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, 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.state.ny.us.

Date(s) of Examination:_____ WCB Case # (if known):_____ Carrier Case #:

A. Patient's Information

1. Name:_____ (Last / First / MI) 2. Date of injury/illness: _____ 3. Soc. Sec. #: ___-___-_____

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

5. Patient's Account #: _____

B. Doctor's Information

1. Your name: _____ (Last / First / MI) 2. WCB Authorization #: _____

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. 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:

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: %_____