# 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:

Enter ICD9 Code: ICD9 Descriptor:

(1) _____ _____

(2) _____ _____

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

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

☐ 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: %_____

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

Describe findings and relevant diagnostic test results: _____

_____

_____

Explain how impairment % was determined: _____

_____

_____

☐ Disfigurement: (Describe findings) _____

_____

_____

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

Body part: _____ Impairment: %_____

Describe findings and relevant diagnostic test results: _____

_____

_____

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:

| | | |
|---|---|---|
| ☐ 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: _____

_____

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