

☐ OCCUPATIONAL THERAPIST'S REPORT
☐ PHYSICAL THERAPIST'S REPORT

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

SERVICES PROVIDED UNDER WCB PREFERRED
PROVIDER ORGANIZATION (PPO) PROGRAM?

YES ☐ NO ☐

<input type="checkbox"/> 48 HR. INITIAL	<input type="checkbox"/> 15 DAY INITIAL	<input type="checkbox"/> 90 DAY PROGRESS	SEE ITEM 1 ON REVERSE FOR FILING INSTRUCTIONS
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PLEASE TYPE ALL INFORMATION - COMPLETE ALL ITEMS

WCB CASE NO.	CARRIER CASE NO. (IF KNOWN)	DATE OF INJURY & TIME	ADDRESS WHERE INJURY OCCURRED (CITY, TOWN OR VILLAGE)	INJURED PERSON'S SOCIAL SECURITY NUMBER
INJURED PERSON	(First Name) (Middle Initial) (Last Name)	ADDRESS (Include Apt. No.)		TELEPHONE NO.
EMPLOYER*				PATIENT'S DATE OF BIRTH
INSURANCE CARRIER				
REFERRING PHYSICIAN/ PODIATRIST				TELEPHONE NO.

*If treatment was under the VFBL or VAWBL show as "Employer" the liable political subdivision and check one:

☐ VFBL ☐ VAWBL

If you have filed a previous report, setting forth a history of the injury, enter its date

and complete Items 3 to 16. If not, complete ALL items.

H I S T O R Y	1. Diagnosis of referring physician/podiatrist.																	
	2. If patient has given any history of pre-existing injury, disease or physical impairment, describe specifically.																	
E V A L U A T I O N / T R E A T M E N T	3. Referral was for: <input type="checkbox"/> Evaluation Only (Complete item a) <input type="checkbox"/> Treatment Only (Complete item b-1,2,3) <input type="checkbox"/> Evaluation and Treatment (Complete items a and b-1,2,3)																	
	a. Your evaluation:																	
	b. (1) Patient's condition and progress:																	
	b. (2) Treatment and planned future treatment. If an authorization request is required (see items 4 & 5 on reverse), check box <input type="checkbox"/> and explain below. If additional space is necessary, please attach request.																	
	b. (3) Was such treatment plan upon prescription or referral of claimant's attending physician or, in the case of physical therapy, authorized physician or podiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, frequency of treatment ordered: Period of treatment ordered:																	
B I L L I N G F O R M	4. Date(s) of visits on which this report is based		Date of First Visit		Will patient be seen again? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: If no, was patient referred back to attending doctor: <input type="checkbox"/> Yes <input type="checkbox"/> No													
	5. Is patient working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date(s) patient: resumed limited work of any kind resumed regular work																	
	6. Diagnosis or nature of disease or injury (Relate Items 1,2,3 or 4 to Item 7E by line.) Enter code and describe nature of injury.																	
	7.																	
	7.																	
S I G N A T U R E	8. Federal Tax I.D. Number		SSN		EIN		9. NYS License Number		10. Patient's Account Number		11. Total Charges		12. Amt. Paid (carrier use only)		13. Bal. Due (carrier use only)			
	Affirmed Under Penalty of Perjury						15. Therapist's Name, Address & Phone No.				16. Therapist's Billing Name, Address & Phone No.				THE INJURED WORKER SHOULD NOT PAY THIS BILL			
	14. Signature of Treating Therapist Date																	