

# 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](http://www.wcb.ny.gov).

## A. Patient's Information

1. Name: \_\_\_\_\_
2. Social Security #: \_\_\_\_\_
3. Home phone #: (\_\_\_\_\_) \_\_\_\_\_
4. WCB Case # (if known): \_\_\_\_\_
5. Carrier Case #: \_\_\_\_\_
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: \_\_\_\_\_  
\_\_\_\_\_
12. Patient's Account #: \_\_\_\_\_

## B. Employer Information

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

## C. Doctor's Information

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

## D. 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: \_\_\_\_\_