   |

Describe/quantify the limitations: \_\_\_\_\_

\_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

**This form is signed under penalty of perjury.**

**Board Authorized** Health Care Provider - Check one:

- ☐ I provided the services listed above.  
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

**Board Authorized** Health Care Provider signature:

Name	Signature	ORTHOPEDIC SURGERY Specialty	/ / Date
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**MEDICAL REPORTING****IMPORTANT-TO THE ATTENDING DOCTOR**

1. 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** - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.  
If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future 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 use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.
2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
5. **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.
6. **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-l 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.
7. **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 this form. 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 Customer Service toll-free number listed 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 HOSPITALES 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."

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Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

**NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

**Customer Service Toll-Free Line: 877-632-4996**

**Statewide Fax Line: 877-533-0337**



# Doctor's Initial Report

**C-4**

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

## A. Patient's Information

1. Name: DENG, BLAKE 2. Social Security #: - -  
Last First MI
3. Home phone #: ( ) 4. WCB Case # (if known): 5. Carrier Case #: 00000004-004
6. Mailing address: \_\_\_\_\_  
Number and Street City State Zip Code
7. Date of injury/onset of illness: 06 / 09 / 2014 8. Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 9. Gender: ☒ Male ☐ Female
10. On the date of injury/illness what was the patient's job title or description: \_\_\_\_\_
11. On the date of injury/illness what were the patient's usual work activities: \_\_\_\_\_
12. Patient's Account #: \_\_\_\_\_

## B. Employer Information

1. Employer when injury occurred: \_\_\_\_\_ 2. Phone #: ( ) \_\_\_\_\_  
Company/Agency Name
3. Employer Address: \_\_\_\_\_  
Number and Street City State Zip Code

## C. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI
3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN
5. Office address: \_\_\_\_\_  
Number and Street City State Zip Code
6. Billing group or practice name: \_\_\_\_\_
7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code
8. Office phone #: ( ) 9. Billing phone #: ( ) 10. Treating Provider's NPI #: \_\_\_\_\_
11. You are a (check one): ☐ Physician ☐ Podiatrist ☐ Chiropractor

## D. Billing Information

1. Employer's insurance carrier: \_\_\_\_\_ 2. Carrier Code #: W
3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code
4. Diagnosis or nature of disease or injury:
- |                   |  |
|-------------------|--|
| Enter ICD9 Code:  | ICD9 Descriptor:                               |
| (1) <u>711.04</u> | <u>PYOGENIC ARTHRITIS, HAND</u>                |
| (2) <u>727.63</u> | <u>NONTRAUMAT RUP EXT TEND HND &amp; WRIST</u> |
| (3) _____         | _____  |
| (4) _____         | _____  |

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: DENG, BLAKE  
Last First MI

Date of injury/onset of illness:        /        /       

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
06	17	14	06	17	14	21		99253	57	1	167.43	1		12208
06	17	14	06	17	14	21		26080	RT	1	594.71	1		12208
06	17	14	06	17	14	21		26418	59	2	371.13	1		12208

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 1143.27	\$	\$

## E. History

- Based on the patient's history, where and how did the injury/illness happen: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- How did you learn about the injury/illness (check one): ☐ Patient ☐ Medical Records ☐ Other(specify): \_\_\_\_\_
- Did another health provider treat this injury/illness including hospitalization and/or surgery? ☐ Yes ☐ No If yes, give details: \_\_\_\_\_  
 \_\_\_\_\_
- Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☐ No If yes, when: \_\_\_\_\_

## F. Exam Information

- Date(s) of Examination: \_\_\_\_\_
- Patient's subjective complaints: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Numbness/Tingling _____	<input type="checkbox"/> Swelling _____
<input type="checkbox"/> Pain _____	<input type="checkbox"/> Weakness _____
<input type="checkbox"/> Stiffness _____	<input type="checkbox"/> Other (specify) _____
- Type/nature of injury: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Abrasion _____	<input type="checkbox"/> Infectious Disease _____
<input type="checkbox"/> Amputation _____	<input type="checkbox"/> Inhalation Exposure _____
<input type="checkbox"/> Avulsion _____	<input type="checkbox"/> Laceration _____
<input type="checkbox"/> Bite _____	<input type="checkbox"/> Needle Stick _____
<input type="checkbox"/> Burn _____	<input type="checkbox"/> Poisoning/Toxic Effects _____
<input type="checkbox"/> Contusion/Hematoma _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Crush Injury _____	<input type="checkbox"/> Puncture Wound _____
<input type="checkbox"/> Dermatitis _____	<input type="checkbox"/> Repetitive Strain Injury _____
<input type="checkbox"/> Dislocation _____	<input type="checkbox"/> Spinal Cord Injury _____
<input type="checkbox"/> Fracture _____	<input type="checkbox"/> Sprain/Strain _____
<input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Torn Ligament, Tendon or Muscle _____
<input type="checkbox"/> Hernia _____	<input type="checkbox"/> Vision Loss _____
<input type="checkbox"/> Other (specify) _____	

Patient's Name: DENG, BLAKE

Last

First

MI

Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

☐ None at present

☐ Bruising \_\_\_\_\_

☐ Burns \_\_\_\_\_

☐ Crepitation \_\_\_\_\_

☐ Deformity \_\_\_\_\_

☐ Edema \_\_\_\_\_

☐ Hematoma/Lump/Swelling \_\_\_\_\_

☐ Joint Effusion \_\_\_\_\_

☐ Laceration/Sutures \_\_\_\_\_

☐ Pain/Tenderness \_\_\_\_\_

☐ Scar \_\_\_\_\_

☐ Other findings: \_\_\_\_\_

☐ Neuromuscular Findings:

☐ Abnormal/Restricted ROM

☐ Active ROM \_\_\_\_\_

☐ Passive ROM \_\_\_\_\_

☐ Gait \_\_\_\_\_

☐ Palpable Muscle Spasm \_\_\_\_\_

☐ Reflexes \_\_\_\_\_

☐ Sensation \_\_\_\_\_

☐ Strength (Weakness) \_\_\_\_\_

☐ Wasting/Muscle Atrophy \_\_\_\_\_

5. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

6. Describe any treatment(s) rendered at this visit: \_\_\_\_\_

7. Describe prognosis for recovery: \_\_\_\_\_

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No

If yes, list and describe: \_\_\_\_\_

## G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No

2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No

3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)

4. What is the percentage (0-100%) of temporary impairment? 100.00 %

5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

## H. Plan of Care

1. What is your proposed treatment? \_\_\_\_\_

2. Medication(s): (a) list medications prescribed: \_\_\_\_\_

(b) list over-the-counter medications advised: \_\_\_\_\_

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

Patient's Name: DENG, BLAKE  
Last First MI

Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan  
☐ EMG/NCS  
☐ MRI (Specify): \_\_\_\_\_  
☐ Labs (Specify): \_\_\_\_\_  
☐ X-rays (Specify): \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor  
☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair  
☐ Other (specify): \_\_\_\_\_

**Important:** Form C-4 AUTH should be used to request any special medical service costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

5. When is the patient's next follow-up appointment?

☐ Within a week ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ \_\_\_\_\_ months ☐ Return as needed

## I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☐ No If yes, date patient first missed work: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the patient currently working? ☐ Yes ☐ No If yes, did the patient return to: ☐ usual work activities ☐ limited work activities

2. Can the patient return to work? (check only one):

- a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_
- b. ☐ The patient can return to work without limitations on \_\_\_\_/\_\_\_\_/\_\_\_\_
- c. ☐ The patient can return to work with the following limitations (check all that apply) on \_\_\_\_/\_\_\_\_/\_\_\_\_
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bending/twisting         | <input type="checkbox"/> Lifting                       | <input type="checkbox"/> Sitting                      |
| <input type="checkbox"/> Climbing stairs/ladders  | <input type="checkbox"/> Operating heavy equipment     | <input type="checkbox"/> Standing                     |
| <input type="checkbox"/> Environmental conditions | <input type="checkbox"/> Operation of motor vehicles   | <input type="checkbox"/> Use of public transportation |
| <input type="checkbox"/> Kneeling                 | <input type="checkbox"/> Personal protective equipment | <input type="checkbox"/> Use of upper extremities     |
| <input type="checkbox"/> Other(explain): _____    |  |   |

Describe/quantify the limitations: \_\_\_\_\_

\_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

**This form is signed under penalty of perjury.**

**Board Authorized** Health Care Provider - Check one:

- ☒ I provided the services listed above.  
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty ORTHOPEDIC SURGERY

**Board Authorized** Health Care Provider signature:

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL REPORTING****IMPORTANT-TO THE ATTENDING DOCTOR**

1. 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** - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.  
If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future 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 use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.
2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
5. **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.
6. **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-l 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.
7. **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 this form. 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 Customer Service toll-free number listed 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.

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UB-04 CMS-1450      APPROVED OMB NO. 0938-0997       NUBC™ National Uniform Billing Committee      THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PHYSICIAN OR SUPPLIER INFORMATION

**Instructions for Completing OWCP-1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)**

**GENERAL INFORMATION-FECA AND EEOICPA CLAIMANTS:** Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for compensable illnesses defined under that Act. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of the disability or illness, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, or osteopathic practitioners within the scope of their practice as defined by State law. However, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

**FEES:** The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

**REPORTS:** A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

**GENERAL INFORMATION-BLBA CLAIMANTS:** The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

**SIGNATURE OF PHYSICIAN OR SUPPLIER:** Your signature in Item 31 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by you or were furnished incident to your professional services by your employee under your immediate personal supervision, except as otherwise expressly permitted by FECA, Black Lung or EEOICPA regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material act, may be prosecuted under applicable Federal or State laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF FECA, BLACK LUNG AND EEOICPA INFORMATION  
(PRIVACY ACT STATEMENT)**

We are authorized by OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. Your response regarding the medical service(s) received or the amount charged is required to receive payment for the claim. See 20 CFR §§ 10.801, 30.701, 725.406, 725.701, and 725.704. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the claim because of incomplete information. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished. You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

**FORM SUBMISSION**

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742-8300, unless otherwise instructed.  
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 8302, London, KY 40742-8302, unless otherwise instructed.  
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304, unless otherwise instructed.

**INSTRUCTIONS FOR COMPLETING THE FORM:** A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

- Item 1. Leave blank.
- Item 1a. Enter the patient's claim number.
- Item 2. Enter the patient's last name, first name, middle initial.
- Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
- Item 4. For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
- Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
- Item 6. Leave blank.
- Item 7. For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
- Item 8. Leave blank.
- Item 9. Leave blank.
- Item 10. Leave blank.
- Item 11. For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.

- Item 11a. Leave blank.  
Item 11b. Leave blank.  
Item 11c. Leave blank.  
Item 11d. Leave blank.  
Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.  
Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.  
Item 14. Leave blank.  
Item 15. Leave blank.  
Item 16. Leave blank.  
Item 17. Leave blank.  
Item 18. Leave blank.  
Item 19. Leave blank.  
Item 20. Leave blank.  
Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.  
Item 22. Leave blank.  
Item 23. Leave blank.  
Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.  
Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).  
Column C: not required.  
Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.  
Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.  
Column F: enter the total charge(s) for each listed service(s).  
Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.  
Column H: Leave blank.  
Column I: Leave blank.  
Column J: Enter NPI.  
Item 25: Enter the Federal tax I.D.  
Item 26: Provider may enter a patient account number that will appear on the remittance voucher.  
Item 27: Leave blank.  
Item 28: Enter the total charge for the listed services in Column F.  
Item 29: If any payment has been made, enter that amount here.  
Item 30: Enter the balance now due.  
Item 31: For BLBA and EEOICPA: sign and date the form. For FECA: signature stamp or "signature on file" is acceptable.  
Item 32: Enter complete name of hospital, facility or physician's office where services were rendered. Item 32a. Enter NPI. Item 32b. Enter taxonomy number.  
Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.  
Item 33a. Enter NPI.  
Item 33b. Enter taxonomy number.

Place of Service (POS) Codes for Item 24B

3	School	34	Hospice
4	Homeless Shelter	41	Ambulance - Land
5	Indian Health Service Free-Standing Facility	42	Ambulance - Air or Water
6	Indian Health Service Provider-Based Facility	50	Federally Qualified Health Center
7	Tribal 638 Free-Standing Facility	51	Inpatient Psychiatric Facility
8	Tribal 638 Provider-Based Facility	52	Psychiatric Facility Partial Hospitalization
11	Office	53	Community Mental Health Center (CMHC)
12	Patient Home	54	Intermediate Care Facility/Mentally Retarded
15	Mobile Unit	55	Residential Substance Abuse Treatment Facility
20	Urgent Care	56	Psychiatric Residential Treatment Center
21	Inpatient Hospital	60	Mass Immunization Center
22	Outpatient Hospital	61	Comprehensive Inpatient Rehabilitation Facility
23	Emergency Room - Hospital	62	Comprehensive Outpatient Rehabilitation Facility
24	Ambulatory Surgical Center	65	End Stage Renal Disease Treatment Facility
25	Birth Center	71	State or Local Public Health Clinic
26	Military Treatment Facility	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other Place of Service
33	Custodial Care Facility		

### Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1240-0044. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1240-0044), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

### 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 your claims examiner to ask about this assistance.

Reset Form

Print Form

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Medicaid #)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DENG, BLAKE												3. PATIENT'S BIRTH DATE MM DD YY				SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)							
CITY												STATE				8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>							
ZIP CODE												TELEPHONE (Include Area Code)				9. INSURED'S POLICY GROUP OR FECA NUMBER							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				11. INSURED'S DATE OF BIRTH MM DD YY							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				a. INSURED'S DATE OF BIRTH MM DD YY							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY												c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME												10d. RESERVED FOR LOCAL USE				c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? If yes, return to and complete item 9 a-d.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____							
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. OUTSIDE LAB? \$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)												22. MEDICAID RESUBMISSION CODE				22. MEDICAID RESUBMISSION ORIGINAL REF. NO.							
23. PRIOR AUTHORIZATION NUMBER												23. PRIOR AUTHORIZATION NUMBER				23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. Place of Service EMG				C. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS				D. DIAGNOSIS DIAGNOSIS POINTER			
1 06/10/14												23				99283				25 ABCD			
2 06/10/14												23				29130				F5 ABCD			
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER												SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____												32. SERVICE FACILITY LOCATION INFORMATION ALBANY, NY 12208				33. BILLING PROVIDER INFO & PH #				33. BILLING PROVIDER INFO & PH #			
28. TOTAL CHARGE \$ 154.92												29. AMOUNT PAID \$ 0.00				30. BALANCE DUE \$				30. BALANCE DUE			

**Instructions for Completing OWCP-1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)**

**GENERAL INFORMATION-FECA AND EEOICPA CLAIMANTS:** Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for compensable illnesses defined under that Act. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of the disability or illness, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, or osteopathic practitioners within the scope of their practice as defined by State law. However, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

**FEES:** The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

**REPORTS:** A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

**GENERAL INFORMATION-BLBA CLAIMANTS:** The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

**SIGNATURE OF PHYSICIAN OR SUPPLIER:** Your signature in Item 31 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by you or were furnished incident to your professional services by your employee under your immediate personal supervision, except as otherwise expressly permitted by FECA, Black Lung or EEOICPA regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material act, may be prosecuted under applicable Federal or State laws.

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(PRIVACY ACT STATEMENT)**

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EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304, unless otherwise instructed.

**INSTRUCTIONS FOR COMPLETING THE FORM:** A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

- Item 1. Leave blank.
- Item 1a. Enter the patient's claim number.
- Item 2. Enter the patient's last name, first name, middle initial.
- Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
- Item 4. For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
- Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
- Item 6. Leave blank.
- Item 7. For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
- Item 8. Leave blank.
- Item 9. Leave blank.
- Item 10. Leave blank.
- Item 11. For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.



- Item 11a. Leave blank.  
Item 11b. Leave blank.  
Item 11c. Leave blank.  
Item 11d. Leave blank.  
Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.  
Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.  
Item 14. Leave blank.  
Item 15. Leave blank.  
Item 16. Leave blank.  
Item 17. Leave blank.  
Item 18. Leave blank.  
Item 19. Leave blank.  
Item 20. Leave blank.  
Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.  
Item 22. Leave blank.  
Item 23. Leave blank.  
Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.  
Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).  
Column C: not required.  
Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.  
Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.  
Column F: enter the total charge(s) for each listed service(s).  
Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.  
Column H: Leave blank.  
Column I: Leave blank.  
Column J: Enter NPI.  
Item 25: Enter the Federal tax I.D.  
Item 26: Provider may enter a patient account number that will appear on the remittance voucher.  
Item 27: Leave blank.  
Item 28: Enter the total charge for the listed services in Column F.  
Item 29: If any payment has been made, enter that amount here.  
Item 30: Enter the balance now due.  
Item 31: For BLBA and EEOICPA: sign and date the form. For FECA: signature stamp or "signature on file" is acceptable.  
Item 32: Enter complete name of hospital, facility or physician's office where services were rendered. Item 32a. Enter NPI. Item 32b. Enter taxonomy number.  
Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.  
Item 33a. Enter NPI.  
Item 33b. Enter taxonomy number.

Place of Service (POS) Codes for Item 24B

3	School	34	Hospice
4	Homeless Shelter	41	Ambulance - Land
5	Indian Health Service Free-Standing Facility	42	Ambulance - Air or Water
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1500

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<div> <div> <div></div> <div></div> <div></div> </div> <div>PICA</div> </div> <div> <div></div> <div></div> <div></div> </div> <div>PICA</div>										<div> <div> <div>1. MEDICARE (Medicare #)</div> <div> <div>MEDICAID (Medicaid #)</div> <div>TRICARE (Sponsor's SSN)</div> <div>CHAMPVA (Medicaid #)</div> </div> <div> <div>GROUP HEALTH PLAN (SSN or ID)</div> <div>FECA BLK LUNG (SSN)</div> <div>OTHER (ID)</div> </div> </div> </div>										<div>1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)</div>																																																																																																			
<div> <div> <div>2DENG, BLAKE</div> </div> </div>										<div> <div>3. PATIENT'S BIRTH DATE</div> <div>MM DD YY</div> <div> <div>M</div> <div>X</div> <div>F</div> </div> </div>										<div>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</div>																																																																																																			
<div>5. PATIENT'S ADDRESS (No., Street)</div>										<div>6. PATIENT RELATIONSHIP TO INSURED</div> <div> <div>Self</div> <div>Spouse</div> <div>Child</div> <div>Other</div> </div>										<div>7. INSURED'S ADDRESS (No., Street)</div>																																																																																																			
<div> <div>CITY</div> <div>STATE</div> </div>										<div>8. PATIENT STATUS</div> <div> <div>Single</div> <div>Married</div> <div>Other</div> </div>										<div> <div>CITY</div> <div>STATE</div> </div>																																																																																																			
<div> <div>ZIP CODE</div> <div>TELEPHONE (Include Area Code)</div> </div>										<div> <div>Employed</div> <div>Full-Time Student</div> <div>Part-Time Student</div> </div>										<div> <div>ZIP CODE</div> <div>TELEPHONE (Include Area Code)</div> </div>																																																																																																			
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div>										<div>10. IS PATIENT'S CONDITION RELATED TO:</div>										<div>11. INSURED'S POLICY GROUP OR FECA NUMBER</div>																																																																																																			
<div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div>										<div>a. EMPLOYMENT? (CURRENT OR PREVIOUS)</div> <div> <div>YES</div> <div>X</div> <div>NO</div> </div>										<div>a. INSURED'S DATE OF BIRTH</div> <div>MM DD YY</div> <div> <div>M</div> <div>X</div> <div>F</div> </div>																																																																																																			
<div>b. OTHER INSURED'S DATE OF BIRTH</div> <div>MM DD YY</div> <div> <div>M</div> <div>X</div> <div>F</div> </div>										<div>b. AUTO ACCIDENT?</div> <div> <div>YES</div> <div>X</div> <div>NO</div> </div>										<div>b. EMPLOYER'S NAME OR SCHOOL NAME</div>																																																																																																			
<div>c. EMPLOYER'S NAME OR SCHOOL NAME</div>										<div>c. OTHER ACCIDENT?</div> <div> <div>YES</div> <div>X</div> <div>NO</div> </div>										<div>c. INSURANCE PLAN NAME OR PROGRAM NAME</div>																																																																																																			
<div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div>										<div>10d. RESERVED FOR LOCAL USE</div>										<div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</div> <div> <div>YES</div> <div>NO</div> </div> <div>If yes, return to and complete item 9 a-d.</div>																																																																																																			
<div>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</div>																				<div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div>																																																																																																			
<div>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</div>																				<div>SIGNED</div>																																																																																																			
<div>14. DATE OF CURRENT:</div> <div>MM DD YY</div>										<div>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)</div>										<div>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.</div> <div>GIVE FIRST DATE</div> <div>MM DD YY</div>										<div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>FROM</div> <div>MM DD YY</div> <div>TO</div> <div>MM DD YY</div>																																																																																									
<div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div>										<div>17a.</div>										<div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</div> <div>FROM</div> <div>MM DD YY</div> <div>TO</div> <div>MM DD YY</div>																																																																																																			
<div>19. RESERVED FOR LOCAL USE</div>										<div>17b. NPI</div>										<div>20. OUTSIDE LAB?</div> <div> <div>YES</div> <div>X</div> <div>NO</div> </div>																																																																																																			
<div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)</div>																				<div>22. MEDICAID RESUBMISSION</div> <div>CODE</div>																				<div>23. PRIOR AUTHORIZATION NUMBER</div>																																																																															
<div>24. A. DATE(S) OF SERVICE</div> <div>From</div> <div>MM DD YY</div> <div>To</div> <div>MM DD YY</div>										<div>B. Place of Service</div> <div>EMG</div>										<div>C. PROCEDURES, SERVICES, OR SUPPLIES</div> <div>(Explain Unusual Circumstances)</div> <div>CPT/HCPCS</div> <div>MODIFIER</div>										<div>D. DIAGNOSIS</div> <div>DIAGNOSIS POINTER</div>										<div>E. \$ CHARGES</div>										<div>F. DAYS OR UNITS</div>										<div>G. EPSDT Family Plan</div>										<div>H. ID QUAL.</div>										<div>I. RENDERING PROVIDER ID. #</div>																																							
<div>1</div>										<div>06/17/14</div>										<div>S</div>										<div>21</div>										<div>01830</div>										<div>AB</div>										<div>195.39</div>										<div>88</div>										<div>NPI</div>										<div></div>																													
<div>2</div>																																																																																																																							
<div>3</div>																																																																																																																							
<div>4</div>																																																																																																																							
<div>5</div>																																																																																																																							
<div>6</div>																																																																																																																							
<div>25. FEDERAL TAX I.D. NUMBER</div> <div>SSN</div> <div>EIN</div>										<div>26. PATIENT'S ACCOUNT NO.</div>										<div>27. ACCEPT ASSIGNMENT?</div> <div>(For govt. claims, see back)</div> <div> <div>YES</div> <div>NO</div> </div>										<div>28. TOTAL CHARGE</div> <div>\$</div> <div>195.39</div>										<div>29. AMOUNT PAID</div> <div>\$</div> <div>0.00</div>										<div>30. BALANCE DUE</div> <div>\$</div>																																																																					
<div>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</div>																				<div>32. SERVICE FACILITY LOCATION INFORMATION</div>																				<div>33. BILLING PROVIDER INFO &amp; PH #</div> <div>( )</div>																																																																															
<div>SIGNED</div>																				<div>DATE</div>																				<div>a.</div>																				<div>b.</div>																				<div>a.</div>																				<div>b.</div>																			

**Instructions for Completing OWCP-1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)**

**GENERAL INFORMATION-FECA AND EEOICPA CLAIMANTS:** Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for compensable illnesses defined under that Act. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of the disability or illness, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, or osteopathic practitioners within the scope of their practice as defined by State law. However, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

**FEES:** The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

**REPORTS:** A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

**GENERAL INFORMATION-BLBA CLAIMANTS:** The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

**SIGNATURE OF PHYSICIAN OR SUPPLIER:** Your signature in Item 31 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by you or were furnished incident to your professional services by your employee under your immediate personal supervision, except as otherwise expressly permitted by FECA, Black Lung or EEOICPA regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material act, may be prosecuted under applicable Federal or State laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF FECA, BLACK LUNG AND EEOICPA INFORMATION  
(PRIVACY ACT STATEMENT)**

We are authorized by OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. Your response regarding the medical service(s) received or the amount charged is required to receive payment for the claim. See 20 CFR §§ 10.801, 30.701, 725.406, 725.701, and 725.704. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the claim because of incomplete information. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished. You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

**FORM SUBMISSION**

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742-8300, unless otherwise instructed.  
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 8302, London, KY 40742-8302, unless otherwise instructed.  
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304, unless otherwise instructed.

**INSTRUCTIONS FOR COMPLETING THE FORM:** A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

- Item 1. Leave blank.
- Item 1a. Enter the patient's claim number.
- Item 2. Enter the patient's last name, first name, middle initial.
- Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
- Item 4. For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
- Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
- Item 6. Leave blank.
- Item 7. For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
- Item 8. Leave blank.
- Item 9. Leave blank.
- Item 10. Leave blank.
- Item 11. For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.

- Item 11a. Leave blank.  
Item 11b. Leave blank.  
Item 11c. Leave blank.  
Item 11d. Leave blank.  
Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.  
Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.  
Item 14. Leave blank.  
Item 15. Leave blank.  
Item 16. Leave blank.  
Item 17. Leave blank.  
Item 18. Leave blank.  
Item 19. Leave blank.  
Item 20. Leave blank.  
Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.  
Item 22. Leave blank.  
Item 23. Leave blank.  
Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.  
Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).  
Column C: not required.  
Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.  
Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.  
Column F: enter the total charge(s) for each listed service(s).  
Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.  
Column H: Leave blank.  
Column I: Leave blank.  
Column J: Enter NPI.  
Item 25: Enter the Federal tax I.D.  
Item 26: Provider may enter a patient account number that will appear on the remittance voucher.  
Item 27: Leave blank.  
Item 28: Enter the total charge for the listed services in Column F.  
Item 29: If any payment has been made, enter that amount here.  
Item 30: Enter the balance now due.  
Item 31: For BLBA and EEOICPA: sign and date the form. For FECA: signature stamp or "signature on file" is acceptable.  
Item 32: Enter complete name of hospital, facility or physician's office where services were rendered. Item 32a. Enter NPI. Item 32b. Enter taxonomy number.  
Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.  
Item 33a. Enter NPI.  
Item 33b. Enter taxonomy number.

Place of Service (POS) Codes for Item 24B

3	School	34	Hospice
4	Homeless Shelter	41	Ambulance - Land
5	Indian Health Service Free-Standing Facility	42	Ambulance - Air or Water
6	Indian Health Service Provider-Based Facility	50	Federally Qualified Health Center
7	Tribal 638 Free-Standing Facility	51	Inpatient Psychiatric Facility
8	Tribal 638 Provider-Based Facility	52	Psychiatric Facility Partial Hospitalization
11	Office	53	Community Mental Health Center (CMHC)
12	Patient Home	54	Intermediate Care Facility/Mentally Retarded
15	Mobile Unit	55	Residential Substance Abuse Treatment Facility
20	Urgent Care	56	Psychiatric Residential Treatment Center
21	Inpatient Hospital	60	Mass Immunization Center
22	Outpatient Hospital	61	Comprehensive Inpatient Rehabilitation Facility
23	Emergency Room - Hospital	62	Comprehensive Outpatient Rehabilitation Facility
24	Ambulatory Surgical Center	65	End Stage Renal Disease Treatment Facility
25	Birth Center	71	State or Local Public Health Clinic
26	Military Treatment Facility	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other Place of Service
33	Custodial Care Facility		

### Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1240-0044. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1240-0044), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

### 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 your claims examiner to ask about this assistance.

## **SAMPLE CLAIM #5 – LOUIS CAMBY**

**Claim #5 Louis Camby/ CC# 00000005-005/ DOA: 9/22/14**

General Information: The Claimant is a male Service Technician who suffered a compensable work related injury on 9/22/14 while descending from a truck. Accident, Notice and Causal Relationship (ANCR) has been established to the lower back. Claimant made a subsequent claim for neck, but this has not yet been established and is currently being litigated. Claimant has remained out from work since the accident and is receiving benefits. Case remains open.

The following services are required for this claim:

- 1) Legal Representation at WCB Hearing: Hearing Type: Basic; Issue: Question of causally related neck (continued); Location: Hudson, NY 12534; Time: 1 hour, inclusive of preparation, hearing and report
- 2) Deposition of claimant's Doctor on the issue of causally related neck. Location: Schodack Landing, NY 12156; Time: 1.5 hours includes: preparation, deposition and report
- 3) Deposition of IME Doctor on the issue of causally related neck. Location: Stuyvesant, NY 12173; Time: 1.5 hours includes: preparation, deposition and report
- 4) Independent Medical Exam w/ Neurologic Doctor for an opinion on causally related neck and degree of disability. Exam is near Stuyvesant, NY 12173
- 5) Review/Adjustment of Emergency Room Bill (attached)
- 6) Review/Adjustment of HICF – X Ray of Cervical Spine (attached)
- 7) Review/Adjustment of Doctor's Initial Report/ C-4 (attached)

On tab #5 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Indemnity)  
Legal Representation (1 basic hearing, 2 depositions)  
Independent Medical Exam (1 exam)  
Medical Bill Review/ Adjustment (3 bills)

**Note:** For the medical bill review, provide the service fees attributable to the review/ adjustment of the bill, **not** the payment due the medical provider. For the purposes of this exercise, assume that each medical bill has the supporting medical documentation necessary to process payment as billed by provider (X Ray to neck is payable).



UB-04 CMS-1450      APPROVED OMB NO. 0938-0997       **NUBC**™ National Uniform  
Billing Committee      THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

□□□ PICA

PICA

PHYSICIAN OR SUPPLIER INFORMATION

**Instructions for Completing OWCP-1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)**

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**REPORTS:** A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

**GENERAL INFORMATION-BLBA CLAIMANTS:** The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

**SIGNATURE OF PHYSICIAN OR SUPPLIER:** Your signature in Item 31 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by you or were furnished incident to your professional services by your employee under your immediate personal supervision, except as otherwise expressly permitted by FECA, Black Lung or EEOICPA regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material act, may be prosecuted under applicable Federal or State laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF FECA, BLACK LUNG AND EEOICPA INFORMATION  
(PRIVACY ACT STATEMENT)**

We are authorized by OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. Your response regarding the medical service(s) received or the amount charged is required to receive payment for the claim. See 20 CFR §§ 10.801, 30.701, 725.406, 725.701, and 725.704. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the claim because of incomplete information. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished. You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

**FORM SUBMISSION**

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742-8300, unless otherwise instructed.  
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 8302, London, KY 40742-8302, unless otherwise instructed.  
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304, unless otherwise instructed.

**INSTRUCTIONS FOR COMPLETING THE FORM:** A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

- Item 1. Leave blank.
- Item 1a. Enter the patient's claim number.
- Item 2. Enter the patient's last name, first name, middle initial.
- Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
- Item 4. For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
- Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
- Item 6. Leave blank.
- Item 7. For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
- Item 8. Leave blank.
- Item 9. Leave blank.
- Item 10. Leave blank.
- Item 11. For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.

- Item 11a. Leave blank.  
Item 11b. Leave blank.  
Item 11c. Leave blank.  
Item 11d. Leave blank.  
Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.  
Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.  
Item 14. Leave blank.  
Item 15. Leave blank.  
Item 16. Leave blank.  
Item 17. Leave blank.  
Item 18. Leave blank.  
Item 19. Leave blank.  
Item 20. Leave blank.  
Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.  
Item 22. Leave blank.  
Item 23. Leave blank.  
Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.  
Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).  
Column C: not required.  
Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.  
Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.  
Column F: enter the total charge(s) for each listed service(s).  
Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.  
Column H: Leave blank.  
Column I: Leave blank.  
Column J: Enter NPI.  
Item 25: Enter the Federal tax I.D.  
Item 26: Provider may enter a patient account number that will appear on the remittance voucher.  
Item 27: Leave blank.  
Item 28: Enter the total charge for the listed services in Column F.  
Item 29: If any payment has been made, enter that amount here.  
Item 30: Enter the balance now due.  
Item 31: For BLBA and EEOICPA: sign and date the form. For FECA: signature stamp or "signature on file" is acceptable.  
Item 32: Enter complete name of hospital, facility or physician's office where services were rendered. Item 32a. Enter NPI. Item 32b. Enter taxonomy number.  
Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.  
Item 33a. Enter NPI.  
Item 33b. Enter taxonomy number.

Place of Service (POS) Codes for Item 24B

3	School	34	Hospice
4	Homeless Shelter	41	Ambulance - Land
5	Indian Health Service Free-Standing Facility	42	Ambulance - Air or Water
6	Indian Health Service Provider-Based Facility	50	Federally Qualified Health Center
7	Tribal 638 Free-Standing Facility	51	Inpatient Psychiatric Facility
8	Tribal 638 Provider-Based Facility	52	Psychiatric Facility Partial Hospitalization
11	Office	53	Community Mental Health Center (CMHC)
12	Patient Home	54	Intermediate Care Facility/Mentally Retarded
15	Mobile Unit	55	Residential Substance Abuse Treatment Facility
20	Urgent Care	56	Psychiatric Residential Treatment Center
21	Inpatient Hospital	60	Mass Immunization Center
22	Outpatient Hospital	61	Comprehensive Inpatient Rehabilitation Facility
23	Emergency Room - Hospital	62	Comprehensive Outpatient Rehabilitation Facility
24	Ambulatory Surgical Center	65	End Stage Renal Disease Treatment Facility
25	Birth Center	71	State or Local Public Health Clinic
26	Military Treatment Facility	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other Place of Service
33	Custodial Care Facility		

### Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1240-0044. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1240-0044), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

### 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 your claims examiner to ask about this assistance.



# Doctor's Initial Report

**C-4**

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

## A. Patient's Information

1. Name: Camby Louis  2. Social Security #: - - -  
Last First MI
3. Home phone #: ( ) 4. WCB Case # (if known): 5. Carrier Case #: 00000005-005
6. Mailing address:       
Number and Street City State Zip Code
7. Date of injury/onset of illness: 09 / 22 / 14 8. Date of Birth:  /  /  9. Gender: ☒ Male ☐ Female
10. On the date of injury/illness what was the patient's job title or description:
11. On the date of injury/illness what were the patient's usual work activities:
12. Patient's Account #:

## B. Employer Information

1. Employer when injury occurred:  2. Phone #: ( )   
Company/Agency Name
3. Employer Address:       
Number and Street City State Zip Code

## C. Doctor's Information

1. Your name:    2. WCB Authorization #:   
Last First MI
3. WCB Rating Code: 4. Federal Tax ID #: The Tax ID # is the (check one): ☐ SSN ☐ EIN
5. Office address:       
Number and Street City State Zip Code
6. Billing group or practice name:
7. Billing address:  SLINGERLANDS NY 12159-9386  
Number and Street City State Zip Code
8. Office phone #: ( ) 9. Billing phone #: ( ) 10. Treating Provider's NPI #:
11. You are a (check one): ☐ Physician ☐ Podiatrist ☐ Chiropractor

## D. Billing Information

1. Employer's insurance carrier: 2. Carrier Code #: W
3. Insurance carrier's address:       
Number and Street City State Zip Code
4. Diagnosis or nature of disease or injury:  

Enter ICD9 Code:	ICD9 Descriptor:
(1) <u>722.52</u>	<u>INTERVERTEBRAL DISC DEGENERATION LUMBAR</u>
(2) <u>722.10</u>	<u>INTERVERTEBRAL DISC DISPLACEMENT LUMBAR W/O MYELOPATHY</u>
(3) <u>724.4</u>	<u>NEURITIS OR RADICULITIS THORACIC OR LUMBOSACRAL UNSPEC</u>
(4) <u>716.98</u>	<u>ARTHROPATHY UNSPEC OTHER SPEC SITES</u>

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: Camby Louis   
Last First MI

Date of injury/onset of illness: 09 / 22 / 14

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
09	24	14	09	24	14	11		99204	:	1, 2, 3, 4	266.79	1		12159-9386
									:					
									:					
									:					
									:					
									:					
									:					

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 266.79	\$	\$

## E. History

- Based on the patient's history, where and how did the injury/illness happen: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- How did you learn about the injury/illness (check one): ☒ Patient ☐ Medical Records ☐ Other(specify): \_\_\_\_\_
- Did another health provider treat this injury/illness including hospitalization and/or surgery? ☐ Yes ☒ No If yes, give details: \_\_\_\_\_  
 \_\_\_\_\_
- Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☒ No If yes, when: \_\_\_\_\_

## F. Exam Information

- Date(s) of Examination: 09/24/14 TO 09/24/14
- Patient's subjective complaints: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Numbness/Tingling _____	<input type="checkbox"/> Swelling _____
<input type="checkbox"/> Pain _____	<input type="checkbox"/> Weakness _____
<input type="checkbox"/> Stiffness _____	<input type="checkbox"/> Other (specify) _____
- Type/nature of injury: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Abrasion _____	<input type="checkbox"/> Infectious Disease _____
<input type="checkbox"/> Amputation _____	<input type="checkbox"/> Inhalation Exposure _____
<input type="checkbox"/> Avulsion _____	<input type="checkbox"/> Laceration _____
<input type="checkbox"/> Bite _____	<input type="checkbox"/> Needle Stick _____
<input type="checkbox"/> Burn _____	<input type="checkbox"/> Poisoning/Toxic Effects _____
<input type="checkbox"/> Contusion/Hematoma _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Crush Injury _____	<input type="checkbox"/> Puncture Wound _____
<input type="checkbox"/> Dermatitis _____	<input type="checkbox"/> Repetitive Strain Injury _____
<input type="checkbox"/> Dislocation _____	<input type="checkbox"/> Spinal Cord Injury _____
<input type="checkbox"/> Fracture _____	<input type="checkbox"/> Sprain/Strain _____
<input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Torn Ligament, Tendon or Muscle _____
<input type="checkbox"/> Hernia _____	<input type="checkbox"/> Vision Loss _____
<input type="checkbox"/> Other (specify) _____	



Patient's Name: Camby Louis Date of injury/onset of illness: 09 / 22 / 14  
Last First MI

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- |   |   |
|---|---|
| <input type="checkbox"/> None at present              | <input type="checkbox"/> Neuromuscular Findings:      |
| <input type="checkbox"/> Bruising _____               | <input type="checkbox"/> Abnormal/Restricted ROM      |
| <input type="checkbox"/> Burns _____                  | <input type="checkbox"/> Active ROM _____             |
| <input type="checkbox"/> Crepitation _____            | <input type="checkbox"/> Passive ROM _____            |
| <input type="checkbox"/> Deformity _____              | <input type="checkbox"/> Gait _____                   |
| <input type="checkbox"/> Edema _____                  | <input type="checkbox"/> Palpable Muscle Spasm _____  |
| <input type="checkbox"/> Hematoma/Lump/Swelling _____ | <input type="checkbox"/> Reflexes _____               |
| <input type="checkbox"/> Joint Effusion _____         | <input type="checkbox"/> Sensation _____              |
| <input type="checkbox"/> Laceration/Sutures _____     | <input type="checkbox"/> Strength (Weakness) _____    |
| <input type="checkbox"/> Pain/Tenderness _____        | <input type="checkbox"/> Wasting/Muscle Atrophy _____ |
| <input type="checkbox"/> Scar _____                   |   |
| <input type="checkbox"/> Other findings: _____        |   |

5. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

6. Describe any treatment(s) rendered at this visit: \_\_\_\_\_

7. Describe prognosis for recovery: \_\_\_\_\_

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No

If yes, list and describe: \_\_\_\_\_

## G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☐ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 0.00 %
5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

## H. Plan of Care

1. What is your proposed treatment? \_\_\_\_\_

2. Medication(s): (a) list medications prescribed: \_\_\_\_\_

(b) list over-the-counter medications advised: \_\_\_\_\_

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below: \_\_\_\_\_

Patient's Name: Camby Louis  
Last First MI

Date of injury/onset of illness: 09 / 22 / 14

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan  
☐ EMG/NCS  
☐ MRI (Specify): \_\_\_\_\_  
☐ Labs (Specify): \_\_\_\_\_  
☐ X-rays (Specify): \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor  
☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair  
☐ Other (specify): \_\_\_\_\_

**Important:** Form C-4 AUTH should be used to request any special medical service costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

5. When is the patient's next follow-up appointment?

☐ Within a week ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ \_\_\_\_\_ months ☐ Return as needed

## I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☐ No If yes, date patient first missed work: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Is the patient currently working? ☐ Yes ☐ No If yes, did the patient return to: ☐ usual work activities ☐ limited work activities

2. Can the patient return to work? (check only one):

- a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_
- b. ☐ The patient can return to work without limitations on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- c. ☐ The patient can return to work with the following limitations (check all that apply) on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bending/twisting         | <input type="checkbox"/> Lifting                       | <input type="checkbox"/> Sitting                      |
| <input type="checkbox"/> Climbing stairs/ladders  | <input type="checkbox"/> Operating heavy equipment     | <input type="checkbox"/> Standing                     |
| <input type="checkbox"/> Environmental conditions | <input type="checkbox"/> Operation of motor vehicles   | <input type="checkbox"/> Use of public transportation |
| <input type="checkbox"/> Kneeling                 | <input type="checkbox"/> Personal protective equipment | <input type="checkbox"/> Use of upper extremities     |
| <input type="checkbox"/> Other(explain): _____    |  |   |

Describe/quantify the limitations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☒ with patient ☐ with patient's employer ☐ N/A

**This form is signed under penalty of perjury.**

**Board Authorized** Health Care Provider - Check one:

- ☒ I provided the services listed above.
- ☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

**Board Authorized** Health Care Provider signature:

Name	Signature	NEUROLOGICAL Specialty	092214 Date
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**MEDICAL REPORTING****IMPORTANT-TO THE ATTENDING DOCTOR**

1. 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** - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.  
If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future 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 use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.
2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
5. **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.
6. **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-l 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.
7. **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 this form. 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 Customer Service toll-free number listed 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 HOSPITALES 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.

Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

**NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

**Customer Service Toll-Free Line: 877-632-4996**

**Statewide Fax Line: 877-533-0337**

## **SAMPLE CLAIM #6 – DANIEL CORMIER**

**Claim #6 – Daniel Cormier/ CC# 00000006-006/ DOA: 4/30/15**

General Information: The Claimant is a male Mechanic who suffered a compensable work related injury when repairing an appliance. Accident, Notice, and Causal Relationship (ANCR) are established for burns to the right leg, right hip, and left inner thigh. Twenty-Six (26) weeks of lost time from work resulted. It is likely that this claim will result in a Schedule Loss of Use (SLU) award.

The following services are required for this claim:

- 1) Legal Representation at WCB Hearing: Hearing Type: Basic; Issue(s): Question of period and extent of disability. Question of Average Weekly Wage (AWW), Rate and lost time; Location: Manhattan, NY 10027; Time: 1 hour, inclusive of preparation, hearing and report
- 2) Legal Representation at WCB Hearing: Hearing Type: Intermediate; Issue(s): Carrier's reimbursement request and information on claimant's sick leave time. Location: Manhattan, NY 10027; Time: 1 hour, inclusive of preparation, hearing and report
- 3) Independent Medical Exam for an opinion on further causally related disability w/ Plastic Surgeon in Manhattan, NY 10025
- 4) Surveillance – Two days with four hour blocks each day; 2 operatives; Location: Manhattan, NY 10025
- 5) Review/Adjustment of Emergency Room/Hospitalization Bill (attached)
- 6) Review/Adjustment of Doctor's Initial Report/ C-4 (attached)
- 7) Review/Adjustment of Doctor's Progress Report/ C-4.2 (attached)

On tab #6 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Indemnity)  
Legal Representation (2 basic hearings)  
Independent Medical Exam (1 exam)  
Surveillance (2 days with 4 hours each day/ 2 operatives)  
Medical Bill Review/ Adjustment (3 bills)

**Note:** For the medical bill review, provide the service fees attributable to the review/ adjustment of the bill, **not** the payment due the medical provider. For the purposes of this exercise, assume that each medical bill has the supporting medical documentation necessary to process payment as billed by provider.

# Doctor's Progress Report

State of New York - Workers' Compensation Board

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

Date(s) of Examination: 09 July 2015

WCB Case Number (if known): \_\_\_\_\_ Carrier Case Number (if known): 000000006-006

## A. Patient's Information

CORMIER DANIEL  
Last First MI

2. Date of injury/illness: 04 / 30 / 15 3. Soc. Sec. #: - - -

4. Address (if changed from previous report): 1345 OAK STREET New York NY 10025  
Number and Street City State Zip Code

5. Patient's Account #: \_\_\_\_\_

## B. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI

3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN

5. Office address: 1900 Gym Street Bronx NY 10453  
Number and Street City State Zip Code

6. Billing Group or Practice Name: \_\_\_\_\_

7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code

8. Office phone #: (\_\_\_\_\_) \_\_\_\_\_ 9. Billing phone #: (\_\_\_\_\_) \_\_\_\_\_ 10. Treating Provider's NPI #: \_\_\_\_\_

## C. Billing Information

1. Employer's insurance carrier: State Insurance Fund 2. Carrier Code #: W

3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code

4. Diagnosis or nature of disease or injury:

Enter ICD9 Code:

ICD9 Descriptor:

(1) 945.0 Burn of Lower Limb

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
07	09	15	07	09	15	11		99214		1	92.98	1		10453

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 92.98	\$	\$

## D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: Noted.

Patient's Name: CORMIER DANIEL Date of injury/onset of illness: 04 / 30 / 15  
Last First MI

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: Noted.

3. List additional body parts affected by this injury, if any: Noted.

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:  
Follow-up at burn clinic and continue applying A&D Cream.

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan ☐ EMG/NCS  
☐ MRI (specify): \_\_\_\_\_  
☐ Labs (specify): \_\_\_\_\_  
☐ X-rays (specify): \_\_\_\_\_  
☐ Other (specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor ☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in: \_\_\_\_\_  
☐ Other (specify): \_\_\_\_\_

**Important: Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.**

6. Describe treatment rendered today: \_\_\_\_\_

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☒ 5-6 wks ☐ 7-8 wks ☐ \_\_\_\_ months ☐ as needed

**E. Doctor's Opinion (based on this examination)**

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No  
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No  
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)  
4. What is the percentage (0-100%) of temporary impairment? 100 %  
5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

**F. Return to Work**

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (check only one):

a. ☒ The patient cannot return to work because (explain): of recent injury.

b. ☐ The patient can return to work without limitations on: \_\_\_\_/\_\_\_\_/\_\_\_\_

c. ☐ The patient can return to work with the following limitations (check all that apply) on: \_\_\_\_/\_\_\_\_/\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bending/twisting         | <input type="checkbox"/> Lifting                       | <input type="checkbox"/> Sitting                      |
| <input type="checkbox"/> Climbing stairs/ladders  | <input type="checkbox"/> Operating heavy equipment     | <input type="checkbox"/> Standing                     |
| <input type="checkbox"/> Environmental conditions | <input type="checkbox"/> Operation of motor vehicles   | <input type="checkbox"/> Use of public transportation |
| <input type="checkbox"/> Kneeling                 | <input type="checkbox"/> Personal protective equipment | <input type="checkbox"/> Use of upper extremities     |
| <input type="checkbox"/> Other (explain): _____   |  |   |

Describe/quantify the limitations: \_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

**This form is signed under penalty of perjury.**

**Board Authorized Health Care Provider - Check one:**

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty IM

**Board Authorized Health Care Provider signature:**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL REPORTING****IMPORTANT - TO THE ATTENDING DOCTOR**

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:

**PROGRESS REPORTS** - Following the filing of Form C-4, Doctor's Initial Report, file this form within 15 days after initial report and thereafter during continuing treatment without further request, when a follow-up visit is necessary, except the intervals between reports shall be no more than 90 days.

When reporting on MMI and/or Permanent Impairment, use Form C-4.3.

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 use Form C-5, Occupational/Physical Therapists use Form OT/PT-4 and Psychologists use Form PS-4 for filing reports.

2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service(s) costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee or shoulder.

***AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY***

5. **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.
6. **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-l 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.**
7. **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 this form. 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 HOSPITALES 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' COMPENSATION BOARD**

Reports should be filed by sending directly to the Workers' Compensation Board at the address below with a copy sent to the insurance carrier:

NYS Workers' Compensation Board  
Centralized Mailing  
PO Box 5205  
Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION



1 JACOBI MEDICAL CENTER 1400 PELHAM PKWY SO BRONX, NY 10461-1138 718-918-3292										2 JACOBI MEDICAL CENTER P.O. BOX 5760 GPO NEW YORK, NY 10087										3a PAT. CNTL. # b. MED. REC. # 5 FED. TAX NO. 000000000										4 TYPE OF BILL 0111 6 STATEMENT COVERS PERIOD FROM 043015 7 050315																																																																																									
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**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.



# Doctor's Initial Report

**C-4**

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

## A. Patient's Information

1. Name: Cormier Daniel 2. Social Security #: - -  
Last First MI  
 3. Home phone #: ( ) 4. WCB Case # (if known): 5. Carrier Case #: 000000006-006  
 6. Mailing address: 1345 OAK STREET NEW YORK NY 10025  
Number and Street City State Zip Code  
 7. Date of injury/onset of illness: 04 / 30 / 2015 8. Date of Birth: 04 / 05 / 1969 9. Gender: ☒ Male ☐ Female  
 10. On the date of injury/illness what was the patient's job title or description: MECHANIC  
 11. On the date of injury/illness what were the patient's usual work activities: \_\_\_\_\_  
 12. Patient's Account #: \_\_\_\_\_

## B. Employer Information

1. Employer when injury occurred: \_\_\_\_\_ 2. Phone #: ( ) \_\_\_\_\_  
Company/Agency Name  
 3. Employer Address: \_\_\_\_\_  
Number and Street City State Zip Code

## C. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI  
 3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN  
 5. Office address: 1900 Gym Street Bronx NY 10453  
Number and Street City State Zip Code  
 6. Billing group or practice name: \_\_\_\_\_  
 7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code  
 8. Office phone #: ( ) 9. Billing phone #: ( ) 10. Treating Provider's NPI #: \_\_\_\_\_  
 11. You are a (check one): ☒ Physician ☐ Podiatrist ☐ Chiropractor

## D. Billing Information

1. Employer's insurance carrier: STATE INSURANCE FUND 2. Carrier Code #: W  
 3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code  
 4. Diagnosis or nature of disease or injury:  
 Enter ICD9 Code: ICD9 Descriptor:  
 (1) 945.0 BURN OF LOWER LIMB  
 (2) \_\_\_\_\_  
 (3) \_\_\_\_\_  
 (4) \_\_\_\_\_

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

Patient's Name: Cormier Daniel   
Last First MI

Date of injury/onset of illness: 04 / 30 / 2015

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					
05	20	15	05	20	15	11		99244	:	1	182.18	1		10453
									:					
									:					
									:					
									:					
									:					
									:					

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$ 182.18	\$	\$

## E. History

- Based on the patient's history, where and how did the injury/illness happen: On day of injury patient was changing parts on a washing machine when he got burned by steam coming from a pipe.
- How did you learn about the injury/illness (check one): ☒ Patient ☐ Medical Records ☐ Other(specify): \_\_\_\_\_
- Did another health provider treat this injury/illness including hospitalization and/or surgery? ☒ Yes ☐ No If yes, give details: \_\_\_\_\_
- Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☒ No If yes, when: \_\_\_\_\_

## F. Exam Information

- Date(s) of Examination: 20 May 2015
- Patient's subjective complaints: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Numbness/Tingling _____	<input type="checkbox"/> Swelling _____
<input checked="" type="checkbox"/> Pain _____	<input type="checkbox"/> Weakness _____
<input type="checkbox"/> Stiffness _____	<input type="checkbox"/> Other (specify) _____
- Type/nature of injury: Check all that apply and identify specific affected body part(s).
 

<input type="checkbox"/> Abrasion _____	<input type="checkbox"/> Infectious Disease _____
<input type="checkbox"/> Amputation _____	<input type="checkbox"/> Inhalation Exposure _____
<input type="checkbox"/> Avulsion _____	<input type="checkbox"/> Laceration _____
<input type="checkbox"/> Bite _____	<input type="checkbox"/> Needle Stick _____
<input checked="" type="checkbox"/> Burn <u>R. Leg, R. Hip, L. Thigh</u>	<input type="checkbox"/> Poisoning/Toxic Effects _____
<input type="checkbox"/> Contusion/Hematoma _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Crush Injury _____	<input type="checkbox"/> Puncture Wound _____
<input type="checkbox"/> Dermatitis _____	<input type="checkbox"/> Repetitive Strain Injury _____
<input type="checkbox"/> Dislocation _____	<input type="checkbox"/> Spinal Cord Injury _____
<input type="checkbox"/> Fracture _____	<input type="checkbox"/> Sprain/Strain _____
<input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Torn Ligament, Tendon or Muscle _____
<input type="checkbox"/> Hernia _____	<input type="checkbox"/> Vision Loss _____
<input type="checkbox"/> Other (specify) _____	

Patient's Name: Cormier Daniel Date of injury/onset of illness: 04 / 30 / 2015  
Last First MI

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- |   |   |
|---|---|
| <input type="checkbox"/> None at present                                  | <input type="checkbox"/> Neuromuscular Findings:      |
| <input type="checkbox"/> Bruising _____                                   | <input type="checkbox"/> Abnormal/Restricted ROM      |
| <input checked="" type="checkbox"/> Burns <u>R. Leg, R. Hip, L. Thigh</u> | <input type="checkbox"/> Active ROM _____             |
| <input type="checkbox"/> Crepitation _____                                | <input type="checkbox"/> Passive ROM _____            |
| <input type="checkbox"/> Deformity _____                                  | <input type="checkbox"/> Gait _____                   |
| <input type="checkbox"/> Edema _____                                      | <input type="checkbox"/> Palpable Muscle Spasm _____  |
| <input type="checkbox"/> Hematoma/Lump/Swelling _____                     | <input type="checkbox"/> Reflexes _____               |
| <input type="checkbox"/> Joint Effusion _____                             | <input type="checkbox"/> Sensation _____              |
| <input type="checkbox"/> Laceration/Sutures _____                         | <input type="checkbox"/> Strength (Weakness) _____    |
| <input type="checkbox"/> Pain/Tenderness _____                            | <input type="checkbox"/> Wasting/Muscle Atrophy _____ |
| <input type="checkbox"/> Scar _____                                       |   |
| <input type="checkbox"/> Other findings: _____                            |   |

5. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

6. Describe any treatment(s) rendered at this visit: \_\_\_\_\_

7. Describe prognosis for recovery: Guarded

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No

If yes, list and describe: \_\_\_\_\_

### G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☐ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

### H. Plan of Care

1. What is your proposed treatment? Follow-up with doctor at burn unit and continue care. Re-evaluation in 4 weeks.

2. Medication(s): (a) list medications prescribed: \_\_\_\_\_

(b) list over-the-counter medications advised: \_\_\_\_\_

Medication restrictions: ☒ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

Patient's Name: Cormier Daniel  
Last First MI

Date of injury/onset of illness: 04 / 30 / 2015

3. Does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan  
☐ EMG/NCS  
☐ MRI (Specify): \_\_\_\_\_  
☐ Labs (Specify): \_\_\_\_\_  
☐ X-rays (Specify): \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor  
☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in \_\_\_\_\_  
☐ Other (Specify): \_\_\_\_\_

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair  
☐ Other (specify): \_\_\_\_\_

**Important:** Form C-4 AUTH should be used to request any special medical service costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

5. When is the patient's next follow-up appointment?

☐ Within a week ☐ 1-2 weeks ☒ 3-4 weeks ☐ 5-6 weeks ☐ 7-8 weeks ☐ \_\_\_\_\_ months ☐ Return as needed

## I. Work Status

1. Has the patient missed work because of the injury/illness? ☒ Yes ☐ No If yes, date patient first missed work: 04 / 30 / 2015

Is the patient currently working? ☐ Yes ☒ No If yes, did the patient return to: ☐ usual work activities ☐ limited work activities

2. Can the patient return to work? (check only one):

- a. ☒ The patient cannot return to work because (explain): of burn injuries.  
b. ☐ The patient can return to work without limitations on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
c. ☐ The patient can return to work with the following limitations (check all that apply) on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
☐ Bending/twisting ☐ Lifting ☐ Sitting  
☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing  
☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation  
☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities  
☐ Other(explain): \_\_\_\_\_

Describe/quantify the limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☒ N/A

3. With whom will you discuss the patient's return to work and/or limitations? ☐ with patient ☐ with patient's employer ☒ N/A

**This form is signed under penalty of perjury.**

**Board Authorized** Health Care Provider - Check one:

- ☒ I provided the services listed above.  
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty <sup>IM</sup> \_\_\_\_\_

**Board Authorized** Health Care Provider signature:

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date / / /

**MEDICAL REPORTING****IMPORTANT-TO THE ATTENDING DOCTOR**

1. 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** - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.  
If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future 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 use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.
2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
5. **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.
6. **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-l 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.
7. **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 this form. 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 Customer Service toll-free number listed 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 HOSPITALES 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.

Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

**NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

**Customer Service Toll-Free Line: 877-632-4996**

**Statewide Fax Line: 877-533-0337**

## **SAMPLE CLAIM #7 – JUSTIN BETTER**



**Claim #7 – Justin Better/ CC# 00000007-007/ DOA: 6/17/15**

General Information: The Claimant is a male Mental Health Worker who was struck by motor vehicle while crossing a street during an unpaid lunch break. He sustained multiple injuries. Thirteen (13) weeks of lost time from work resulted. This claim will result in a notice of controversy being filed.

The following services are required for this claim:

- 1) C-7 / SROI-04 Investigation w/ Claimant. Obtain: signed statement from claimant (not yet represented) regarding the accident and medical releases. Location: Staten Island, NY 10314
- 2) C-7 / SROI-04 Investigation w/ Employer. Obtain: signed statement from employer regarding the accident; contact information for potential witnesses; employee manual and time and attendance records. Location: Manhattan, NY 10027
- 3) Legal Representation at WCB Pre-Hearing Conference: Hearing Type: Basic Issue(s): Completion of the OC400.5 & PH16.2. Location: Staten Island, NY 10301; Time: 1 Hour, inclusive of review and analysis of folder, attendance at hearing, subpoena of witnesses
- 4) Legal Representation at WCB Hearing: Hearing Type: Complex: Testimony of the claimant and lay witness; Location: Staten Island, NY 10301; Time: 2 Hours: Review and analysis of folder, witness preparation, hearing and report
- 5) Legal Representation: Appeal (Board Review) of Administrative Law Judge's (ALJ) Decision. Includes: composition and filing; Time: 5 Hours
- 6) Independent Medical Exam for an opinion on causal relationship and degree of disability w/ Orthopedic Surgeon in Staten Island, NY 10314

On tab #7 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Indemnity)  
C7 / SROI-04 Investigations (Employer & Claimant)  
Legal Representation (1 basic hearing, 1 complex hearing, 1 appeal)  
Independent Medical Exam (1 exam)

**Note:** For the Administrative "Life of Claim" fee, the outcome of the controversy was ultimately found in favor of the carrier. The claim is not compensable; no benefits were paid to claimant.

## **SAMPLE CLAIM #8 – STEPHANIE SHEETS**

**Claim #8 – Stephanie Sheets / CC# 00000008-008/ DOA: 7/17/14**

General Information: The Claimant is a female Scientist who speaks limited English. She suffered a compensable work related injury when the train on which she was traveling derailed. Accident, Notice and Causal Relationship (ANCR) established to the lumbar spine. Fifty-Two (52) weeks of lost time resulted and the claimant remains out of work. It is likely that the Claimant will be found to have a Permanent Partial Disability (PPD).

The following services are required for this claim:

- 1) Telephone Interpretation/Translation Services for initial contact with Claimant.  
Location: Syracuse, NY 13201 Time: 1 Hour
- 2) Deposition of the Claimant's Neurologist on the issue of permanency of the lumbar spine.  
Location: Dewitt, NY 13214. Time: 1.5 hours includes: preparation, deposition and report
- 3) Deposition of IME Neurologist on the issue of permanency of the lumbar spine.  
Location: Syracuse, NY 13203. Time: 1.5 hours includes: preparation, deposition and report
- 4) Legal Representation at WCB Hearing: Hearing Type: Complex; Issue(s): Loss of Wage Earning Capacity, Attachment Labor Market, testimony of the claimant and summations; Location: Syracuse, NY 13203; Time: 3 Hours: inclusive of preparation, hearing and report
- 5) Independent Medical Exam for an opinion on permanency w/ Neurologist in Syracuse, NY 13203
- 6) Review/Adjustment of Emergency Room/Hospitalization Bill (attached)

On tab #8 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Indemnity)

Legal Representation (1 complex, 2 depositions)

Independent Medical Exam (1 exam)

Medical Bill Review/ Adjustment (1 bill)

Telephone Interpretation/Translation Services

**Note:** For the medical bill review, provide the service fees attributable to the review/ adjustment of the bill, **not** the payment due the medical provider. For the purposes of this exercise, assume that each medical bill has the supporting medical documentation necessary to process payment as billed by provider.

1 MOUNT SINAI HOSPITAL 1 GUSTAVE L LEVY PLACE NEW YORK, NY 100296-6500										2 MOUNT SINAI HOSPITAL PO BOX 27759 NEW YORK, NY 10087										3a PAT. CNTL. # b. MED. REC. # 5 FED. TAX NO. 000000000										4 TYPE OF BILL 0111 6 STATEMENT COVERS PERIOD FROM 071714 THROUGH 071814																																																																																																			
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**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(i) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

## **SAMPLE CLAIM #9 – CHRISTOPHER BEACH**

**Claim #9 – Christopher Beach / CC# 00000009-009/ DOA: 05/06/14**

General Information: The Claimant is a male Cook who sustained a compensable work related injury when he tripped and fell on a grate. Accident, Notice and Causal Relationship (ANCR) is established to the neck, right shoulder, left wrist, right knee and right ankle. Twenty-Six (26) weeks of lost time resulted. It is likely that this claim will result in a Schedule Loss of Use (SLU) award.

The following services are required for this claim:

- 1) Independent Medical Exam for an opinion on permanency/ SLU w/ Orthopedic Doctor in Albany, NY 12241
- 2) Legal Representation at WCB Hearing: Hearing Type: Basic; Issue(s): Summations on SLU; Location: Albany, NY 12241; Time: 1.5 Hours, inclusive of preparation, hearing and report
- 3) Claimant Activity Check. Requires meeting with Claimant and confirming that he resides at address of record and confirming that benefits are being received; inquiring with neighbors about Claimant's work status; Location: Albany, NY 12241; Time: 30 minutes
- 4) Review/ Adjustment of Ancillary Medical Report C-4AMR (attached)
- 5) Review/ Adjustment of Doctor's Narrative Report C-4.2 (attached)
- 6) Review/ Adjustment of HICF Office Visit (attached)

On tab #9 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Indemnity)

Legal Representation (1 basic hearing)

Activity Check (30 minutes)

Independent Medical Exam (1 exam)

Medical Bill Review/ Adjustment (3 bills)

**Note:** For the medical bill review, provide the service fees attributable to the review/ adjustment of the bill, **not** the payment due the medical provider. For the purposes of this exercise, assume that each medical bill has the supporting medical documentation necessary to process payment as billed by provider.

1500

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE (Medicare #) 2. MEDICAID (Medicaid #) 3. TRICARE (Sponsor's SSN) 4. CHAMPVA (Medicaid #) 5. GROUP HEALTH PLAN (SSN or ID) 6. FECA BLK LUNG (SSN) 7. OTHER (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 000000009-009														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Beach Christopher					3. PATIENT'S BIRTH DATE (MM/DD/YY) 10/15/1968					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Beach Christopher									
5. PATIENT'S ADDRESS (No., Street) 25 Chestnut Street					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)									
CITY Albany					STATE NY					CITY									
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					CITY									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. OTHER INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>									
c. EMPLOYER'S NAME OR SCHOOL NAME					10d. RESERVED FOR LOCAL USE					b. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME NYSIF					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.					c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: (MM/DD/YY) 05/06/2014					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM/DD/YY)									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. <input type="checkbox"/> NPI <input type="checkbox"/>					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM/DD/YY) FROM 05/06/2014 TO									
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY) FROM TO					20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 726.10 2. 3. 4.										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE (From To MM/DD/YY MM/DD/YY) 1. 05/30/2014 05/30/2014 2. 3. 4. 5. 6.										B. Place of Service 11					C. EMG				
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 99213										E. DIAGNOSIS POINTER 1					F. \$ CHARGES 64.04				
G. DAYS OR UNITS 1										H. EPSDT Family Plan					I. ID QUAL.				
J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
25. FEDERAL TAX I.D. NUMBER 000000000										SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO.				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION MMC - 1250 Waters Place Albany, NY 12241					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				
33. BILLING PROVIDER INFO & PH # ( ) MMC Faculty Practice - PO Box 27125 New York NY 10087										28. TOTAL CHARGE \$ 64.04					29. AMOUNT PAID \$ 0.00				
30. BALANCE DUE \$ 64.04										a.					b.				



**Instructions for Completing OWCP-1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)**

**GENERAL INFORMATION-FECA AND EEOICPA CLAIMANTS:** Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for compensable illnesses defined under that Act. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of the disability or illness, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, or osteopathic practitioners within the scope of their practice as defined by State law. However, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

**FEES:** The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

**REPORTS:** A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

**GENERAL INFORMATION-BLBA CLAIMANTS:** The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

**SIGNATURE OF PHYSICIAN OR SUPPLIER:** Your signature in Item 31 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by you or were furnished incident to your professional services by your employee under your immediate personal supervision, except as otherwise expressly permitted by FECA, Black Lung or EEOICPA regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material act, may be prosecuted under applicable Federal or State laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF FECA, BLACK LUNG AND EEOICPA INFORMATION  
(PRIVACY ACT STATEMENT)**

We are authorized by OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. Your response regarding the medical service(s) received or the amount charged is required to receive payment for the claim. See 20 CFR §§ 10.801, 30.701, 725.406, 725.701, and 725.704. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the claim because of incomplete information. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished. You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

**FORM SUBMISSION**

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742-8300, unless otherwise instructed.

BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 8302, London, KY 40742-8302, unless otherwise instructed.

EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304, unless otherwise instructed.

**INSTRUCTIONS FOR COMPLETING THE FORM:** A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

- Item 1. Leave blank.
- Item 1a. Enter the patient's claim number.
- Item 2. Enter the patient's last name, first name, middle initial.
- Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
- Item 4. For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
- Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
- Item 6. Leave blank.
- Item 7. For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
- Item 8. Leave blank.
- Item 9. Leave blank.
- Item 10. Leave blank.
- Item 11. For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.

- Item 11a. Leave blank.  
 Item 11b. Leave blank.  
 Item 11c. Leave blank.  
 Item 11d. Leave blank.  
 Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.  
 Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.  
 Item 14. Leave blank.  
 Item 15. Leave blank.  
 Item 16. Leave blank.  
 Item 17. Leave blank.  
 Item 18. Leave blank.  
 Item 19. Leave blank.  
 Item 20. Leave blank.  
 Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.  
 Item 22. Leave blank.  
 Item 23. Leave blank.  
 Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.  
 Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).  
 Column C: not required.  
 Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.  
 Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.  
 Column F: enter the total charge(s) for each listed service(s).  
 Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.  
 Column H: Leave blank.  
 Column I: Leave blank.  
 Column J: Enter NPI.  
 Item 25: Enter the Federal tax I.D.  
 Item 26: Provider may enter a patient account number that will appear on the remittance voucher.  
 Item 27: Leave blank.  
 Item 28: Enter the total charge for the listed services in Column F.  
 Item 29: If any payment has been made, enter that amount here.  
 Item 30: Enter the balance now due.  
 Item 31: For BLBA and EEOICPA: sign and date the form. For FECA: signature stamp or "signature on file" is acceptable.  
 Item 32: Enter complete name of hospital, facility or physician's office where services were rendered. Item 32a. Enter NPI. Item 32b. Enter taxonomy number.  
 Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.  
 Item 33a. Enter NPI.  
 Item 33b. Enter taxonomy number.

Place of Service (POS) Codes for Item 24B

3	School	34	Hospice
4	Homeless Shelter	41	Ambulance - Land
5	Indian Health Service Free-Standing Facility	42	Ambulance - Air or Water
6	Indian Health Service Provider-Based Facility	50	Federally Qualified Health Center
7	Tribal 638 Free-Standing Facility	51	Inpatient Psychiatric Facility
8	Tribal 638 Provider-Based Facility	52	Psychiatric Facility Partial Hospitalization
11	Office	53	Community Mental Health Center (CMHC)
12	Patient Home	54	Intermediate Care Facility/Mentally Retarded
15	Mobile Unit	55	Residential Substance Abuse Treatment Facility
20	Urgent Care	56	Psychiatric Residential Treatment Center
21	Inpatient Hospital	60	Mass Immunization Center
22	Outpatient Hospital	61	Comprehensive Inpatient Rehabilitation Facility
23	Emergency Room - Hospital	62	Comprehensive Outpatient Rehabilitation Facility
24	Ambulatory Surgical Center	65	End Stage Renal Disease Treatment Facility
25	Birth Center	71	State or Local Public Health Clinic
26	Military Treatment Facility	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other Place of Service
33	Custodial Care Facility		

### Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1240-0044. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1240-0044), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

### 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 your claims examiner to ask about this assistance.

# Doctor's Progress Report

State of New York - Workers' Compensation Board

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

Date(s) of Examination: \_\_\_\_\_

WCB Case Number (if known): \_\_\_\_\_ Carrier Case Number (if known): \_\_\_\_\_

## A. Patient's Information

1. Name: \_\_\_\_\_ 2. Date of injury/illness: \_\_\_\_/\_\_\_\_/\_\_\_\_ 3. Soc. Sec. #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Last First MI

4. Address (if changed from previous report): \_\_\_\_\_  
Number and Street City State Zip Code

5. Patient's Account #: \_\_\_\_\_

## B. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI

3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN

5. Office address: \_\_\_\_\_  
Number and Street City State Zip Code

6. Billing Group or Practice Name: \_\_\_\_\_

7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code

8. Office phone #: (\_\_\_\_) \_\_\_\_\_ 9. Billing phone #: (\_\_\_\_) \_\_\_\_\_ 10. Treating Provider's NPI #: \_\_\_\_\_

## C. Billing Information

1. Employer's insurance carrier: \_\_\_\_\_ 2. Carrier Code #: **W** \_\_\_\_\_

3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code

4. Diagnosis or nature of disease or injury: \_\_\_\_\_

Enter ICD9 Code: ICD9 Descriptor:

- (1) \_\_\_\_\_  
(2) \_\_\_\_\_  
(3) \_\_\_\_\_  
(4) \_\_\_\_\_

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER					

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$	\$	\$

## D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: \_\_\_\_\_

3. List additional body parts affected by this injury, if any: \_\_\_\_\_

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: \_\_\_\_\_

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

**Tests:**

- ☐ CT Scan ☐ EMG/NCS  
☐ MRI (specify): \_\_\_\_\_  
☐ Labs (specify): \_\_\_\_\_  
☐ X-rays (specify): \_\_\_\_\_  
☐ Other (specify): \_\_\_\_\_

**Referrals:**

- ☐ Chiropractor ☐ Internist/Family Physician  
☐ Occupational Therapist  
☐ Physical Therapist  
☐ Specialist in: \_\_\_\_\_  
☐ Other (specify): \_\_\_\_\_

**Important: Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.**

6. Describe treatment rendered today: \_\_\_\_\_

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ \_\_\_\_ months ☐ as needed

### E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No  
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No  
3. Is the patient's history of the injury/illness consistent with your objective findings? ☐ Yes ☐ No ☐ N/A (no findings at this time)  
4. What is the percentage (0-100%) of temporary impairment? \_\_\_\_\_ %  
5. Describe findings and relevant diagnostic test results: \_\_\_\_\_

### F. Return to Work

1. Is patient working now? ☐ Yes ☐ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: \_\_\_\_\_

How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (check only one):

- a. ☐ The patient cannot return to work because (explain): \_\_\_\_\_  
b. ☐ The patient can return to work without limitations on: \_\_\_\_/\_\_\_\_/\_\_\_\_  
c. ☐ The patient can return to work with the following limitations (check all that apply) on: \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Bending/twisting ☐ Lifting ☐ Sitting  
☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing  
☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation  
☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities  
☐ Other (explain): \_\_\_\_\_

Describe/quantify the limitations: \_\_\_\_\_

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

**This form is signed under penalty of perjury.**

**Board Authorized Health Care Provider - Check one:**

- ☐ I provided the services listed above.  
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

**Board Authorized Health Care Provider signature:**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL REPORTING****IMPORTANT - TO THE ATTENDING DOCTOR**

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:

**PROGRESS REPORTS** - Following the filing of Form C-4, Doctor's Initial Report, file this form within 15 days after initial report and thereafter during continuing treatment without further request, when a follow-up visit is necessary, except the intervals between reports shall be no more than 90 days.

When reporting on MMI and/or Permanent Impairment, use Form C-4.3.

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 use Form C-5, Occupational/Physical Therapists use Form OT/PT-4 and Psychologists use Form PS-4 for filing reports.

2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. 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.
4. **AUTHORIZATION FOR SPECIAL SERVICES** - Form C-4 AUTH should be used to request any special medical service(s) costing over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee or shoulder.

**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**

5. **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.
6. **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-l 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.**
7. **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 this form. 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 HOSPITALES 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 CERCA 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' COMPENSATION BOARD**

Reports should be filed by sending directly to the Workers' Compensation Board at the address below with a copy sent to the insurance carrier:

NYS Workers' Compensation Board

Centralized Mailing

PO Box 5205



Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION



# Ancillary Medical Report

State of New York - Workers' Compensation Board

## C-4 AMR

Use this form to report ancillary medical services such as x-ray, anesthesia, pathology or diagnostic services by other than the attending provider. A medical provider who is only giving clearance for surgery may also use this form. THIS FORM SHOULD NOT BE USED TO REPORT TREATMENT PROVIDED.

Please answer all questions completely, attaching the report for the services provided, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary services, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at [www.wcb.ny.gov](http://www.wcb.ny.gov).

### A. Patient's Information

1. Name: \_\_\_\_\_ 2. Soc. Sec. #: \_\_\_\_\_  
Last First MI  
3. Mailing address: \_\_\_\_\_  
Number and Street City State Zip Code  
4. Home phone #: (\_\_\_\_) \_\_\_\_\_ 5. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 6. Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_  
7. WCB Case # (if known): \_\_\_\_\_ 8. Carrier Case #: \_\_\_\_\_ 9. Patient's Account #: \_\_\_\_\_

### B. Doctor's Information

1. Your name: \_\_\_\_\_ 2. WCB Authorization #: \_\_\_\_\_  
Last First MI  
3. WCB Rating Code: \_\_\_\_\_ 4. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one): ☐ SSN ☐ EIN  
5. Office address: \_\_\_\_\_  
Number and Street City State Zip Code  
6. Billing group or practice name: \_\_\_\_\_  
7. Billing address: \_\_\_\_\_  
Number and Street City State Zip Code  
8. Office phone #: (\_\_\_\_) \_\_\_\_\_ 9. Billing phone #: (\_\_\_\_) \_\_\_\_\_ 10. Provider's NPI #: \_\_\_\_\_  
11. Referring Doctor: \_\_\_\_\_  
Last First MI

### C. Billing Information

1. Employer's insurance carrier: \_\_\_\_\_ 2. Carrier Code #: **W** \_\_\_\_\_  
3. Insurance carrier's address: \_\_\_\_\_  
Number and Street City State Zip Code  
4. Diagnosis or nature of disease or injury:  
Enter ICD9 Code: \_\_\_\_\_ ICD9 Descriptor: \_\_\_\_\_  
(1) \_\_\_\_\_  
(2) \_\_\_\_\_  
(3) \_\_\_\_\_

Relate ICD9 codes in (1), (2) or (3) to Diagnosis Code column by line.

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			Procedures, Services or Supplies CPT/HCPCS	MODIFIER					

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
\$	\$	\$

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above. ☐ I actively supervised the health-care provider named below who provided these services.

Provider's name \_\_\_\_\_ Specialty \_\_\_\_\_

Board Authorized Health Care Provider signature: \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL REPORTING****IMPORTANT - TO THE SERVICE PROVIDER**

1. This form is to be used to file reports for ancillary medical services such as x-ray, anesthesia, pathology or diagnostic services by other than the attending provider in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases. A medical provider who is only giving clearance for surgery may also use this form.

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.

This form is not used to report treatment. To report treatment or to report an ancillary service where treatment is also provided, use forms:

- C-4, 48 HOUR REPORT, complete in all details, within 48 hours after you first render treatment.
- C-4.2 to report continued treatment.
- C-4.3 to report permanent impairment.

Ophthalmologists use Form C-5, Occupational/Physical Therapists use Form OT/PT-4 and Psychologists use Form PS-4 for filing reports.

2. 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.
3. This form must be signed by the doctor providing or supervising the ancillary service and must contain his/her authorization certificate number, code letters and NPI number. 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.
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**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.**

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**NYS Workers' Compensation Board  
Centralized Mailing  
PO Box 5205  
Binghamton, NY 13902-5205**

**Customer Service Toll-Free Number: 877-632-4996**

*Statewide Fax Line: 877-533-0337*



## **SAMPLE CLAIM #10 – JENNIFER LEVY**

**Claim #10 – Jennifer Levy / CC# 00000010-010/ DOA: 8/10/15**

General Information: The claimant is a female Medical Director who sustained a work related injury when she slipped and fell on a waxed tile floor on her employer's premises. The Claimant reported suffering minor injury to her left shin and left wrist. Claimant was examined the employers health clinic where minor abrasions were treated. The Claimant sought no additional medical treatment and lost no time from work as a result of this incident. There were no reports received from the Workers' Compensation Board regarding this incident.

On tab #10 of the excel spreadsheet titled "Sample Claims Worksheet", provide the total fees for the following services and how they were calculated:

"Life of Claim" Administrative fee for this claim (Report Only).