



# Doctor's Initial Report

State of New York - Workers' Compensation Board

# C-4

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

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board and to the insurance carrier. 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.state.ny.us](http://www.wcb.state.ny.us).

## A. Patient's Information

1. Name: \_\_\_\_\_ 2. Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First MI
3. Home phone #: (\_\_\_\_\_) \_\_\_\_\_ 4. WCB Case # (if known) \_\_\_\_\_ 5. Carrier Case # (if known) \_\_\_\_\_
6. Mailing address: \_\_\_\_\_  
Number and Street City State Zip Code
7. Date of injury/onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_ 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: \_\_\_\_\_

## B. Employer Information

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

## C. Doctor's Information

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

## D. Billing Information

1. Employer's insurance company: \_\_\_\_\_
2. Insurance company's address: \_\_\_\_\_  
Number and Street City State Zip Code
3. Diagnosis or nature of disease or injury:  
 Enter ICD9 Code: ICD9 Descriptor:  
 (1) \_\_\_\_\_  
 (2) \_\_\_\_\_  
 (3) \_\_\_\_\_  
 (4) \_\_\_\_\_

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

Patient's Name: \_\_\_\_\_  
Last First MI

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

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

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

Total Charge \$	Amount Paid (Carrier Use Only) \$	Balance Due (Carrier Use Only) \$
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### E. History

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

### F. Exam Information

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

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

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

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

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

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

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

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

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

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

### G. Doctor's Opinion

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

### H. Plan of Care

- What is your proposed treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Medication(s):(a) list medications prescribed: \_\_\_\_\_  
(b) list over-the-counter medications advised: \_\_\_\_\_  
Medication restrictions:  None  May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:  
\_\_\_\_\_  
\_\_\_\_\_

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

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

**Tests:**

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

**Referrals:**

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

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

**Important:** You **must** fill out form C-4 AUTH to request any special medical service over \$1000 that is not on the pre-authorized procedures list.

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

6. Did you adhere to the New York Treatment Guidelines for your evaluation and treatment of this injury/illness?  Yes  No

If yes, identify applicable sections of Treatment Guidelines: \_\_\_\_\_

If no, explain why not, including the basis for any variance from the Guidelines: \_\_\_\_\_

## 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 \_\_\_\_/\_\_\_\_/\_\_\_\_
  - Bending/twisting
  - Climbing stairs/ladders
  - Environmental conditions
  - Kneeling
  - Other (explain): \_\_\_\_\_
  - Lifting
  - Operating heavy equipment
  - Operation of motor vehicles
  - Personal protective equipment
  - Sitting
  - Standing
  - Use of public transportation
  - Use of upper extremities

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**

- 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.
- Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.
- This form must be signed by the attending doctor and must contain her/his authorization certificate number, 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.
- AUTHORIZATION FOR SPECIAL SERVICES** - You MUST follow the instructions contained on the form C-4 AUTH to request any special medical service over \$1000.  
**AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY**
- LIMITATION OF PODIATRY TREATMENT** - Podiatry treatment is limited as defined in Section 7001 of the Education Law and Section 13-k(2) of the Workers' Compensation Law.
- LIMITATION OF CHIROPRACTIC TREATMENT** - Chiropractic treatment is limited as defined in Section 6551 of the Education Law and the Chair's Rules Relative to Chiropractic Practice Under Section 13-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.**
- HIPAA NOTICE** - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

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

**BILLING INFORMATION**

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

**IMPORTANT TO THE PATIENT**

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

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

**IMPORTANTE PARA EL PACIENTE**

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

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

TAMBIEN MENCIONE EN SU COMUNICACION ORAL O ESCRITA SU NUMERO DE SEGURO SOCIAL.

**WORKERS' COMPENSATION BOARD DISTRICT OFFICES**

Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

**Albany DO - 100 Broadway-Menands, Albany NY 12241 866-750-5157** (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)

**Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY 13901 866-802-3604** (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)

**Buffalo DO - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 866-211-0645** (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)

**Rochester DO - 130 Main Street West, Rochester NY 14614 866-211-0644** (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)

**Syracuse DO - 935 James Street, Syracuse NY 13203 866-802-3730** (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence)

**Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC 800-877-1373; in Hempstead 866-805-3630; in Hauppauge 866-681-5354; in Peekskill 866-746-0552** (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)



# Doctor's Progress Report

# C-4.2

State of New York - Workers' Compensation Board

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 and to the insurance carrier. 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.state.ny.us](http://www.wcb.state.ny.us).

Date(s) of Examination: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ WCB Case # (if known): \_\_\_\_\_ Carrier Case # (if known): \_\_\_\_\_

## A. Patient's Information

1. Name: \_\_\_\_\_ 2. Date of injury/illness: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 3. Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First MI

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

## B. Doctor's Information

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

3. WCB Rating Code: \_\_\_\_\_

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

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

6. Office phone #: (\_\_\_\_\_) \_\_\_\_\_ 7. Billing phone #: (\_\_\_\_\_) \_\_\_\_\_ 8. NPI #: \_\_\_\_\_

9. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one):  SSN  EIN

## C. Billing Information

1. Diagnosis or nature of disease or injury:  
Enter ICD9 Code: \_\_\_\_\_ ICD9 Descriptor: \_\_\_\_\_  
(1) \_\_\_\_\_  
(2) \_\_\_\_\_  
(3) \_\_\_\_\_  
(4) \_\_\_\_\_

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

From		Dates of Service				Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/Units	COB	Zip code where service was rendered
MM	DD	YY	MM	DD	YY			Procedures, Services or Supplies	Modifier					

<input type="checkbox"/> 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) \$
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## D. Examination and Treatment

- Describe any diagnostic test(s) rendered at this visit: \_\_\_\_\_
- 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: \_\_\_\_\_  
\_\_\_\_\_
- List additional body parts affected by this injury, if any: \_\_\_\_\_

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

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
- MRI (specify): \_\_\_\_\_
- Labs (specify): \_\_\_\_\_
- X-rays (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

**Referrals:**

- Chiropractor
- Occupational Therapist
- Physical Therapist
- Specialist in: \_\_\_\_\_
- Other (specify): \_\_\_\_\_

EMG/NCS

Internist/Family Physician

**Important:** You **must** fill out form C-4 AUTH to request any special medical service over \$1000 that is not on the pre-authorized procedures list.

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

8. Did you adhere to the New York Treatment Guidelines for your evaluation and treatment of this injury/illness?  Yes  No

If yes, identify applicable sections of Treatment Guidelines: \_\_\_\_\_

If no, explain why not, including the basis for any variance from the Guidelines: \_\_\_\_\_

**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
- Climbing stairs/ladders
- Environmental conditions
- Kneeling
- Other (explain): \_\_\_\_\_
- Lifting
- Operating heavy equipment
- Operation of motor vehicles
- Personal protective equipment
- Sitting
- Standing
- Use of public transportation
- Use of upper extremities

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**

- This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:
  - 45 DAY PROGRESS REPORTS** - Following the filing of the C-4 form, Doctor's Initial Report, file this form at intervals of 45 days during continuing treatment, unless change of condition necessitates additional reporting.
  - 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.
- Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.
- This form must be signed by the attending doctor and must contain her/his authorization certificate number, 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.
- AUTHORIZATION FOR SPECIAL SERVICES** - You MUST follow the instructions contained on the form C-4 AUTH to request any special medical service over \$1000.

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

- LIMITATION OF PODIATRY TREATMENT** - Podiatry treatment is limited as defined in Section 7001 of the Education Law and Section 13-k(2) of the Workers' Compensation Law.
- LIMITATION OF CHIROPRACTIC TREATMENT** - Chiropractic treatment is limited as defined in Section 6551 of the Education Law and the Chair's Rules Relative to Chiropractic Practice Under Section 13-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.**
- 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.

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**BILLING INFORMATION**

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

**IMPORTANT TO THE PATIENT**

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**IMPORTANTE PARA EL PACIENTE**

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

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

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



# Doctor's Report of MMI/Permanent Impairment

# C-4.3

State of New York - Workers' Compensation Board

Use this form when a patient has reached *Maximum Medical Improvement* and to render an opinion on permanent impairment, if any. (To report the first time you treated the patient, use Form C-4. For continuing treatment, use Form C-4.2.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board and to the insurance carrier. 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.state.ny.us](http://www.wcb.state.ny.us).

Date(s) of Examination: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ WCB Case # (if known): \_\_\_\_\_ Carrier Case # (if known): \_\_\_\_\_

## A. Patient's Information

1. Name: \_\_\_\_\_ 2. Date of injury/illness: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 3. Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First MI

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

## B. Doctor's Information

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

3. WCB Rating Code: \_\_\_\_\_

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

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

6. Office phone #: (\_\_\_\_\_) \_\_\_\_\_ 7. Billing phone #: (\_\_\_\_\_) \_\_\_\_\_ 8. NPI #: \_\_\_\_\_

9. Federal Tax ID #: \_\_\_\_\_ The Tax ID # is the (check one):  SSN  EIN

## C. Billing Information

1. Diagnosis or nature of disease or injury:

Enter ICD9 Code: \_\_\_\_\_ ICD9 Descriptor: \_\_\_\_\_

(1) \_\_\_\_\_

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

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

Dates of Service						Place of Service	Leave Blank	Use WCB Codes		Diagnosis Code	\$ Charges	Days/ Units	COB	Zip code where service was rendered
From MM	DD	YY	To MM	DD	YY			Procedures, Services or Supplies CPT/HCPCS	MODIFIER					

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

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

## D. Permanent Impairment/Work Status

1. Has the patient reached Maximum Medical Improvement?  Yes  No If yes, provide the date patient reached MMI: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. Is there permanent impairment?  Yes  No If yes, check the boxes that apply:

Schedule loss of use of member: (Identify impairment rating according to NY Impairment Guidelines and attach separate sheet for additional body parts.)

Body part: \_\_\_\_\_ Impairment: % \_\_\_\_\_

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

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

Applicable section(s) of NY Impairment Guidelines used: \_\_\_\_\_

Explain how impairment % was determined: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Non-Schedule losses: (Identify impairment rating according to NY Impairment Guidelines and attach separate sheet for additional body parts.)

Body part: \_\_\_\_\_ Impairment: % \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Applicable section(s) of NY Impairment Guidelines used: \_\_\_\_\_

Explain how impairment % was determined: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

For multiple impairments from an injury/illness:

a. Combined aggregate impairment: % \_\_\_\_\_

b. Explain how % was determined: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. Is patient working now?  Yes at the pre-injury job  Yes at other employment  Not working

4. Does the patient have work limitations?  Yes  No If yes, check all of the following that apply:

- |   |  |   |
|---|--|---|
| <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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. With whom have you discussed patient's returning to work and/or limitations?  with patient  with patient's employer  N/A

6. Would patient benefit from vocational rehabilitation?  Yes  No If yes, explain \_\_\_\_\_

\_\_\_\_\_

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

**Board Authorized Health Care Provider signature:**

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

**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:

When your patient has reached Maximum Medical Improvement and to render an opinion on permanent impairment, if any.

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.
4. **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.
5. **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.  
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**STATEMENT OF MEDICAL NECESSITY**

Pursuant to 12 NYCRR 325-1.4(a)(1), it is the attending physician's burden to set forth the medical necessity of the special services required. Failure to do so may delay the authorization process.

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.....

I certify that I am making the above request for authorization. This request was made by telephone on (date) \_\_\_\_\_ to (person contacted) \_\_\_\_\_ This form was also mailed to the self-insured employer/carrier and a copy was provided to the Board on the date below.

Provider's Signature: ..... Date: .....

**SELF-INSURED EMPLOYER / CARRIER RESPONSE TO AUTHORIZATION REQUEST**

**Response Time and Notification Required:**

**If claimant is hospitalized:** The self-insured employer/carrier must grant or deny each request for authorization of special service to the doctor by telephone within 4 working days. This response must be confirmed in writing **by completing this form and mailing it, within five days of the examination of the patient**, to the doctor, claimant's legal counsel if any, and the Workers' Compensation Board.

**If claimant is not hospitalized:** The self-insured employer/carrier must grant or deny each request for authorization of special service to the doctor by telephone and confirm its response in writing **by completing this form and mailing it, within thirty days**, to the doctor, claimant's legal counsel if any, and the Workers' Compensation Board.

**Denial of the Request for Authorization of a Special Service:** A denial of authorization of a special service to an established body part **must** be based upon and accompanied by a **conflicting second opinion** rendered by a physician authorized to treat workers' compensation claimants. If the compensation case is controverted, the conflicting second opinion must address medical necessity only and such authorization shall not be construed as an admission that the condition for which these services are required is compensable. The employer/carrier shall not be responsible for the payment of such services until the question of compensability is resolved. When denying authorization for a special service, the employer/carrier must also file with the Board within 5 days of such denial **Board Form C-8.1 Part A** (Notice of Treatment Issue(s)/Disputed Bill Issue(s)). Failure to file timely the conflicting second opinion and Board Form C-8.1 Part A will render the denial defective.

**Failure to Timely Respond to C-4 AUTH:** The special service(s) for which authorization has been requested will be **deemed authorized** by Order of the Chair if the self-insured employer/carrier fails to respond within the time specified above. An Order of the Chair is not subject to an appeal under Section 23 of the Workers' Compensation Law.

**REASON FOR DENIAL(S), IF ANY. (ATTACH CONFLICTING SECOND MEDICAL OPINION AS EXPLAINED ABOVE.)**

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

I certify that the self-insured employer/carrier **telephoned** the office of the health care provider listed above within the response time-frame indicated above and advised that the self-insured employer/carrier had either granted or denied approval for the special services for which authorization was sought, as indicated above, on the date below:

**and**

I certify that copies of this form were **mailed** to the health care provider listed above and to the Workers' Compensation Board on the date below:

By: ..... Title: .....  
(Please print name)

Signature: ..... Date: .....

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

1. This form is used for a workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit case as follows:  
To confirm a telephone request for written authorization for special service(s) costing over \$1,000 in a non-emergency situation.
2. SPECIAL SERVICES - Services for which authorization must be requested are as follows:  
*Physicians* - To engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than \$1,000.  
*Podiatrists* - In treating the foot, to provide physiotherapeutic procedures, X-ray examinations, or special diagnostic laboratory tests costing more than \$1,000.  
*Chiropractors* - In treating a condition as provided in Section 6551 of the Education Law, to engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than \$1,000.  
*Occupational/Physical Therapists* - In treating a condition as provided in Article 136 or 156 of the Education Law, in the Workers' Compensation Law, and the Rules of the Chair relative to Occupational/Physical Therapy Practice to provide occupational/physical therapy procedures costing more than \$1,000.
2. When requesting authorization over the telephone, be sure to obtain the name of the person contacted since you must indicate this information along with the date of contact and certify its validity on the form.
3. It is the attending physician's burden to set forth the medical necessity of the special services required. Be sure to provide this information in the Statement of Medical Necessity section of this form.
4. This form must be signed by the attending doctor (original signature only) and must contain her/his authorization certificate number and code letters. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.
5. Please ask your patient for his/her WCB case number and the carrier's case number and show these numbers on this form. In addition, ask your patient if he/she has retained a representative. If represented, ask for the name and address of the representative.  
This request must be sent to the Workers' Compensation Board, the workers' compensation insurance carrier or self-insured employer, and, if the patient is represented by an attorney or licensed representative, such legal representative. If your patient is not represented, a copy must be sent to your patient.
6. If authorization or denial is not forthcoming within the 4 working days if the patient is hospitalized, or within the 30 calendar days if the patient is not hospitalized, notify the nearest office of the Workers' Compensation Board.
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.

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