

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.

A. Patient's Information	1					
1. Name:	First		MI	2. 9	Social Security #:	
3. Home phone #: ()		Case # (if known):				
6. Mailing address:						
7. Date of injury/onset of illness:				City	9. Gender: Male	Zip Code Female
10. On the date of injury/illness wha	it was the patient's j	ob title or description: _				
11. On the date of injury/illness wha	t were the patient's	usual work activities:				
12. Patient's Account #:		_				
B. Employer Informatio	n					
1. Employer when injury occurred:		Company/Agency Name			2. Phone #: ()_	
3. Employer Address:						
C. Doctor's Information		oreet		City	State	Zip Code
1. Your name:				2. W	CB Authorization #:	
3. WCB Rating Code:		First ral Tax ID #:	MI	The ⁻	Fax ID # is the (check one): SSN ===
5. Office address:). — 0011 — 2
J. Office address.	Number and Street			City	State	Zip Code
6. Billing group or practice name:_						
7. Billing address:		- <u>-</u> -				
8. Office phone #: ()				City 10 Trea	State ting Provider's NPI #:	'
				10. 1100	ang riovider 5 Nr 17.	
11. You are a (check one):	Tilysiciali P00	iatrist Uniropracto	or			
D. Billing Information						
Employer's insurance carrier:					2. Carrier Code #: W	
3. Insurance carrier's address:	Number a	and Street	_	City	State	Zip Code
4. Diagnosis or nature of disease of	or injury:					
Enter ICD9 Code:	ICD9 Descriptor:					
(1)	_					
(2)	_					
(3)	_					
(4)	_					

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE

WITH DISABILITIES WITHOUT DISCRIMINATION

				Last				First	M		ate of injury/on			
		Dates	of Servi	се		Place	Leave		WCB Codes Services or Supplies	I	I	Days/	000	Zip code where service was
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. Bas	sed o	n the	patien	t's hist	tory, v	where	and h	ow did the inj	ury/illness happer	n:				
_														
Hov	v did	you le	earn al	bout th	ne ini	ury/illn	iess (d	check one):	☐ Patient ☐ M	edical Records	Other(spe	cifv):		
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Did	anot	her he	eaith p	rovide	er trea	at this	injury/	illness includi	ng hospitalizaton	and/or surgery'	′ □ Yes □	INO II	yes, g	ive details.
. Did	anot	her he	eaith p	rovide	er trea	at this	injury/	illness includi	ng hospitalizaton	and/or surgery'	' □ Yes □	INO II	yes, y	TVO dotails.
 . Ha\	ve yo	u pre	viously	treate	ed thi									
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. Hav	ve yo	u prev	riously	treate	ed thi	s patie	ent for	a similar work	c-related injury/illr	ess? \[Yes [
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atient's Name:	Date of injury/onset of illness:/					
4. Physical examination: Check all relevant objective find	****					
None at present	Neuromuscular Findings:					
Bruising	Abnormal/Restricted ROM Active ROM					
Burns						
Crepitation	Passive ROM					
Deformity	Gait					
Edema	Palpable Muscle Spasm					
Hematoma/Lump/Swelling						
Joint Effusion	Competing					
Laceration/Sutures	Sensation					
Pain/Tenderness	Strength (Weakness)					
Scar	Wasting/Muscle Atrophy					
Other findings:						
5. Describe any diagnostic test(s) rendered at this visit:						
C Describe any transfer ant/a) randoned at this visit.						
b. Describe any treatment(s) rendered at this visit:						
If yes, list and describe: Doctor's Opinion						
Doctor's Opinion In your opinion, was the incident that the patient description.	ibed the competent medical cause of this injury/illness? Yes No					
2. Are the patient's complaints consistent with his/her his/						
3. Is the patient's history of the injury/illness consistent wi	ith your objective findings?					
4. What is the percentage (0-100%) of temporary impairn	nent?%					
5. Describe findings and relevant diagnostic test results:_						
I. Plan of Care						
What is your proposed treatment?						
2. Medication(s):(a) list medications prescribed:						
(b) list over-the-counter medications advi-	sed:					
Medication restrictions: None May affect pat	tient's ability to return to work, make patient drowsy, or other issue. Explain below:					
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3. Does the patient need diagnostic tests or referrals? Yes No	atient's Name:	Last	First	MI	— Date of injury/onset of illness://
Tests: Referrals: CT Scan					
EMGNCS Internistif-amily Physician MRI (Specify):	•	ed diagnostic test	s or referrals?	J ,	
MRI (Specify):	CT Scan			Ch	niropractor
Labs (Specify):	☐ EMG/NCS			Int	ternist/Family Physician
X-rays (Specify):	MRI (Specify)):		00	ccupational Therapist
Other (Specify):	Labs (Specify	/):		Ph	nysical Therapist
4. Assistive devices prescribed for this patient:	X-rays (Spec	ify):			pecialist in
Other (specify): Important: Form C-4 AUTH should be used to request any special medical service costing over \$1000 or for those services require pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder. 5. When is the patient's next follow-up appointment? Within a week 1-2 weeks 3-4 weeks 5-6 weeks 7-8 weeks months Return as needed 1. Work Status New Press New Pre	Other (Specif	ý):		Ot	ther (Specify):
pre-authorization pursuant to the Medical Treatment Guidelines for the back, neeck, knee and shoulder. Within a week 1-2 weeks 3-4 weeks 5-6 weeks 7-8 weeks	Other (specify	y):			
Within a week	mportan	pre-authorization	on pursuant to the Med	dical Treatment Guid	delines for the back, neck, knee and shoulder.
I. Work Status 1. Has the patient missed work because of the injurylillness?			<u> </u>		
1. Has the patient missed work because of the injury/filness?	Within a week	1-2 weeks	3-4 weeks	6 weeks	weeksmonths Return as needed
Is the patient currently working? Yes No If yes, did the patient return to: usual work activities limited work activities 2. Can the 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 / General Bending/twisting Lifting Sitting Sitting Sitting Sitting Sitting 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 Describe/quantify the limitations: Describe/quantify the limitations: With whom will you discuss the patient's return to work and/or limitations? with patient with patient's employer N/A 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 Signature Specialty Date Signature Signature Specialty Date Signature Specialty Date Signature Signature Specialty Date Signature Signature Specialty Date Signature Sign	I. Work Status				
2. Can the patient return to work? (check only one): a.	1. Has the patient mis	sed work because	of the injury/illness?	Yes No	If yes, date patient first missed work:/
2. Can the patient return to work? (check only one): a.	Is the patient currer	itly working?	Yes No If yes,	did the patient retur	rn to: usual work activities limited work activities
b.				•	
b.	a.	ent cannot return t	o work because (expla	ain):	
c.	b. The patie	ent can return to w	ork without limitations		
Bending/twisting Lifting Sitting 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: Describe/quantify the 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 return to work and/or limitations? with patient with patient's employer N/A 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 Specialty Specialty Specialty Specialty Date Specialty Date Signature Specialty Date Description Description Description Description Description Description Descripti					
Climbing stairs/ladders	<u> </u>			•	
Environmental conditions		•		•	
Describe/quantify the limitations: How long will these limitations apply?		•			
Describe/quantify the limitations: How long will these limitations apply?	Kne	eling		•	<u> </u>
Describe/quantify the limitations: How long will these limitations apply?	Othe	er (explain):			_
How long will these limitations apply?	Describe/gua				
3. With whom will you discuss the patient's return to work and/or limitations? with patient with patient's employer N/A 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:	2000/120/440	intiny the inflittations	o		
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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	How long will	these limitations a	apply?	☐ 3-7 days ☐	8-14 days
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	3. With whom will you	discuss the patier	nt's return to work and	/or limitations?	with patient
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	This form is signed	d under penalty	of perjury.		÷
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Board Authorized Health Care Provider signature: // / Name Signature Specialty Date	_ ,			·	
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	C-4 () (1-11) Page 4 o	f <u> </u>			www.web.nv

MEDICAL REPORTING

IMPORTANT-TO THE ATTENDING DOCTOR

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:

48 HOUR INITIAL REPORT - Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.

If you continue to treat, use form C-4.2 for future reporting. DO NOT use this form for future reporting.

All reports are to be filed with the Workers' Compensation Board, the workers' compensation insurance carrier, self-insured employer, and if the patient is represented by an attorney or licensed representative, with such representative. If the claimant is not represented, a copy must be sent to the claimant.

Ophthalmologists use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.

- 2. Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.
- 3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.
- 4. **AUTHORIZATION FOR SPECIAL SERVICES** 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.

AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY

- LIMITATION OF PODIATRY TREATMENT Podiatry treatment is limited as defined in Section 7001 of the Education Law and Section 13-k(2) of the Workers'
 Compensation Law.
- 6. **LIMITATION OF CHIROPRACTIC TREATMENT** Chiropractic treatment is limited as defined in Section 6551 of the Education Law and the Chair's Rules Relative to Chiropractic Practice Under Section 13-I of the Workers' Compensation Law.
 - A CHIROPRACTOR OR PODIATRIST FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY LAWFULLY BE TREATED AS DEFINED IN THE EDUCATION LAW AND, WHERE IT DOES NOT, HAS ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS/HER CHOICE.
- 7. HIPAA NOTICE In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

BILLING INFORMATION

Complete all billing information contained on this form. Use continuation Form C-4.1, if necessary. The workers' compensation carrier has 45 days to pay your bill or to file an objection to it. Contact the workers' compensation carrier if you receive neither payment nor an objection within this time period. After contacting the carrier, you may, if necessary, contact the Board's Disputed Bill Unit, at the Customer Service toll-free number listed below, for information/assistance.

IMPORTANT TO THE PATIENT

YOUR DOCTORS' BILLS (AND BILLS FOR HOSPITALS AND OTHER SERVICES OF A MEDICAL NATURE) WILL BE PAID BY YOUR EMPLOYER, THE LIABLE POLITICAL SUBDIVISION OR ITS INSURANCE COMPANY OR THE UNAFFILIATED VOLUNTEER AMBULANCE SERVICE IF YOUR CLAIM IS ALLOWED. DO NOT PAY THESE BILLS YOURSELF, UNLESS YOUR CASE IS DISALLOWED OR CLOSED FOR FAILURE TO PROSECUTE.

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OFTHIS NOTICE, OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO COMMUNICATE WITH THE BOARD OR THE CARRIER. ALSO, MENTION YOUR SOCIAL SECURITY NUMBER IF YOU WRITE OR CALL THE BOARD.

IMPORTANTE PARA EL PACIENTE

LAS FACTURAS POR SERVICIOS MEDICOS INCLUYENDO HOSPITALES Y TODO SERVICIO DE NATURALEZA MEDICA SERA PAGADO POR EL PATRONO O POR LA ENTIDAD RESPONSABLE O SU COMPANIA DE SEGUROS SEGUN SEA EL CASO; SI SU RECLAMACION ES APROBADA. NO PAGUE ESTAS FACTURAS A MENOS QUE SU CASO SEA DESESTIMADO EN SU FONDO O ARCHIVADO POR NO REALIZAR LOS TRAMITES CORRESPONDIENTES.

SI USTED TIENE ALGUNA PREGUNTA, EN RELACION A ESTA NOTIFICACION O A SU CASO O EN RELACION A SUS DERECHOS BAJO LA LEY DE COMPENSACION OBRERA O LA LEY DE BOMBEROS VOLUNTARIOS O LA LEY DE SERVICIOS DE AMBULANCIAS VOLUNTARIOS DEBE COMUNICARSE CON LA OFICINA MAS CERCANA DE LA JUNTA PARA ORIENTACION. SIEMPRE USE EL NUMERO DEL CASO QUE APARECE EN LA PARTE DEL FRENTE DE ESTA NOTIFICACION, O EN OTROS DOCUMENTOS RECIBIDOS POR USTED. SI LE ES NECESARIO COMUNICARSE CON LA JUNTA O CON EL "CARRIER."

TAMBIEN MENCIONE EN SU COMUNICACION ORAL O ESCRITA SU NUMERO DE SEGURO SOCIAL.

Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

Customer Service Toll-Free Line: 877-632-4996 Statewide Fax Line: 877-533-0337