Doctor's Progress Report

C-4.2

State of New York - Workers' Compensation Board

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. 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.

Date(s) of Examination: _____

WCB Case Number (if known): _____ Carrier Case Number (if known): _____

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. 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 #: _____

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) _____ _____

(3) _____ _____

(4) _____ _____

Relate ICD9 codes in (1), (2), (3), or (4) 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. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

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

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:

☐ CT Scan ☐ EMG/NCS
☐ MRI (*specify*): _____
☐ Labs (*specify*): _____
☐ X-rays (*specify*): _____
☐ Other (*specify*): _____

Referrals:

☐ Chiropractor ☐ Internist/Family Physician
☐ Occupational Therapist
☐ Physical Therapist
☐ Specialist in: _____
☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: _____

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☐ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? _____%
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☐ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):

a. ☐ The patient cannot return to work because (explain): _____

b. ☐ The patient can return to work without limitations on: _____

c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____

☐ 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: _____

How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.
☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

_____ _____ _____ _____
Name Signature Specialty Date