

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, 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									
1. Name:	First		MI	2. 8	Social Security #:					
3. Home phone #: ()		5. Carrier Case #:								
6. Mailing address:										
7. Date of injury/onset of illness:				City	9. Gender:	State Male	Zip Code Female			
10. On the date of injury/illness wha	at was the patient's job	title or description: _								
11. On the date of injury/illness wha	it were the patient's us	sual work activities:								
12. Patient's Account #:										
B. Employer Informatio	n									
1. Employer when injury occurred:		Company/Agency Name			2. Phone #: (_)_				
3. Employer Address:				City		01.1	Zip Code			
C. Doctor's Information		190 1		City		State	Zip Code			
1. Your name:				2. W	CB Authorization	#:				
	1. Your name: Last First 3. WCB Rating Code: 4. Federal Tay ID #				The Tax ID # is the (<i>check one</i>): ☐ SSN ☐					
5. Office address:					(6)	,	-			
J. Office address.	Number and Street			City		State	Zip Code			
6. Billing group or practice name:_										
7. Billing address:	N. J. JOL.					N. 1				
7. Billing address:				City State Zip Code 10. Treating Provider's NPI #:						
11. You are a (check one):				10. 11001	ing i Tovidor o M					
	niysician Podia	trist Uniropracto)ľ							
D. Billing Information										
Employer's insurance carrier:					2. Carrier Code #	: W				
3. Insurance carrier's address:	Number and	d Street	_	City		State	Zip Code			
4. Diagnosis or nature of disease of	or injury:									
Enter ICD9 Code:	ICD9 Descriptor:									
(1)	_									
(2)	_									
(3)	_									
(4)	_									

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Have you previously treated this patient for a similar work-related injury/illness? \[\text{Yes} \] No \[\text{If yes, when:} \] Exam Information Date(s) of Examination: \[\text{Patient's subjective complaints: } Check all that apply and identify specific affected body part(s). \] Numbness/Tingling \[\text{Swelling} \] Pain \[\text{Weakness} \] Stiffness \[\text{Other (specify)} \] Ivpe/nature of injury: Check all that apply and identify specific affected body part(s). \] Abrasion \[\text{Infations Exposure} \] Amputation \[\text{Infations Exposure} \] Amputation \[\text{Laceration} \] Bite \[\text{Poisoning/Toxic Effects} \] Contusion/Hematoma \[\text{Poisoning/Toxic Effects} \] Cortush Injury \[\text{Pouncture Wound} \] Dermatitis \[\text{Repetitive Strain Injury} \] Pislocation \[\text{Spinal Cord Injury} \] Fracture \[\text{Spinal Cord Injury} \] Hernia \[\text{Vision Loss} \]																
Date(s) of Examination: Patient's subjective complaints: Check all that apply and identify specific affected body part(s). Numbness/Tingling	Did	anot	ner h	ealth p	orovide	er trea	at this	injury/	uliness includin	g nospitalizaton	and/or surgery?	' □ Yes □	No If	yes, g	ive details:	
Date(s) of Examination: Patient's subjective complaints: Check all that apply and identify specific affected body part(s). Numbness/Tingling																
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Pain Weakness Other (specify)	. Pat	ient's	subje	ective	compl	aints	Chec	k all th	hat apply and ic	lentify specific a	ffected body pa	t(s).				
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Abrasion											Other (specify)					
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atient's Name:	Date of injury/onset of illness://
4. Physical examination: Check all relevant objective	findings and identify specific affected body part(s).
☐ None at present	Neuromuscular Findings:
☐ Bruising	Abnormal/Restricted ROM
Burns	Active ROM
Crepitation	Passive ROM
Deformity	Gait
Edema	
Hematoma/Lump/Swelling	Palpable Muscle Spasm
Joint Effusion	
Laceration/Sutures	
Pain/Tenderness	
Scar	Wasting/Muscle Atrophy
Other findings:	
5. Describe any diagnostic test(s) rendered at this visit	t:
, ,	
Describe any treatment(s) rendered at this visit:	
	xisting condition(s) that may affect the treatment and/or prognosis?
If yes, list and describe:	
G. Doctor's Opinion	
•	escribed the competent medical cause of this injury/illness?
2. Are the patient's complaints consistent with his/her	history of the injury/illness?
3. Is the patient's history of the injury/illness consister	nt with your objective findings?
4. What is the percentage (0-100%) of temporary imp	pairment?%
5. Describe findings and relevant diagnostic test resu	lts:
I. Plan of Care	
1. What is your proposed treatment?	
-	
	advised:
• •	t patient's ability to return to work, make patient drowsy, or other issue. Explain below.
	. patiente domity to return to work, make patient drowsy, or other issue. Explain below.
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atient's Name:	Date of injury/onset of illness://
3. Does the patient need diagnostic tests or referrals? Yes	
CT Scan	Chiropractor
☐ EMG/NCS	☐ Internist/Family Physician
MRI (Specify):	Occupational Therapist
Labs (Specify):	Physical Therapist
X-rays (Specify):	Specialist in
Other (Specify):	Other (Specify):
4. Assistive devices prescribed for this patient: Cane Other (specify): Important: Form C-4 AUTH should be used to repre-authorization pursuant to the Med	Crutches Orthotics Walker Wheelchair equest any special medical service costing over \$1000 or for those services requidical Treatment Guidelines for the back, neck, knee and shoulder.
5. When is the patient's next follow-up appointment?	
_ · _ · _ · _ ·	6 weeks
I. Work Status	
	Yes No If yes, date patient first missed work: //
•	
2. Can the patient return to work? (check only one):	did the patient return to: usual work activities limited work activities
a. The patient cannot return to work because (expla	ain):
b. The patient can return to work without limitations	
Climbing stairs/ladders O Environmental conditions O Kneeling Po	Iffing Sitting perating heavy equipment Standing peration of motor vehicles Use of public transportation ersonal protective equipment Use of upper extremities
How long will these limitations apply?	☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/
3. With whom will you discuss the patient's return to work and/	/or limitations?
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	w who provided these services
	·
Provider's name	Specialty
Board Authorized Health Care Provider signature:	

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MEDICAL REPORTING

IMPORTANT-TO THE ATTENDING DOCTOR

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

48 HOUR INITIAL REPORT - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.

If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future reporting.

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

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

- 2. Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.
- 3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.
- 4. **AUTHORIZATION FOR SPECIAL SERVICES** Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY

- 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-I of the Workers' Compensation Law.
 - A CHIROPRACTOR OR PODIATRIST FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY LAWFULLY BE TREATED AS DEFINED IN THE EDUCATION LAW AND, WHERE IT DOES NOT, HAS ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS/HER CHOICE.
- 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 OFTHIS 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