

CATEGORY B – SAMPLE CLAIMS

SAMPLE CLAIM #11 – KAREN BEREN

Claim #11 – Karen Beren/ CC# 00000011-011/ DOA: 11/15/99

General Claim Information: The Claimant is a female Plumber who suffered a compensable work related injury when she tripped and fell onto a pipe. Accident, Notice and Causal Relationship (ANCR) has been established to the Back, Right Shoulder and Right Hip. The Claimant has not returned to work and has been classified Permanently Partially Disabled (PPD).

The following services are required for this claim:

- 1) Legal Representation at WCB Hearing: Hearing Type: Basic; Issue: Question of Deficiency Compensation after 3rd Party Credit is exhausted. Location: Garden City, NY 11530; Time: 1 hour, inclusive of preparation, hearing and report
- 2) Claimant Activity Check. Requires meeting with Claimant and confirming that she resides at address of record and confirming that benefits are being received; inquiring with neighbors about Claimant's work status; Location: West Palm Beach, Florida 33401; Time: 30 minutes
- 3) Surveillance – Two days with four hour blocks each day; 1 operative; Location: West Palm Beach, Florida 33401
- 4) Review/Adjustment of HICF/ Chiropractic
- 5) Review/Adjustment of HICF/ Office Visit

On tab #11 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
Legal Representation (1 basic hearing)
Claimant Activity Check (30 minutes)
Surveillance (2 days with 4 hours each day/ 1 operative)
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.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Medicaid #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input checked="" type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 0000011				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BEREN, KAREN					3. PATIENT'S BIRTH DATE (MM, DD, YY) <input type="text"/> M <input type="text"/> F <input type="text"/>				
5. PATIENT'S ADDRESS (No., 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) 					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				
CITY <input type="text"/> STATE <input type="text"/>					CITY <input type="text"/> STATE <input type="text"/>				
ZIP CODE <input type="text"/> TELEPHONE (Include Area Code) <input type="text"/>					ZIP CODE <input type="text"/> TELEPHONE (Include Area Code) <input type="text"/>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
a. OTHER INSURED'S POLICY OR GROUP NUMBER 					11. INSURED'S POLICY GROUP OR FECA NUMBER 				
b. OTHER INSURED'S DATE OF BIRTH (MM, DD, YY) <input type="text"/> M <input type="text"/> F <input type="text"/>					a. INSURED'S DATE OF BIRTH (MM, DD, YY) <input type="text"/> M <input type="text"/> F <input type="text"/>				
c. EMPLOYER'S NAME OR SCHOOL NAME 					b. EMPLOYER'S NAME OR SCHOOL NAME 				
d. INSURANCE PLAN NAME OR PROGRAM NAME 					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 _____					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.				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM, DD, YY <input type="text"/>					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM, DD, YY <input type="text"/>				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. SMITH					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM, DD, YY <input type="text"/> TO MM, DD, YY <input type="text"/>				
19. RESERVED FOR LOCAL USE 					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES <input type="text"/>				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <input type="text"/> 3. <input type="text"/> 2. <input type="text"/> 4. <input type="text"/>					22. MEDICAID RESUBMISSION CODE <input type="text"/> ORIGINAL REF. NO. <input type="text"/>				
24. A. DATE(S) OF SERVICE From MM, DD, YY <input type="text"/> To MM, DD, YY <input type="text"/> B. Place of Service <input type="text"/> C. EMG <input type="text"/> D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS <input type="text"/> MODIFIER <input type="text"/> E. DIAGNOSIS POINTER <input type="text"/>					23. PRIOR AUTHORIZATION NUMBER 				
1 06/03/15 06/03/15 11 99213 A					F. \$ CHARGES 255.00 G. DAYS OR UNITS 1 H. EPSDT Family Plan <input type="checkbox"/> I. ID QUAL. <input type="text"/> J. RENDERING PROVIDER ID. # <input type="text"/>				
2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					NPI <input type="text"/>				
3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					NPI <input type="text"/>				
4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					NPI <input type="text"/>				
5 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					NPI <input type="text"/>				
6 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					NPI <input type="text"/>				
25. FEDERAL TAX I.D. NUMBER <input type="text"/> SSN <input type="text"/> EIN <input type="text"/>					26. PATIENT'S ACCOUNT NO. <input type="text"/>				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 255.00				
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.) SIGNED _____ DATE _____					29. AMOUNT PAID \$ <input type="text"/>				
32. SERVICE FACILITY LOCATION INFORMATION BOYTON BEACH, FL 334357944					30. BALANCE DUE \$ <input type="text"/>				
a. <input type="text"/> b. <input type="text"/>					33. BILLING PROVIDER INFO & PH # (<input type="text"/>) <input type="text"/>				

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.

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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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)		3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)		8. PATIENT STATUS		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											
2. BEREN, KAREN		MM DD YY		M F						Self Spouse Child Other				Single Married Other				Employed Full-Time Student Part-Time Student													
10. ZIP CODE		10. TELEPHONE (Include Area Code)		11. CITY		11. STATE		12. ZIP CODE		12. TELEPHONE (Include Area Code)		13. CITY		13. STATE		14. ZIP CODE		14. TELEPHONE (Include Area Code)		15. CITY		15. STATE									
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		12. INSURED'S DATE OF BIRTH		12. SEX		13. EMPLOYER'S NAME OR SCHOOL NAME		14. INSURANCE PLAN NAME OR PROGRAM NAME		15. IS THERE ANOTHER HEALTH BENEFIT PLAN?		16. YES		16. NO		17. IF yes, return to and complete item 9 a-d.		18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. OTHER INSURED'S DATE OF BIRTH		b. SEX		c. EMPLOYER'S NAME OR SCHOOL NAME		d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		14. SIGNED		14. DATE		15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		16. FROM		16. TO									
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. SIGNED		13. DATE		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		17. FROM		17. TO		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		19. FROM		19. TO		20. OUTSIDE LAB?		20. \$ CHARGES							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		17b. NPI		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE		24. B. PLACE OF SERVICE		24. C. EMG		24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		24. E. DIAGNOSIS POINTER		25. \$ CHARGES		26. DAYS OR UNITS		27. EPSDT Family Plan		28. ID QUAL.		29. RENDERING PROVIDER ID. #	
1. 722.52		3. 722.2		2. 723.1		4. 725.85		24. A. DATE(S) OF SERVICE		24. B. PLACE OF SERVICE		24. C. EMG		24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		24. E. DIAGNOSIS POINTER		25. \$ CHARGES		26. DAYS OR UNITS		27. EPSDT Family Plan		28. ID QUAL.		29. RENDERING PROVIDER ID. #		30. BALANCE DUE			
09/04/15		09/04/15		11		98941		ABCD		90.00		1																			
25. FEDERAL TAX I.D. NUMBER		25. SSN		25. EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE		31. BILLING PROVIDER INFO & PH #		32. THE VILLAGES, FL 32162-5608		33. THE VILLAGES, FL 32162-5608		34. SIGNED		34. DATE		35. SIGNED		35. DATE			
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. THE VILLAGES, FL 32162-5608		34. SIGNED		34. DATE		35. SIGNED		35. DATE		36. SIGNED		36. DATE		37. SIGNED		37. DATE		38. SIGNED		38. DATE		39. SIGNED		39. DATE			

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.

SAMPLE CLAIM #12 – KEVIN OXFORD

Claim #12 – Kevin Oxford / CC# 00000012-012/ DOA: 10/5/79

General Claim Information: The Claimant is a male Landscaper who suffered a compensable work related injury when he slipped and fell on wet grass. Accident, Notice and Causal Relationship (ANCR) is established to the Back and Left Knee. The Claimant has not returned to work and has been classified Permanently Partially Disabled (PPD).

The following services are required for this claim:

- 1) 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: Huntington Station, NY 11746; Time: 30 minutes
- 2) Review/ Adjustment of C-4.2 – Pain Management (attached)
- 3) Review/ Adjustment of HICF – X Ray (attached)
- 4) Review/ Adjustment of C-4.2 – Steroid Injections (attached)

On tab #12 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
Claimant Activity Check (30 minutes)
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.

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)

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.

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- 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.
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Column J: Enter NPI.
Item 25: Enter the Federal tax I.D.
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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
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11	Office	53	Community Mental Health Center (CMHC)
12	Patient Home	54	Intermediate Care Facility/Mentally Retarded
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32	Nursing Facility	99	Other Place of Service
33	Custodial Care Facility		

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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.

Date(s) of Examination: 08/11/2015

WCB Case Number (if known): _____ Carrier Case Number (if known): _____

A. Patient's Information

1. Name: OXFORD KEVIN 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: PO BOX 10668 ALBANY NY 12201-5668
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) 729.1 UNSPECIFIED MYALGIA AND MYOSIT
(2) 722.83 POSTLAMINECTOMY SYNDROME, LUMB
(3) 338.4 CHRONIC PAIN SYNDROME
(4) 738.4 ACQUIRED SPONDYLOLISTHESIS

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	27	15	07	27	15	11		99214		1234	230.00	1		11706-7036

☐ 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)
\$ 230.00	\$	\$

D. Examination and Treatment

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

Patient's Name: OXFORD KEVIN 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 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

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.

Date(s) of Examination: 08/11/2015

WCB Case Number (if known): _____ Carrier Case Number (if known): _____

A. Patient's Information

1. Name: OXFORD KEVIN 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: BAY SHORE NY 11706-6943
Number and Street City State Zip Code

6. Billing Group or Practice Name: _____

7. Billing address: PO BOX 10668 ALBANY NY 12201-5668
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) 721.3 LUMBOSACRAL SPONDYLOSIS WITHOU

(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					
08	11	15	08	11	15	24		64493	50	1	1500.00	1		11706-6943
08	11	15	08	11	15	24		64494	50	1	878.00	1		

☐ 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)
\$ 2378.00	\$	\$

D. Examination and Treatment

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

Patient's Name: OXFORD KEVIN 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 ____/____/____

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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

SAMPLE CLAIM #13 – JANINE WATERS

Claim #13 – Janine Waters/ CC# 00000013-013/ DOA: 10/7/92

General Claim Information: The Claimant is a female Clerk who suffered a compensable work related injury while bending down to take a file out of a cabinet. Accident, Notice and Causal Relationship (ANCR) has been established to the back. She was classified with a permanent partial disability at a hearing held on 7/11/1993. She later relocated to Lady Lake, FL 32158.

The following services are required for this claim:

- 1) Claimant Activity Check. Requires meeting with Claimant and confirming that she resides at address of record and confirming that benefits are being received; inquiring with neighbors about Claimant's work status; Location; Lady Lake, FL 32158
- 2) Surveillance – Two days with four hour blocks each day; 1 operative; Lady Lake, FL 32158
- 3) Review/ Adjustment of HICF Office Visit (attached)
- 4) Review/ Adjustment of HICF Physical Therapy (attached)

On tab #13 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
Claimant Activity Check (30 minutes)
Surveillance (2 days with 4 hours each day/ 1 operative)
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.

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 00000013-013		(FOR PROGRAM IN ITEM 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Waters Janine										3. PATIENT'S BIRTH DATE MM DD YY 02/02/1945 M F X				4. INSURED'S NAME (Last Name, First Name, Middle Initial) Waters Janine							
5. PATIENT'S ADDRESS (No., Street) 398 Palm Court										6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other				7. INSURED'S ADDRESS (No., Street)							
CITY Lady Lake STATE FL										8. PATIENT STATUS Single Married X Other Employed Full-Time Student Part-Time Student				CITY STATE ZIP CODE TELEPHONE (Include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) X YES NO b. AUTO ACCIDENT? YES PLACE (State) c. OTHER ACCIDENT? YES NO				11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY M F X				b. EMPLOYER'S NAME OR SCHOOL NAME							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F X										c. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME NYSIF							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X 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. 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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 10/07/1992										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? \$ CHARGES YES X NO				22. MEDICAID RESUBMISSION ORIGINAL REF. NO. CODE							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 724.2 2. 724.3 3. 729.1 4. 739.5										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. #							
25. FEDERAL TAX I.D. NUMBER SSN EIN 00-0000000										26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO				28. TOTAL CHARGE \$ 170.00			
29. AMOUNT PAID \$										30. BALANCE DUE \$ 170.00				33. BILLING PROVIDER INFO & PH # ()							
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 9000 New Highway, Suite 45 Lady Lake, FL 32159-8975				9000 New Highway, Suite 45 Lady Lake FL 32159							
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.

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>																			
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) 00000013-013														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Waters Janine					3. PATIENT'S BIRTH DATE (MM DD YY) 02/02/1945					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Waters Janine									
5. PATIENT'S ADDRESS (No., Street) 398 Palm Court					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 Lady Lake					STATE FL					8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>									
ZIP CODE 32158					TELEPHONE (Include Area Code)					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					12. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>									
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"/>					c. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					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.									
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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 10/07/1992					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO									
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					23. PRIOR AUTHORIZATION NUMBER					24. A. DATE(S) OF SERVICE (From To) MM DD YY MM DD YY 090415 090415 B. Place of Service 11 C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 99213 E. DIAGNOSIS POINTER 1,2,3,4 F. \$ CHARGES 90.00 G. DAYS OR UNITS 1 H. EPSDT Family Plan I. ID QUAL. NPI J. RENDERING PROVIDER ID. #									
1. 722.52 2. 722.2					3. 723.1 4. 728.85					25. FEDERAL TAX I.D. NUMBER 00-0000000									
26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 90.00									
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.) SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION 50 Rust Manor Drive #65 The Villages, FL 32162-5608					29. AMOUNT PAID \$ 30. BALANCE DUE \$ 90.00									
33. BILLING PROVIDER INFO & PH # 50 Rust Manor Drive #65 The Villages FL 32162																			

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.

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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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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		

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NOTICE

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SAMPLE CLAIM #14 – JEFFERY CHEESEMAN

Claim #14 – Jeffery Cheeseman/ CC# 00000014-014/ DOA: 7/24/94

General Claim Information: The Claimant is a male Part-Time Helper who suffered a compensable work related injury when he was involved in an MVA. Accident, Notice and Causal Relationship (ANCR) is established to the neck and back. He was classified with a permanent partial disability at a hearing held on 4/4/1999.

The following services are required for this claim:

- 1) 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: East Islip, NY 11730
- 2) Surveillance – One day for six hours; 1 operative; East Islip, NY 11730
- 3) Legal Representation at WCB Hearing: Hearing Type: Basic; Issue(s): C8.1 Part B (Issue of disputed medical bills). Question of authorization for treatment/tests; Location: Hauppauge, NY 11787; Time: 45 Minutes, inclusive of preparation, hearing and report
- 4) Legal Representation at WCB Hearing: Hearing Type: Basic; Issue(s): To consider agreement pursuant to Section 32 of the Workers' Compensation Law; Location: Hauppauge, NY 11787; Time: 1 Hour, inclusive of preparation, hearing and report
- 5) Review/Adjustment of Doctor's Progress Report/ C-4.2 (attached)
- 6) Review/ Adjustment of HICF (attached)
- 7) Review of MG-2 (attached)

On tab #14 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
Claimant Activity Check (30 minutes)
Surveillance (1 day for six hours/ 1 operative)
Legal Representation (2 basic hearings)
Medical Bill Review/ Adjustment (2 bills)
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 the medical justification needed to meet the "burden of proof" standard for continuing treatment; exceeds number of injections authorized under the MTGs.



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: 00000014-014	Date of Injury: 07/24/1994
------------------------	-----------------------------------	----------------------------

A. Patient's Name: Jeffery Cheeseman Social Security No.: _____

Patient's Address: 75 Rose Lane, East Islip, NY 11730

Employer's Name & Address: _____

Insurance Carrier's Name & Address: State Insurance Fund

B. Attending Doctor's Name & Address: 250 West Main Street, Babylon, NY 11702

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: ☐B - ☐D ☐6 ☐f ☐ (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)

Lumbar Facet Block Injection @ L4/5 - L5/S1 fluoroscopically guided.

Outpatient (x1)

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: Jul 8, 2015

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

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) Jul 15, 2015 and spoke to (person spoke to or was not able to speak to anyone) case manager.

☒ A copy of this form was sent to the carrier/employer/self-insured employer/Special Fund (fax number or email address required) 631-000-0000

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: Jul 15, 2015

Patient Name: Jeffery Cheeseman	WCB Case Number: _____	Date of Injury: 07/24/1994
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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.

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)									
												<input checked="" type="checkbox"/>		00000014-014									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)														3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
Cheeseman Jeffery														12/25/1931		M <input checked="" type="checkbox"/> F <input type="checkbox"/>		Cheeseman Jeffery					
5. PATIENT'S ADDRESS (No., Street)														6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)					
75 Rose Lane														Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY STATE														8. PATIENT STATUS				CITY STATE					
East Islip NY														Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
ZIP CODE TELEPHONE (Include Area Code)														Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE TELEPHONE (Include Area Code)					
11730																							
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. EMPLOYMENT? (CURRENT OR PREVIOUS)				a. INSURED'S DATE OF BIRTH SEX					
a. OTHER INSURED'S POLICY OR GROUP NUMBER														<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 checked="" 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 checked="" type="checkbox"/> NO				NYSIF					
d. INSURANCE PLAN NAME OR PROGRAM NAME														10d. RESERVED FOR LOCAL USE				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.					
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							
07/24/1994														MM DD YY		FROM TO		MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE														17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
														17b. NPI		FROM 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 CODE		ORIGINAL REF. NO.							
1. 721.3														3. 959.6									
2. 724.4														4. 719.46									
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																							
081015 081015 11 99213 1,2,3,4														215.00		1							
081015 081015 11 1036F 1,2,3,4														0.01		1							
081015 081015 11 G8427 1,2,3,4														0.01		1							
081015 081015 11 G8730 1,2,3,4														0.01		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"/> YES <input type="checkbox"/> NO		\$ 215.03		\$		\$ 215.03	
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 #					
														600 West Main Street				PO Box 50697					
														Babylon, NY 11702-3439				Albany NY 12201					
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.

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.

Date(s) of Examination: 07/08/2015

WCB Case Number (if known): _____ Carrier Case Number (if known): 00000014-014

A. Patient's Information

1. Name: Cheeseman Jeffery 2. Date of injury/illness: 07 / 24 / 94 3. Soc. Sec. #: - - -
Last First MI
4. Address (if changed from previous report): 75 Rose Lane East Islip NY 11730
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: 250 West Main Street Babylon NY 11702
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) 721.3 _____
(2) 724.4 _____
(3) 959.6 _____
(4) 719.4 _____

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	08	15	07	08	15	11		99214		1,2,3,4	230.00	1		11702-3439

☐ 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)
\$ 230.00	\$	\$

D. Examination and Treatment

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

Patient's Name: Cheeseman Jeffery Date of injury/onset of illness: 07 / 24 / 1994
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: _____

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 ☒ 6 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? 75 %

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): Permanent Partial Disability

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 AN-PM

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

SAMPLE CLAIM #15 – JAMES IRONS

Claim #15 – James Irons/ CC# 00000015-015/ DOA: 9/29/88

General Information: The Claimant is a male Volunteer Firefighter who suffered a compensable injury in the line of duty during practice drills. Accident, Notice and Causal Relationship (ANCR) has been established to neck and back. He was classified with a permanent partial disability at a hearing held on 8/19/1992.

The following services are required for this claim:

- 1) 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
- 2) Independent Medical Exam for an opinion on further causally related disability, post surgery, w/ Orthopedic Doctor in Albany, NY 12241
- 3) Legal Representation at WCB Hearing: Hearing Type: Intermediate; Issue(s): Question of further causally related disability; Location: Albany, NY 12241; Time: 1 hour, inclusive of preparation, hearing and report
- 4) Review/Adjustment of Doctor's Initial Report/ C-4 (attached)
- 5) Review/Adjustment of Emergency Room/Hospitalization Bill (attached)

On tab #15 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

Field Investigation (1)

Legal Representation (1 intermediate hearing)

Independent Medical Exam (1 exam)

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. Please note that C-4 includes a continuation which lists additional dates of service.

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997  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.

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.

A. Patient's Information

1. Name: IRONS JAMES
Last First MI

2. Social Security #: - -

3. Home phone #: ()
4. WCB Case # (if known):
5. Carrier Case #: 00000015-015

6. Mailing address:
Number and Street City State Zip Code

7. Date of injury/onset of illness: 09 / 29 / 88
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: _____
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
MANHASSET NY 11030-3876

6. Billing group or practice name: _____

7. Billing address: _____
Number and Street City State Zip Code
LITTLE NECK NY 11362-1428

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) 715.18	DJD, RIBD/SPINE/CERVICSL/THORACIC/LUMBAR/MULT
(2) 359.5	DO NOT USE - USE 259.9
(3) 724.3	SCIATICA
(4) 719.49	PAIN MULTIPLE SITES

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

Patient's Name: IRONS JAMES
Last First MI

Date of injury/onset of illness: 09 / 29 / 88

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	14	15	07	14	15	21		99255	...	1	400.00	1		11030-3876
07	15	15	07	15	15	21		99233	...	2,3,4,1	188.50	1		11030-3876
07	16	15	07	16	15	21		99233	...	2,3,4,1	188.50	1		11030-3876
07	17	15	07	17	15	21		99233	...	2,3,4,1	188.50	1		11030-3876
07	18	15	07	18	15	21		99233	...	2,3,4,1	188.50	1		11030-3876
07	19	15	07	19	15	21		99233	...	2,3,4,1	188.50			11030-3876

☐ 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)
\$ 4358.50	\$	\$

E. History

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

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: 07/14-15-08/04/15

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 BACK AND RIGHT LEG | <input type="checkbox"/> Weakness _____ |
| <input type="checkbox"/> Stiffness _____ | <input checked="" type="checkbox"/> Other (specify) BACK AND LEGS |

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 type="checkbox"/> Other (specify) _____ | |

Patient's Name: IRONS JAMES Date of injury/onset of illness: 09 / 29 / 88

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: _____
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 _____

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