Doctor's Report of MMI/Permanent Impairment 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.

5. Patient's Account #:	Pate(s) of Examination:	WCB Case # (if know	n): Ca	rrier Case #:		
4. Address (if changed from previous report): Number and Street	. Patient's Information					
Address (if changed from previous report): Number and Street	1. Name:	2. Date (of injury/illness:	3. Soc. Sec. #:		
Number and Street Doctor's Information 1. Your name:						
1. Your name:	Address (if changed from previous report	.):Number and Stree	et	City	State Zip Code	
1. Your name: Last First MI 2. WCB Authorization #: 4. Office address: Number and Street City State Zip Code 6. Office phone #: (5. Patient's Account #:			·	·	
3. WCB Rating Code: 4. Office address: Number and Street City State Zip Code 6. Office phone #: () 9. Federal Tax ID #: The Tax ID # is the (check one): SSN EIN EBIlling Information 1. Employer's insurance carrier; 2. Carrier Code #: W 3. Insurance carrier's address: A. Diagnosis or nature of disease or injury: Permanent Impairment/Work Status 1. Has the patient reached Maximum Medical Improvement? Yes No If yes, provide the date patient reached MMI:	. Doctor's Information					
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5. Billing address: Number and Street City State Zip Code						
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9. Federal Tax ID #: The Tax ID # is the (check one): SSNEIN 2. Carrier Code #: W		Number and Street	City	Stat	ie Zip Code	
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