☐ **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 ☐

☐ **48 HR. INITIAL** ☐ **15 DAY INITIAL** ☐ **90 DAY PROGRESS** *SEE ITEM 1 ON REVERSE FOR FILING INSTRUCTIONS*

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.

HISTORY

1. Diagnosis of referring physician/podiatrist.

2. If patient has given any history of pre-existing injury, disease or physical impairment, describe specifically.

EVALUATION/TREATMENT

3. Referral was for: ❑ Evaluation Only (Complete item a) ❑ Treatment Only (Complete item b-1,2,3) ❑ 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 ☐ 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? ❑ Yes ❑ No If yes, frequency of treatment ordered: Period of treatment ordered:

4. Date(s) of visits on which this report is based	Date of First Visit	Will patient be seen again? ❑ Yes ❑ No If yes, when: If no, was patient referred back to attending doctor: ❑ Yes ❑ No

5. Is patient working? ❑ Yes ❑ No If yes, date(s) patient: resumed limited work of any kind resumed regular work

BILLING FORM

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. A Dates of Service From MM DD YY To MM DD YY	B Place of Service	C Leave Blank	D (USE WCB CODES) Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E Diagnosis Code	F $ Charges	G Days or Units	H COB	I Zip Code Where Service was Rendered

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)

SIGNATURE

Affirmed Under Penalty of Perjury

14. Signature of Treating Therapist Date

15. Therapist's Name, Address & Phone No.

16. Therapist's Billing Name, Address & Phone No.

THE INJURED WORKER SHOULD NOT PAY THIS BILL