Printed on :

Patient Information

Personal Information

First Name		**Middle Name**	
Last Name		**D.O.B**	
Gender		**Address**	
City		**State**	
Cell Phone #		**Home Phone**	
Work		**Zip**	
Email		**Extn.**	
Attorney		**Case Type**	
Attorney Address		**Attorney Phone**	
Case Status		**SSN**	

Insurance Information

Policy Holder		**Name**	
Address		**City**	
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	
Policy #			

Accident Information

Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information

Name		**Phone**	
Extension		**Fax**	
Email			

NEW YORK STATE | Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #:	Administrator Claim (carrier case) #:	Date of Injury/Illness:

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

Patient's Address: _____

Employer's Name & Address: _____

Insurer's Name & Address: _____

B. Attending Doctor's Name & Address: Dr. Anjani Sinha; 164-10 Northern Blvd, Flushing, NY 11358

Individual Provider's WCB Authorization No.: 1 4 7 4 4 8 - 5 w NPI No.: 1932233715

Telephone No.: 718-886-2011 Fax No.: 929-333-7950

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

Guideline Reference: _ - D 6 F _

*(In first box, indicate injury and/or condition: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck, C = **C**arpal Tunnel, P = Non-Acute **P**ain. 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)

STATEMENT OF MEDICAL NECESSITY - See item 5 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 patient 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 attached: _____

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

Provider **must** enter in **A** the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete **B**. If you are unable to send or receive email or fax, complete **C**.

A. *Insurer's designated fax # or email address as provided on the Board's website:* _____

☐ ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* _____

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:* _____

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 patient understands and agrees to undergo the proposed medical care. I ☐ did / ☑ did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) _____ and spoke to (person spoke to or was not able to speak to anyone) _____

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. 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: _____

MG-2.0 4-18

Patient Name:	WCB Case #:	Date of Injury/Illness:

D. **INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW**

☐ The self-insurer/insurer hereby gives notice that it will have the patient 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. **INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST**

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer 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.

_____

_____

_____

_____

_____

INSURER'S / EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space provided.

☐ Granted
☐ Granted in Part
☐ Without Prejudice

☐ Denied
☐ Burden of Proof Not Met
☐ 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 representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/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 ☐ through WCB adjudication. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, 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 INSURER / EMPLOYER**

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

By: (print name) _____ Title: _____

Insurer's Signature: _____ Date: _____

G. **CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF INSURER'S / EMPLOYER'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 INSURER'S DENIAL OF THE PROVIDER'S VARIANCE REQUEST.

☐ I request that the Workers' Compensation Board review the insurer'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 ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, 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
PO Box 5205
Binghamton, NY 13902-52055

Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: (877) 632-4996 • Statewide Fax: (877) 533-0337