WORKERS' COMPENSATION BOARD

Doctor's Progress Report

State of New York - Workers' Compensation Board

C-4.2

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

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:

   PROGRESS REPORTS - Following the filing of Form C-4, Doctor's Initial Report, file this form within 15 days after initial report and thereafter during continuing treatment without further request, when a follow-up visit is necessary, except the intervals between reports shall be no more than 90 days.

   When reporting on MMI and/or Permanent Impairment, use Form C-4.3.

   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(s) costing over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee or 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 Albany address indicated 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.

WORKERS' COMPENSATION BOARD

Reports should be filed by sending directly to the Workers' Compensation Board at the address below with a copy sent to the insurance carrier:

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

Statewide Fax Line: 877-533-0337

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION