WORKERS' COMPENSATION BOARD
New York State

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. Name: _____ (Last / First / MI) 2. Social Security #: ___ - ___ - ____

3. Home phone #: (____)_____ 4. WCB Case # (if known):_____ 5. Carrier Case #: _____

6. Mailing address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

7. Date of injury/onset of illness: ____/____/____ 8. Date of Birth: ____/____/____ 9. Gender: ☐ Male ☐ Female

10. On the date of injury/illness what was the patient's job title or description: _____

11. On the date of injury/illness what were the patient's usual work activities:_____

_____

12. Patient's Account #:_____

B. Employer Information

1. Employer when injury occurred: _____ (Company/Agency Name) 2. Phone #: (____)_____

3. Employer Address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

C. 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 #:_____

11. You are a (*check one*): ☐ Physician ☐ Podiatrist ☐ Chiropractor

D. 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 on page 2 by line.

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

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)
$	$	$

E. History

1. Based on the patient's history, where and how did the injury/illness happen: _____

2. How did you learn about the injury/illness (*check one*): ☐ Patient ☐ Medical Records ☐ Other(*specify*): _____

3. Did another health provider treat this injury/illness including hospitalizaton and/or surgery? ☐ Yes ☐ No If yes, give details:

4. Have you previously treated this patient for a similar work-related injury/illness? ☐ Yes ☐ No If yes, when: _____

F. Exam Information

1. Date(s) of Examination: _____

2. Patient's subjective complaints: *Check all that apply and identify specific affected body part(s).*

☐ Numbness/Tingling _____ ☐ Swelling _____
☐ Pain _____ ☐ Weakness _____
☐ Stiffness _____ ☐ Other (*specify*) _____

3. Type/nature of injury: *Check all that apply and identify specific affected body part(s).*

☐ Abrasion _____ ☐ Infectious Disease _____
☐ Amputation _____ ☐ Inhalation Exposure _____
☐ Avulsion _____ ☐ Laceration _____
☐ Bite _____ ☐ Needle Stick _____
☐ Burn _____ ☐ Poisoning/Toxic Effects _____
☐ Contusion/Hematoma _____ ☐ Psychological _____
☐ Crush Injury _____ ☐ Puncture Wound _____
☐ Dermatitis _____ ☐ Repetitive Strain Injury _____
☐ Dislocation _____ ☐ Spinal Cord Injury _____
☐ Fracture _____ ☐ Sprain/Strain _____
☐ Hearing Loss _____ ☐ Torn Ligament,Tendon or Muscle _____
☐ Hernia _____ ☐ Vision Loss _____
☐ Other (*specify*) _____

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

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- ☐ None at present
- ☐ Bruising _____
- ☐ Burns _____
- ☐ Crepitation _____
- ☐ Deformity _____
- ☐ Edema _____
- ☐ Hematoma/Lump/Swelling _____
- ☐ Joint Effusion _____
- ☐ Laceration/Sutures _____
- ☐ Pain/Tenderness _____
- ☐ Scar _____
- ☐ Other findings: _____

- ☐ Neuromuscular Findings:
  - ☐ Abnormal/Restricted ROM
    - ☐ Active ROM _____
    - ☐ Passive ROM _____
  - ☐ Gait _____
  - ☐ Palpable Muscle Spasm _____
  - ☐ Reflexes _____
  - ☐ Sensation _____
  - ☐ Strength (Weakness) _____
  - ☐ Wasting/Muscle Atrophy _____

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

6. Describe any treatment(s) rendered at this visit: _____

7. Describe prognosis for recovery: _____

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ☐ Yes ☐ No
If yes, list and describe: _____

G. Doctor's Opinion

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: _____

H. Plan of Care

1. What is your proposed treatment? _____

2. Medication(s):(a) list medications prescribed: _____
(b) list over-the-counter medications advised: _____

Medication restrictions: ☐ None ☐ May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

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

3. 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): _____

4. Assistive devices prescribed for this patient: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair

☐ Other (specify): _____

Important: *Form C-4 AUTH should be used to request any special medical service costing over $1000* or for those services requiring 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

I. Work Status

1. Has the patient missed work because of the injury/illness? ☐ Yes ☐ No If yes, date patient first missed work: ____/____/____

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 _____/_____/_____

- ☐ Bending/twisting
- ☐ Climbing stairs/ladders
- ☐ Environmental conditions
- ☐ Kneeling
- ☐ Lifting
- ☐ Operating heavy equipment
- ☐ Operation of motor vehicles
- ☐ Personal protective equipment
- ☐ Sitting
- ☐ Standing
- ☐ Use of public transportation
- ☐ 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 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:

_____ _____ _____ ____/____/____
Name Signature Specialty Date

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

5. **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-l 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**