AmTrust North America
An AmTrust Financial Company

New York
Worker’s Compensation
Claim Kit

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An AmTrust Financial Company

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Dear Policyholder,

We are distributing this bulletin to remind all policyholders of the critical importance of reporting any potential New York workers' compensation claims under your workers' compensation policy as soon as possible after any incident giving rise to such a claim.

The New York State Workers' Compensation Board (Board) is strictly enforcing timely reporting and assessing statutory penalties for non-compliance.

If one of your employees has a work-related injury or illness, you must complete and file a C-2F with us as soon after the incident as you can so we can report to the Board within 10 days of the injury/illness or be subject to a penalty. The Board now has procedures in place to track timely reporting and has the authority to issue a $1,000 fine and/or a $2,500 penalty directly to the policyholder if claims are not reported in a timely manner.

In addition, if your employee initially loses no time from work, but later goes out, you MUST notify us immediately.

Both your workers' compensation policy and New York State law require that claims under your policy be reported in a timely manner. The best procedure is to report all incidents to us within 24 hours of occurrence.

When reporting the claim, be sure to include the actual return to work date or if employee hasn't returned to work, be sure to specifically state this.

Please immediately report all claims and potential claims under your policy to AmTrust utilizing one of the following reporting mechanisms:

Fax: 877.669.9140 or 775.908.3724
Email: amtrustclaims@qrm-inc.com
Phone: 866.272.9267
Website: www.amtrustnorthamerica.com (instructions below)

Thank you for your attention to this matter.

Sincerely,

AmTrust North America
Claims Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 888.239.3909 • www.amtrustnorthamerica.com

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EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

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Helpful Hints:

"**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time

Enter the hours in the first box and the minutes in the second box

All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX

For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box

If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North America
Claims Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

WORKERS' COMPENSATION BOARD New York State

State of New York - Workers' Compensation Board

Employer's First Report of Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name ______

WCB Case Number (JCN) ______ **Date of Injury** ______

Claim Administrator Claim Number ______

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name ______ **Insurer ID** ______

Name ______

Info/Attn ______

Address P.O. BOX 6935

City CLEVELAND **State** OH

Postal Code 44101 **Country** USA

Claim Admin ID ______

EMPLOYEE INFORMATION

First Name ______ **Middle Name/Initial** ______

Last Name ______ **Suffix** ______

Mailing Address ______

City ______ **State** ______

Postal Code ______ **Country** ______

Phone Number ______ **Date of Hire** ______

Date of Birth ______ **Gender** ☐ Male ☐ Female ☐ Unknown

Employee SSN ______

Occupation Description ______

CLAIM INFORMATION

Time of Injury ______________________ **Date Employer Had Knowledge of the Injury** ____________

Employment Status ______________________ **Date Employer Had Knowledge of Date of Disability** ____________

Estimated Weekly Wage ______________________ **Number of Days Worked Per Week** ____________

Work Week Type ☐ Standard Work Week ☐ Fixed Work Week ☐ Varied Work Week

Work Days Scheduled ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury ☐ Yes ☐ No **Employer Paid Salary in Lieu of Compensation** ☐ Yes ☐ No

Initial Treatment ☐ No Medical Treatment ☐ Minor On-Site Treatment By Employer ☐ Minor Clinic/Hospital Treatment ☐ Emergency Evaluation ☐ Hospitalization Greater Than 24 Hours ☐ Future Major Medical/Lost Time Anticipated

Death Result of Injury ☐ Yes ☐ No ☐ Unknown **Date of Death** ____________ **Number of Dependents** ______

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) ______________________

Part of Body (i.e. left arm, right foot, head, multiple, etc) ______________________

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) ______________________

Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked ____________ **Return To Work Type** ☐ Actual ☐ Released

Initial Date Disability Began ____________ **Physical Restrictions** ☐ Yes ☐ No

Initial Return to Work Date ____________ **Return To Work Same Employer** ☐ Yes ☐ No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) ☐ Employer ☐ Lessee ☐ Other

Organization Name ______________________

Street ______________________ **State** ____________

City ______________________ **Postal Code** ____________

County ______________________ **Country** ____________

Location Narrative ______________________

Witnesses **Business Phone Number**

EMPLOYER INFORMATION

Name ______ Employer FEIN ______

UI Number ______ Manual Classification Code ______

Industry Code ______

Info/Attn ______

Mailing Address ______

City ______ State ______

Postal Code ______ Country ______

Physical Addr ______

City ______ State ______

Postal Code ______ Country ______

Contact Name ______

Contact Business Phone Number ______

INSURED INFORMATION

Insured Name ______ Insured FEIN ______

Insured Type ☐ Insured ☐ Self-Insured ☐ Uninsured Insured Location ID ______

Policy Number ID ______

Policy Effective Date ______ Policy Expiration Date ______

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form ______ Date ______

Print Name ______

Title ______ Phone Number ______

State of New York – Workers' Compensation Board

Instructions for Completing Form C-2F
"Employer's First Report of Work-Related Injury/Illness"

Enter the name of the injured employee at the top of the report. Fill out the Date of Injury/Illness, to the best of your knowledge. If you do not have or know the Workers' Compensation Board Case Number or Claim Administrator Claim Number, please leave the corresponding field blank. It is not required to process the form.

Insurer / Claim Administrator Information:

- **Insurer Name** – the name of your Workers' Compensation Insurer or Self-Insured Group name.
- **Insurer ID** – Carrier Code Number (**W** Number) issued by the Workers' Compensation Board. If you do not know the **W** number, contact your insurer.
- **Name** – the name of the Claim Administrator (claim adjusting office handling the claim).
- **Info/Attn** –any additional pertinent contact information for the Claim Administrator.
- **Address, City, State, Postal Code, & Country** – address of claims administrator, if known.
- **Claim Admin ID** – Carrier Code Number (**W** Number) or Third Party Administrator Number (**T** Number) issued by the Workers' Compensation Board. If you do not know the Third Party Administrator Number (**T** Number), contact your Claim Administrator.

Employee Information:

- **First Name, Middle Initial, Last Name, Suffix** – the injured employee's full legal name.
- **Mailing Address, City, State, Postal Code, & Country** – the full address of the injured employee.
- **Phone Number** – the employee's phone number including area code.
- **Date of Hire** - the date the employee was hired.
- **Date of Birth** – the employee's date of birth.
- **Gender** – check the appropriate gender.
- **Employee SSN** – the employee's Social Security Number (SSN).
- **Occupation Description** – identify employee's primary occupation at the time of accident

Claim Information:

- **Time of Injury** – the time when the injury/illness occurred.
- **Date Employer Had Knowledge of the Injury** – the date the employer had knowledge of the injury/illness.
- **Employment Status** – the applicable employment status for the employee (i.e. full time, part time, seasonal, volunteer, etc.).
- **Date Employer Had Knowledge of Date of Disability** – the date the employer was notified or became aware of employee's work related disability/incapacity.
- **Estimated Weekly Wage** – enter the employee's average weekly gross pay before the injury/illness.
- **Number of Days Worked Per Week** – enter the number of regularly scheduled workdays per week (1-7).
- **Work Week Type** - Check which type of work week the claimant was working at the time of injury. Standard (5 Days, scheduled Monday through Friday), Fixed (Set days of the week worked but not scheduled 5 Days, Monday through Friday), or Varied (Employee had no specific set work week schedule).
- **Work Days Scheduled** - Check which days of the week correspond with the claimant's work schedule at the time of the injury. If Work Week Type of "Varied Work Week" is selected, this field may be left blank.

Employee Injury:

- **Full Wages Paid for Date of Injury** – check *Yes* or *No*.
- **Employer Paid Salary in Lieu of Compensation** – check *Yes* or *No* to indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.
- **Initial Treatment** – check the initial treatment type.
- **Death Result of Injury** – check *Yes*, *No* or *Unknown* to indicate if the injury/illness resulted in death.
- **Date of Death** – indicate the date of death, if applicable.
- **Number of Dependents** – the number of dependents, *if known (for death cases only).*
- **Natures of Injury -** indicate the type of injury (i.e. Laceration, Burns, Fracture, Strain, etc.).
- **Part of Body** – indicate the part of body that was injured (i.e. left arm, right foot, head, multiple, etc.).
- **Causes of Injury -** indicate what caused the injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.).
- **Accident/Injury Description** – describe how the accident occurred and the resulting injuries.

Work Status:

- **Initial Date Last Day Worked** – the last day worked prior to lost time.
- **Return to Work Type** – check *Actual* for employee actually returned to work, or check *Released* for employee was released to work but did not do so.
- **Initial Date Disability Began** – first day of disability (lost time) after the 7 day waiting period requirement has been met. If the employee was a Volunteer Ambulance Worker or Volunteer Firefighter there is no 7 day waiting period.
- **Physical Restrictions** – check *Yes* if the employee has returned to work with restrictions; check *No* if the employee has returned to work without restrictions.
- **Initial Return to Work Date** – if the employee has returned to work, indicate the initial return to work date.
- **Return to Work Same Employer** – check *Yes* or *No*.

Accident Location and Witnesses:

- **Premises** – check appropriate location where injury occurred. *Employer*-accident occurred on employer's premises; *Lessee*-accident occurred on the premises of the lessee for which the employee was hired to work; or *Other*-accident occurred at a location other than the employer for which the employee was hired to work. Check *Employer*, if employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department and was injured while working for his/her own service/department. Check *Other,* if the employee was injured working in an official capacity for a Volunteer Ambulance Service or Volunteer Fire Department other than the one he/she was a member of.
- **Organization Name** – the name of the organization where the injury/illness occurred.
- **Street, City, State, Postal Code, County, & Country** – the address where the injury/illness occurred.
- **Location Narrative** – provide any additional description of the location (i.e. Building C, 4th Floor in Room 101).
- **Witnesses & Business Phone Number** – indicate the names and business phone numbers of any witnesses to the injury/illness.

Employer Information:

- **Name** – the name of the company or the owner's name and DBA name. If the employee was member of a Volunteer Ambulance Service or Volunteer Fire Department, the name of the Political subdivision should be entered.
- **Employer FEIN** – your Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the employer was a Volunteer Ambulance Service or Volunteer Fire Department, the FEIN of the Political subdivision should be entered.
- **UI Number** – enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.
- **Manual Classification Code** – the New York Compensation Insurance Rating Board (NYCIRB) manual classification code, if known. This can be found on your workers' compensation insurance policy.
- **Industry Code** – the North American Industry Classification System (NAICS). If you do not know your NAICS, please describe the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
- **Info/Attn** – indicate any additional pertinent contact information for the employer.
- **Mailing Address, City, State, Postal Code, & Country** – the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
- **Physical Address, City, State, Postal Code, & Country** – the physical address of the employer (if different).
- **Supervisor Name** & **Supervisor Business Phone Number** – indicate the name and phone number for the employee's direct supervisor, including area code.

Insured Information:

- **Insured Name** – the name of the insured entity. If the employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department, the name of the ambulance service or fire department should be entered.
- **Insured FEIN** – the Insured's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the insured is a Volunteer Ambulance Service or Volunteer Fire Department the FEIN of the ambulance service or fire department should be entered.
- **Insured Location ID** – indicate the Insured Location ID, if any (i.e. Store 202, Jobsite 51, etc.).
- **Insured Type** – check the insurance arrangement: *Insured*, *Self-Insured*, or *Uninsured*.
- **Policy Number ID** – your Workers' Compensation Insurance Policy Number.
- **Policy Effective** & **Expiration Date** – the policy effective and expiration dates.

Workers' Compensation Board

PO Box 5205, Binghamton, NY 13902-5205

www.wcb.ny.gov

State of New York - Workers' Compensation Board

REPORT OF WORK-RELATED INJURY OR OCCUPATIONAL DISEASE

This form is to be filed with the Workers' Compensation Board within 10 days of a work-related injury or illness. A copy of this report should be provided to your insurance carrier. No hearing will be scheduled at the Board in response to this report of injury.

EMPLOYER'S NAME AND MAILING ADDRESS	INSURANCE CARRIER'S NAME AND MAILING ADDRESS

FILING ENTITY: ☐ Employer ☐ Carrier ☐ Other (If "Other", give name and address.)	CARRIER ID NUMBER W-	CARRIER CASE NUMBER
	WC POLICY NUMBER	EFFECTIVE DATE OF POLICY

INJURED EMPLOYEE (First Name, Middle Initial, Last Name)	EMPLOYEE'S ADDRESS (Street No. & Name, Apt No., City, State & Zip Code)
UNION NAME & LOCAL NUMBER	

EMPLOYEE'S SOCIAL SECURITY NUMBER	DATE OF BIRTH	TELEPHONE NUMBER	GENDER ☐ M ☐ F ☐ X

SPECIFIC DETAILS AS TO OCCURRENCE OF INJURY AND PART(S) OF BODY AFFECTED

ADDRESS WHERE INJURY OCCURRED	DATE OF INJURY	TIME OF INJURY
	DATE SUPERVISOR FIRST KNEW OF INJURY	

WAS MEDICAL CARE PROVIDED? ☐ YES ☐ NO IF YES, BY WHOM?

DATE(S) MEDICAL CARE PROVIDED: ______________________________

IS THIS A DEATH CASE? ☐ YES ☐ NO

HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, DATE OF RETURN: ________/________/________

Prepared by	Official Title
Date of this Report	Telephone Number & Extension

ADR-1 ADR-1 ADR-1 ADR-1 ADR-1

Prescribed by Chair
Workers' Compensation Board
State of New York

SEE FILING INSTRUCTIONS ON REVERSE

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

FILING INSTRUCTIONS

Please note that the ADR-1 Report of Injury form must be submitted to the Workers' Compensation Board within 10 days of a work related injury or illness, as required by 12 NYCRR § 314.2(d)(5).

The ADR-2 Final Disposition of Claim form must be filed with the Workers' Compensation Board's local district office within 30 days of the final resolution of a claim through settlement, mediation,or arbitration, as required by 12 NYCRR § 314.7(a).

Failure to file the prescribed ADR forms with the Workers' Compensation Board in a timely manner may result in revocation of the parties' authorization to participate in the Alternative Dispute Resolution Pilot Program.

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Locating a Workers' Compensation Medical Provider (Doctor) for Treatment

Pursuant to the Workers' Compensation Law "An injured employee may, when care is required, select to treat him or her any physician authorized by the chair to render medical care." There are many avenues available to locate such a physician, including the NYS Workers' Compensation Board Website

https://www.wcb.ny.gov/HealthCareProviderSearch/?submitHome=Search+for+Health+Care+Provider+or+IME

AmTrust maintains a list of doctors that it has a contractual relationship with and you are not required to use these health care providers. However, that list may be found at **https://www.talispoint.com/amtrust/external/**

Please review the two Sections of the New York State Workers' Compensation Law listed below to understand your rights as an Injured Worker.

13-a (1) An injured employee may, when care is required, select to treat him or her any physician authorized by the chair to render medical care, as hereafter provided. If for any reason during the period when medical treatment and care is required, the employee wishes to transfer his or her treatment and care to another authorized physician, he or she may do so, in accordance with rules prescribed by the chair. In such instance the remuneration of the physician whose services are being dispensed with shall be limited to the value of treatment rendered at fees as established in the schedule for his or her location, unless payment in higher amounts has been approved as authorized in section thirteen, paragraph a. If a claimant shall receive treatment in any hospital or other institution operated in whole or in part by the state of New York, the employer shall be liable for food, clothing and maintenance furnished by the hospital or other institution to such employee. If the employee is unable due to the nature of the injury to select such authorized physician and the emergency nature of the injury requires immediate medical treatment and care, or if he or she does not desire to select a physician, and in writing so advises the employer, the employer shall promptly provide him or her with the necessary medical care, provided however, that nothing herein contained shall operate to prevent such employee, when subsequently able to do so, from selecting for continuance of any medical treatment or care required, any physician authorized by the chair to render medical care as hereinafter provided.

In addition, pursuant to Section 13-a(6)

(6) (a) Any interference by any person with the selection by an injured employee of an authorized physician to treat him, except when the selection is made pursuant to article

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ten-A of this chapter, and the improper influencing or attempt by any person improperly to influence the medical opinion of any physician who has treated or examined an injured employee, shall be a misdemeanor; provided, however, that it shall not constitute interference or improper influence if, in the presence of such injured employee's physician, an employer, his carrier or agent should recommend or provide information concerning rehabilitation services or the availability thereof to an injured employee or his family.

(b) Except as otherwise permitted by law, an employer, carrier, or third-party administrator shall not interfere or attempt to interfere with the selection by an injured employee of, or treatment by, an authorized medical provider, including by directing or attempting to direct that the injured employee seek treatment from a specific provider or type of provider selected by the employer, carrier, or third-party administrator. It shall not constitute improper interference under this paragraph if the direction or attempt to direct the injured employee to receive treatment from a specific provider or type of provider originates from the authorized medical provider while in the course of providing treatment to the injured employee.

P.O. Box 6935 • Cleveland, OH 44101-19354
(p) 631.465.1400 • (p) 866.203.3037 • (f) 518.213.1908 • (f) 800.487.9654 • www.amtrustnorthamerica.com

Optum

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Workers' Compensation Notification Pharmacy Benefit Network

Your employer and your workers' compensation claims administrator have selected Optum as their workers' compensation pharmacy benefit manager (PBM) to provide medications for your work- related injury through their pharmacy network, Tmesys®.

This means that your work-related injury medications (and other services) should only be obtained from designated companies or providers.

If you have any questions about how to obtain prescribed medications, call 1-866-599-5426.

LOCATING A PLAN PHARMACY

Nearly 5,000 Locations in New York

1. Go to the Tmesys website at **optum.co/AMTR-pharmacy-locator**
2. Select the search method you prefer

Call **1-866-599-5426** to speak to a customer care specialist

This requirement applies unless:

- You have a medical emergency and it is not reasonably possible to purchase medications you need for that emergency.
- Ordering by mail or telephone is not an option in the network, no pharmacy in the network will deliver to you, and none of these pharmacies is within fifteen miles if you live in a rural area, or five miles if not. If you believe this is the case for you, please call one of the numbers on the bottom of this page or log onto our website at **optum.co/AMTR-pharmacy-locator** to find the nearest pharmacy.

How to obtain medicines

1. Your employer will provide you information and notification on the network and how to obtain medications upon implementation or when you were hired.
2. Upon receiving a notice of first injury, your employer will provide you with additional notification of requirements as well as a First Fill card.
3. Give the card to the pharmacist at a participating network pharmacy with your prescription.
4. The pharmacist will fill your prescription. You should not receive a bill for these medications.
5. A permanent workers' compensation pharmacy card will be mailed to you.
6. Use the permanent card each time you have a prescription filled for your work-related injury.

We look forward to serving you. If you have any questions about how to obtain prescribed medications, call 1-866-599-5426 or visit our Pharmacy Center on optum.co/AMTR-pharmacy-locator.

IMP-23-1833

PO Box 152539
Tampa, FL 33684-2539

Making it easy to get workers' compensation prescriptions filled

Optum has been chosen to manage your workers' compensation pharmacy benefits under New York regulations for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury prescriptions.

Find a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call **1-866-599-5426** or visit **optum.co/AMTR-pharmacy-locator**.

Representatives are available to answer any questions you have about your pharmacy benefits. You may also contact the New York State Workers' Compensation Board at **general_information@wcb.ny.gov** or by phone at **1-877-632-4996** or the Advocate for Injured Workers at **1-800-580-6665**. You may also find further information on the web at **wcb.ny.gov**.

Questions? Need Help?

1-866-599-5426

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust
CARRIER/TPA | EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER | DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: **tmesys.com**.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	**004261**	or	**002538**
RxPCN	**CAL**	or	**Envoy Acct. #**
GROUP	AMTRFF		

NOTE: This First Fill card is only valid for your workers' compensation injury.

The following entities comprise the Optum Workers' Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers' Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers' Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers' Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers' Compensation Medical Services, collectively and individually referred as "Optum."

IMP-23-1728

Optum

AmTrust North America
An AmTrust Financial Company

Hacemos más sencillo que se le abastezca las recetas de su programa de compensación por accidentes laborales

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:

Si necesita que se le abastezca su receta médica para una lesión relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones relacionadas con su trabajo.

Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al **1-866-599-5426** o visite **optum.co/AMTR-pharmacy-locator**.

Nuestros representantes están disponibles para responder cualquier pregunta que tenga sobre sus beneficios farmacéuticos. También puede comunicarse con el directorio del Programa de compensación por accidentes laborales de Nueva York a través de **general_information@wcb.ny.gov** o llamando al **1-877-632-4996** o con el Defensor de los trabajadores accidentados llamando al **1-800-580-6665**. También puede encontrar más información en la web visitando **wcb.ny.gov**.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.

Optum

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust

PORTADORA EMPLEADOR

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite **tmesys.com**.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	**004261**	or	**002538**
RxPCN	**CAL**	or	**Envoy Acct. #**
GROUP	AMTRFF		

NOTA: Esta tarjeta First Fill solo es válida para una lesión cubierta por su programa de compensación por accidentes laborales.

The following entities comprise the Optum Workers' Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers' Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers' Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers' Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers' Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP-23-1728

Optum

AmTrust North America
An AmTrust Financial Company

Notificación del programa de compensación por accidentes laborales sobre la red de beneficios de farmacia

Su empleador y su administrador de reclamaciones de compensación por accidentes laborales han seleccionado a Optum como su gerente de beneficios de farmacia (PBM, por sus siglas en inglés) de su programa de compensación por accidentes laborales, a fin de brindarle medicamentos para la lesión relacionada con su trabajo a través de su red de farmacias, Tmesys®.

Esto significa que sus medicamentos para lesiones relacionadas con el trabajo (y otros servicios) solo deben obtenerse de compañías o proveedores designados.

Si tiene alguna pregunta sobre cómo obtener medicamentos recetados, llame al 1-866-599-5426.

CÓMO UBICAR UNA FARMACIA DEL PLAN

Cerca de 5,000 ubicaciones en Nueva York

1. Visite el sitio web de Tmesys en optum.co/AMTR-pharmacy-locator
2. Seleccione su método de búsqueda preferido.

Llame al **1-866-599-5426** para hablar con un especialista en atención al cliente.

Este requisito se aplica a menos que:

- Tenga una emergencia médica y no sea razonablemente posible comprar los medicamentos que necesita para dicha emergencia.
- Hacer un pedido por correo o por teléfono no es una opción dentro de la red, ninguna farmacia de la red le enviará un pedido, y ninguna de estas farmacias se encuentra a menos de 15 millas de distancia si usted vive en un área rural o a menos de cinco millas si no vive en un área rural. Si considera que este es su caso, llame a uno de los números que aparecen en la parte inferior de esta página o inicie sesión en nuestro sitio web en optum.co/AMTR-pharmacy-locator para encontrar la farmacia más cercana.

Cómo obtener medicamentos

1. Su empleador le proporcionará información y notificación de la red y cómo obtener medicamentos durante la implementación o al momento de su contratación.
2. Al momento de recibir un aviso sobre una primera lesión, su empleador le brindará una notificación adicional de los requisitos así como una tarjeta First Fill.
3. Muéstrele la tarjeta al farmacéutico en una farmacia participante de la red junto con la receta.
4. El farmacéutico abastecerá su receta médica. No se le facturará por estos medicamentos.
5. Se le enviará una tarjeta permanente de farmacia del programa de compensación por accidentes laborales por correo.
6. Use la tarjeta permanente cada vez que se le abastezca una receta médica para una lesión relacionada con su trabajo.

Esperamos poder atenderlo. Si tiene alguna pregunta sobre cómo obtener medicamentos recetados, llame al 1-866-599-5426 o visite nuestro Centro de Farmacias en optum.co/AMTR-pharmacy-locator.

IMP-23-1907

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper.*

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception: *I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

Workers' Compensation Board

You were injured at work. What now?

If you have suffered a workplace injury or illness, you may be eligible for workers' compensation benefits. You may have already received medical treatment. If you haven't, you should seek medical care as soon as possible.

For assistance with your claim, call the **Workers' Compensation Board (Board)** at **(877) 632-4996**.

YOUR RESPONSIBILITIES

- Notify your employer, in writing, detailing when, where and how you were injured or became ill. Do this as soon as possible within 30 days of injury or illness. Do not text it; instead send a letter, email or other document that can be saved or printed.
- Advise your health care providers that you have a work-related injury or illness and give the name of your employer's workers' compensation insurer. If you do not know the name of your employer's insurer, either ask your employer or contact the Board immediately. Your health care provider will file medical reports with the Board and with your employer or its insurer. A medical report needs to be filed with the Board for you to access your benefits.
- File an ***Employee Claim (Form C-3)*** reporting your injury or illness to the Board as soon as possible. You must notify the Board of your injury or illness within two years. If you injured the same body part before, or had a similar illness, you must also file a ***Limited Release of Health Information (Form C-3.3)***.
  Citizenship and immigration status are not factors in workers' compensation.

How to file a claim
Quickest method: Visit wcb.ny.gov and select "File a Claim."
For questions about filing a *Form C-3*, or to receive a copy of the form, please call (877) 632-4996. A Board representative will help you.

MEDICAL AND TRAVEL EXPENSES

Medical care to treat your work-related injury or illness is a workers' compensation benefit that is provided at no cost to you. Medical bills for your injury or illness are paid directly by your employer's workers' compensation insurer to your health care provider. If your case is disputed by the insurer, the health care providers will be paid if the Board decides your case in your favor. However, if the Board decides against you, or if you don't pursue a case, you will have to pay the health care provider or hospital (or submit the bill(s) to your own health insurer).

Your employer's workers' compensation insurance covers medically necessary drugs and equipment your health care provider prescribes. You may also be reimbursed for mileage, public transportation or other necessary expenses incurred when traveling for treatment. Submit those expenses (including receipts if you have any) to your employer's workers' compensation insurer and to the Board on a ***Claimant's Record of Medical and Travel Expenses and Request for Reimbursement (Form C-257)***.

Generally, you can choose any health care provider authorized by the Board. You can search for an authorized health care provider in your area using the "Health Care Provider Search" feature at **wcb.ny.gov**. You can also use occupational health clinics. However, if your employer's workers' compensation insurer has a Preferred Provider Organization (PPO) to provide care for workers' compensation injuries, you must get your first treatment from the PPO network. If that insurer also has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them. However, in an emergency, you can see any provider.

BENEFITS FOR LOST WAGES

You are entitled to a portion of your lost wages, which must be paid promptly, if your injury or illness affects you in one or more of the following ways:

1. It keeps you from work for more than seven calendar days;
2. Part of your body is determined to be permanently disabled; and/or
3. Your pay is reduced because you now work fewer hours or do other work.

After you have healed from your injury or illness and when no further medical improvement is expected (typically one year after the date of accident/illness or surgery, if surgery was performed), you can ask your doctor to evaluate whether your accident/illness has resulted in a permanent injury/condition. To learn more about this benefit, please visit **wcb.ny.gov**, click on the “Workers” section, then select “Disability Classifications.”

You may hire an attorney or licensed representative for help with your claim, but it isn’t required. You or your family should not directly pay your attorney or licensed representative. Their fees are approved by the Board and deducted from your lost wage award.

If your case is disputed, you may receive disability benefits while the case is pending review by the Board. To get a ***Notice and Proof of Claim for Disability Benefits (Form DB-450)***, visit **wcb.ny.gov**; call the Board for assistance; or visit a Board office. If the case is resolved in your favor, the disability benefits will be deducted from your lost wages award.

WHAT’S NEXT?

The workers’ compensation insurer will contact you. If your claim is accepted, your health care providers will be paid, and lost wage benefits begin. If your case needs a hearing, the Board will contact you. There are online resources available to make the hearing process easier:

- **eCase:** You can upload and view case-related documents online with the Board’s eCase system, which is used to process claims for injured workers. You must register for eCase at **wcb.ny.gov**.
- **Virtual Hearings:** You have the option of attending hearings without having to travel to a Board office by using virtual hearings. Learn more about virtual hearings, and the Board’s free app, at **wcb.ny.gov/virtual-hearings**.

HELP IS AVAILABLE

Sometimes you need help getting back to work. Your employer may have alternative or light duty assignments that enable you to work while you heal. An injury or illness can also cause family or financial problems. The Board has vocational rehabilitation counselors and social workers to help. Call the Board for more information on available services and for assistance.

If you are concerned about dependency on opioid pain medications, please call the NYS OASAS HOPELine at **877-8-HOPENY (877-846-7369).**

Important Contact Information		
Workers’ Compensation Board	(877) 632-4996	claims@wcb.ny.gov
		wcb.ny.gov

New York State Workers’ Compensation Board
PO BOX 5205
Binghamton, NY 13902-5205

Workers’ Compensation Board

Occupational injury/illness STATEMENT OF RIGHTS

Workers' Compensation Board

To all workers who are injured while working or who suffer from an occupational disease: You may be entitled to workers' compensation benefits

1. You may be entitled to lost wage benefits if your work-related injury/illness keeps you from work for more than seven days, causes you to earn lower wages, or results in a permanent disability. In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury/illness.
2. You are entitled to medical treatment related to your injury/illness and should get it immediately. You can see any health care provider in an emergency. After that, you must see a NYS Workers' Compensation Board (Board) authorized provider or go to an occupational health clinic. You can search for a provider at **wcb.ny.gov**. Do not pay the health care provider directly; they will bill your employer's workers' compensation insurer. If that insurer has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them.
3. Your employer is liable for repairing or replacing any prosthesis (e.g., artificial members, false teeth, eyeglasses) that has been lost or damaged in the course of employment. You are also entitled to reimbursement for medication, crutches, or any equipment properly prescribed by your provider, as well as transportation and other necessary expenses for travel to and from your health care provider's office or hospital. (You should get receipts for all such expenses.)
4. Your employer is not permitted to ask you to waive your right to compensation or deduct money from your wages to pay for workers' compensation insurance premiums. Further, you cannot be fired or discriminated against because you filed a claim for benefits.
5. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire an attorney or licensed representative, you should not pay them directly. Any fee will be set by the Board and will be deducted from your award.
6. If your claim is disputed on the grounds that your injury/illness is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may be required to cover the costs of your medical treatment. You may qualify for disability benefits for non-work injuries. For information on disability benefits, contact the Board at **(877) 632-4996**.

Note: A quick return to work and an active lifestyle may help you get better faster. For help returning to work, or with family or financial problems due to your injury/illness, call the Board at **(877) 632-4996** and ask for vocational rehabilitation or social work assistance.

To file a claim:

1. Tell your employer, in writing, that you were injured or made ill due to your job, within 30 days of the accident or onset of illness.
2. Report your injury/illness to the Board as soon as possible. To do so, obtain and file an ***Employee Claim (Form C-3)***. Note: Volunteer firefighters file the ***Volunteer Firefighter's Claim for Benefits (Form VF-3)***, volunteer ambulance workers file the ***Volunteer Ambulance Worker's Claim for Benefits (Form VAW-3)***.
   IMPORTANT: If you do not notify the Board of your injury or illness within two years, you risk losing the right to benefits.
3. Tell your health care provider to send copies of medical reports concerning your claim to the Board and to your employer's insurance company at the addresses on the bottom of this form.

FOR HELP OBTAINING A CLAIM FORM OR FILLING IT OUT, OR OTHER QUESTIONS ABOUT A WORK-RELATED INJURY OR ILLNESS, PLEASE CALL (877) 632-4996. A BOARD REPRESENTATIVE WILL HELP YOU.

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board,
Centralized Mailing, PO Box 5205,
Binghamton, NY 13902-5205

WCB.NY.GOV

Enfermedad o lesión profesional
DECLARACIÓN DE DERECHOS

Workers' Compensation Board

A todos los trabajadores que se lesionan mientras trabajan o que sufren una enfermedad profesional: pueden tener derecho a las prestaciones de compensación obrera

1. Puede tener derecho a las prestaciones por pérdida de salario si su enfermedad o lesión relacionada con el trabajo le impide trabajar durante más de siete días, le hace ganar un salario inferior o le provoca una incapacidad permanente. Los bomberos voluntarios y los trabajadores voluntarios de ambulancias pueden recibir la indemnización por el tiempo perdido o la pérdida de la capacidad de generar ingresos a partir de la fecha de la lesión o enfermedad.
2. Tiene derecho a recibir tratamiento médico relacionado con su lesión o enfermedad y debe recibirlo de inmediato. Puede acudir a cualquier profesional médico en caso de emergencia. Después debe acudir a un proveedor autorizado por la Junta de Compensación Obrera del Estado de Nueva York (la Junta) o a una clínica de salud ocupacional. Puede buscar un proveedor en **wcb.ny.gov**. No pague la consulta; el profesional médico facturará a la aseguradora de compensación de los trabajadores de su empleador. Si la aseguradora tiene una red de farmacias o de diagnóstico, debe recibir los servicios dentro de estas redes. La aseguradora debe informarle sobre sus redes de proveedores obligatorias y cómo utilizarlas.
3. Su empleador es responsable de reparar o sustituir cualquier prótesis (por ejemplo, miembros artificiales, dientes postizos, gafas) que se haya perdido o dañado en el transcurso del trabajo. También tiene derecho al reembolso de los medicamentos, muletas o cualquier equipo debidamente prescrito por su médico, así como el transporte y otros gastos necesarios para ir y volver de la consulta médica o del hospital (debe solicitar los recibos de todos esos gastos).
4. Su empleador no puede pedirle que renuncie a su derecho a una indemnización ni deducirle dinero de su salario para pagar las primas del seguro de accidentes de trabajo. Además, no puede ser despedido ni discriminado por haber presentado una reclamación de prestaciones.
5. Tiene derecho a ser representado por un abogado o representante autorizado, pero no es un requisito. Si contrata a un abogado o representante autorizado, no debe pagarle directamente. La Junta fijará sus honorarios y se deducirán de su indemnización.
6. Si se impugna su reclamación por considerar que su lesión o enfermedad no está relacionada con el trabajo o no se produjo en el ejercicio de las funciones de bombero voluntario o trabajador de ambulancias, es posible que se le exija que cubra los costos de su tratamiento médico. Puede calificar para recibir las prestaciones de incapacidad por lesiones no laborales. Para más información sobre las prestaciones por incapacidad, llame a la Junta al **(877) 632-4996**.

Nota: una rápida reincorporación al trabajo y un estilo de vida activo pueden ayudarle a mejorar más rápido. Si necesita ayuda para volver al trabajo, o para resolver problemas familiares o económicos debidos a su lesión o enfermedad, llame a la Junta al **(877) 632-4996** y solicite rehabilitación profesional o asistencia social.

Para presentar un reclamo:

1. Comunique a su empleador, por escrito, que se ha lesionado o enfermado debido a su trabajo, en los 30 días siguientes de producido el accidente o del inicio de la enfermedad.
2. Comunique su lesión o enfermedad a la Junta lo antes posible. Para hacerlo, solicite y presente una ***Reclamación del Empleado (Formulario C-3)***. Nota: los bomberos voluntarios presentan la ***Solicitud de Prestaciones para Bomberos Voluntarios (Formulario VF-3)***, los trabajadores voluntarios de ambulancias presentan la ***Solicitud de Prestaciones para Trabajadores Voluntarios de Ambulancias (Formulario VAW-3)***.

   IMPORTANTE: si no notifica a la Junta su lesión o enfermedad en el plazo de dos años, se arriesga a perder el derecho a las prestaciones.
3. Pídale a su médico que envíe copias de los informes médicos relativos a su reclamo a la Junta y a la compañía de seguros de su empleador a las direcciones que figuran en la parte inferior de este formulario.

SI NECESITA AYUDA PARA SOLICITAR UN FORMULARIO DE RECLAMACIÓN O PARA RELLENARLO, O SI TIENE ALGUNA OTRA PREGUNTA SOBRE UNA LESIÓN O ENFERMEDAD RELACIONADA CON EL TRABAJO, LLAME AL (877) 632-4996. UN REPRESENTANTE DE LA JUNTA LE AYUDARÁ.

Este documento es una presentación simplificada de sus derechos bajo la Ley de Compensación Obrera. La compañía aseguradora de su empleador la proporciona, tal como lo exige el artículo 110 de la Ley de Compensación Obrera:

ESTABLECIDO POR LA PRESIDENCIA, JUNTA DE COMPENSACIÓN OBRERA
NYS Workers' Compensation Board,
Centralized Mailing, PO Box 5205,
Binghamton, NY 13902-5205
WCB.NY.GOV

Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): ______________________

A. YOUR INFORMATION (Employee)

1. Name: ____________________ (First) ____ (MI) ____________________ (Last) 2. Date of Birth: ____/____/____
3. Mailing address: ____________________ (Number and Street/PO Box/Apartment No.) ________ (City) ____ (State) ____ (Zip Code)
4. Social Security Number: ____-____-____ 5. Phone Number: (____)__________ 6. Gender: ☐ M ☐ F ☐ X
7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? __________

B. YOUR EMPLOYER(S)

1. Employer when injured: ____________________ 2. Phone Number: (____)__________
3. Your work address: ____________________ (Number and Street) ________ (City) ____ (State) ____ (Zip Code)
4. Date you were hired: ____/____/____ 5. Your supervisor's name: ____________________
6. List names/addresses of any other employer(s) at the time of your injury/illness: ____________________
7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? ____________________
2. What types of activities did you normally perform at work? ____________________
3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: __________
4. What was your gross pay (before taxes) per pay period? __________ 5. How often were you paid? __________
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: __________

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: __________ ☐ AM ☐ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) ____________________
4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? ____________________
5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) ____________________
6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) ____________________
7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): ____________________

YOUR NAME: ______________________________ (First, MI, Last) DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? ____________

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): ____________
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: ____________

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: ____________ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: ____________

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? ____________ How often are you paid? ____________

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: ____________
   ____________ Phone Number: (____)____________
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: ____________
   ____________ Phone Number: (____)____________
5. Have you had another injury to the same body part, or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   ____
   ____
   ____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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.

Employee's Signature: ____________ Print Name: ____________ Date: ____/____/____

On behalf of Employee: ____________ Print Name: ____________ Date: ____/____/____

An individual may sign on behalf of the employee only if they are legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): ____________ Date: ____/____/____

Print Name: ____________ Title: ____________

ID No., if any: **R** ____________ If Licensed Representative, License No.: ____________ Expiration Date: ____/____/____

Instructions for Completing Employee Claim (Form C-3)

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the end of these instructions. If you need additional help completing this form, contact the Workers' Compensation Board at **1-877-632-4996.** You may also fill this form out online at **wcb.ny.gov**. If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

In Section A, enter your name, address and other requested information.
Note on Item 7: Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

> **Notification Pursuant to the New York Personal Privacy Protection Law**
> **(Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).**
>
> The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.
Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

Section C - Your Job on the Date of the Injury or Illness:

In Section C, enter your job title, work activities and pay information.

Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.
Item 1: Enter the date you were injured or the first date you noticed you became ill.
If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand).
This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now).
Item 8: Indicate if some object was involved in the accident **other than** a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate the date you stopped working. If you have not stopped working, check No and skip to the next section.
Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)
Item 3: If you have returned to work, indicate who you are working for now.
Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.
Item 2: Check if you were first treated on the job for this injury or illness.
Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).
Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise, check No.
Item 5: If you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**
Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided they are authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, their fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:
New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996

Workers' Compensation Board

Reclamo del empleado

C-3

Estado de Nueva York - Junta de Compensación Obrera

Complete este formulario para solicitar beneficios de compensación obrera por una lesión laboral o una enfermedad relacionada con el trabajo. Escriba en letra de imprenta prolija o con texto mecanografiado. Este formulario también se puede completar en línea en www.wcb.ny.gov.

Nro. de caso de la WCB (si lo sabe): ____________________

A. SU INFORMACIÓN (empleado)

1. Nombre: ____________________ (Nombre / Inicial del segundo nombre / Apellido) 2. Fecha de nacimiento: ___/___/___

3. Dirección de correo: ____________________ (Número y calle / apartado postal /apartamento nro. / Ciudad / Estado / Código postal)

4. Número de Seguro Social: ___-___-___ 5. Teléfono: (   ) ________ 6. Género: ☐ M ☐ F ☐ X

7. ¿Necesitará un traductor si debe asistir a una audiencia de la Junta? ☐ Sí ☐ No Si la respuesta es sí, ¿de qué idioma? ________

B. SU(S) EMPLEADOR(ES)

1. Empleador cuando se lesionó: ____________________ 2. Teléfono: (   ) ________

3. Su dirección de trabajo: ____________________ (Número y calle / Ciudad / Estado / Código postal)

4. Fecha de contratación: ___/___/___ 5. Nombre de su supervisor: ____________________

6. Indique los nombres/las direcciones de cualquier otro empleador al momento de su lesión/enfermedad: ____________________

7. ¿Perdió tiempo de trabajo en su(s) otro(s) empleo(s) como resultado de su lesión/enfermedad? ☐ Sí ☐ No

C. SU TRABAJO en la fecha de la lesión o enfermedad

1. ¿Cuál era su puesto y la descripción del puesto? ____________________

2. ¿Qué tipos de actividades realizaba normalmente en el trabajo? ____________________

3. Su trabajo era... (marcar una opción) ☐ De tiempo completo ☐ De medio tiempo ☐ Por temporada ☐ Como voluntario
Otro: ____________________

4. ¿Cuál era su paga bruta (antes de los impuestos) por período de pago? ________ 5. ¿Con qué frecuencia le pagaban? ________

6. ¿Recibía alojamiento o propinas además de su paga? ☐ Sí ☐ No Si la respuesta es sí, describa: ____________________

D. SU LESIÓN O ENFERMEDAD

1. Fecha de su lesión o fecha de aparición de la enfermedad: ___/___/___ 2. Hora de la lesión: ________ ☐ AM ☐ PM

3. ¿Dónde sucedió la lesión/enfermedad? (por ejemplo, 1 Main Street, Pottersville, en la puerta principal) ____________________

4. ¿Esta era su ubicación usual de trabajo? ☐ Sí ☐ No Si la respuesta es no, ¿usted se encontraba en esta ubicación? ____________________

5. ¿Qué estaba haciendo cuando se lesionó o enfermó? (por ejemplo, descargando un camión, escribiendo un informe) ____________________

6. ¿Cómo sucedió la lesión/enfermedad? (por ejemplo, me tropecé con un caño y me caí al piso) ____________________

7. Explique completamente la naturaleza de la lesión/enfermedad; enumere las partes del cuerpo afectadas (por ejemplo, torcedura de tobillo y corte en la frente): ____________________

NOMBRE: ______________________________ **FECHA DE LA LESIÓN/ENFERMEDAD:** ___/___/___

Nombre Inicial del segundo nombre Apellido

D. SU LESIÓN O ENFERMEDAD (*continuación*)

8. ¿Hubo un objeto (por ejemplo, un montacargas, martillo, ácido) involucrado en la lesión/enfermedad? ☐ Sí ☐ No
   Si la respuesta es sí, ¿qué? ______________
9. ¿La lesión fue el resultado del uso o la operación de un vehículo motorizado licenciado? ☐ Sí ☐ No
   Si la respuesta es sí, ☐ su vehículo ☐ vehículo del empleador ☐ otro vehículo Número de patente (si lo sabe): ______________
   Si su vehículo estuvo involucrado, indique el nombre y la dirección de su aseguradora: ______________
10. ¿Usted le ha dado a su empleador (o supervisor) aviso de lesión/enfermedad? ☐ Sí ☐ No
    Si la respuesta es sí, se notificó a: ______________ ☐ verbalmente ☐ por escrito Fecha de notificación: ___/___/___
11. ¿Alguien vio cuando y cómo se lesionó? ☐ Sí ☐ No ☐ Se desconoce Si la respuesta es sí, indique sus nombres: ______________

E. REGRESO AL TRABAJO

1. ¿Tuvo que dejar de trabajar a causa de su lesión/enfermedad? ☐ Sí, ¿en qué fecha? ___/___/___ ☐ No, pasar a la Sección F.
2. ¿Ha regresado a trabajar? ☐ Sí ☐ No ☐ Si la respuesta es sí, ¿en qué fecha? ___/___/___ ☐ tareas regulares ☐ tareas limitadas
3. Si ha regresado a trabajar, ¿para quién trabaja ahora? ☐ Mismo empleador ☐ Empleador nuevo ☐ Trabaja por cuenta propia
4. ¿Cuál es su paga bruta (antes de los impuestos) por período de pago? ______________ ¿Con qué frecuencia le pagan? ______________

F. TRATAMIENTO MÉDICO PARA ESTA LESIÓN O ENFERMEDAD

1. ¿Cuál fue la fecha de su primer tratamiento? ___/___/___ ☐ No recibió tratamiento (pasar a la pregunta F-5)
2. ¿Recibió tratamiento en el sitio? ☐ Sí ☐ No
3. ¿Dónde recibió su primer tratamiento médico fuera del sitio por su lesión/enfermedad? ☐ No recibió tratamiento
   ☐ Sala de emergencias ☐ Consultorio médico ☐ Clínica/hospital/atención de urgencia ☐ Hospitalización durante más de 24 horas

   Nombre y dirección del lugar donde recibió tratamiento por primera vez: ______________
   ______________ Teléfono: (   ) ______________
4. ¿Sigue recibiendo tratamiento por esta lesión/enfermedad? ☐ Sí ☐ No
   Proporcione el nombre y la dirección de los médicos que lo están tratando por esta lesión/enfermedad: ______________
   ______________ Teléfono: (   ) ______________
5. ¿Sufrió otra lesión en la misma parte del cuerpo, o una enfermedad similar? ☐ Sí ☐ No
   Si la respuesta es sí, ¿lo trató un doctor? ☐ Sí ☐ No Si la respuesta es sí, proporcione los nombres y las direcciones de los doctores que lo trataron y **COMPLETE Y PRESENTE EL FORMULARIO C-3.3 JUNTO CON ESTE FORMULARIO:**
   ____
6. ¿La lesión/enfermedad anterior fue relacionada con el trabajo? ☐ Sí ☐ No
   Si la respuesta es sí, ¿estaba trabajando para el mismo empleador para el que trabaja ahora? ☐ Sí ☐ No

Por el presente realizo un reclamo de beneficios conforme la la Ley de Compensación Obrera. Mi firma afirma que la información que brindo es verdadera y correcta, a mi leal saber y entender.

Cualquier persona que, deliberadamente y con la INTENCIÓN DE DEFRAUDAR, presente, cause la presentación, o prepare con el conocimiento o la creencia de que se presentará a una aseguradora o un autoasegurado, o que será presentada por una aseguradora o un autoasegurado, cualquier información que contenga una DECLARACIÓN MATERIAL FALSA o que oculte cualquier hecho material SERÁ CULPABLE DE UN DELITO y quedará sujeto a MULTAS CONSIDERABLES Y PRISIÓN.

Firma del empleado: ______________ Nombre en letra de imprenta: ______________ Fecha: ___/___/___

En nombre del empleado: ______________ Nombre en letra de imprenta: ______________ Fecha: ___/___/___

Una persona solo puede firmar en nombre del empleado si está legalmente autorizada a hacerlo y el empleado es un menor o una persona mentalmente incompetente o incapacitada.

Certifico, a mi leal saber y entender, formados luego de una indagatoria razonable dadas las circunstancias, que los alegatos y otros asuntos de hecho afirmados anteriormente tienen pruebas respaldatorias, o posiblemente tengan pruebas respaldatorias, luego de una oportunidad razonable de llevar adelante investigaciones adicionales o un proceso de recabación y presentación de pruebas.

Firma del abogado/representante (si lo hubiere): ______________ Fecha: ___/___/___

Nombre en letra de imprenta: ______________ Cargo: ______________

Nro. de ID, si lo hubiere: **R**______________ Si es un representante matriculado, número de matrícula: ______ Fecha de vencimiento: ______

Instrucciones para completar el Reclamo del empleado (Formulario C-3)

Por favor, complete este formulario y envíelo a la dirección de correo postal centralizada de la Junta de Compensación Obrera indicada al final de estas instrucciones.
Si necesita ayuda adicional para completar este formulario, comuníquese con la Junta de Compensación Obrera al **1-877-632-4996**. También puede completar este formulario en línea en **wcb.ny.gov.** Si no tiene o no sabe su Número de Caso de la Junta de Compensación Obrera, deje este campo en blanco. No es obligatorio para procesar su reclamo. Recuerde ingresar su nombre y la fecha de su lesión/enfermedad arriba de todo en la página dos.

Sección A - Su información (empleado):

En la Sección A, ingrese su nombre, su dirección y otra información solicitada.
Nota sobre el punto 7: Las audiencias de la Junta se realizan en inglés. Si necesita un traductor, seleccione **Sí** e indique el idioma que necesita.

Notificación conforme a la Ley de protección de la privacidad personal de Nueva York
(Artículo 6-A de la Ley de funcionarios públicos) y la Ley federal de privacidad de 1974 (§ 552a del título 5 del U.S.C.).

La autoridad de la Junta de Compensación Obrera (Junta) para solicitar que el demandante lesionado proporcione la información personal, incluido su número de seguro social, se deriva de la autoridad investigadora de la Junta de conformidad con la Ley de Compensación Obrera (Worker's Compensation Law, WCL), § 20 y su autoridad administrativa de acuerdo con la WCL, § 142. Esta información es recolectada para ayudar a la junta a investigar y administrar los reclamos de la manera más conveniente posible y para ayudarla a mantener los registros de reclamos precisos. Proporcionar su número de seguro social a la Junta es voluntario. No hay penalidad por no proporcionar su número de seguro social en este formulario; no traerá como consecuencia una denegación de su reclamo o una reducción en los beneficios. La junta protegerá la confidencialidad de toda la información personal en su posesión y la divulgará solo en cumplimiento de sus deberes oficiales de acuerdo con las leyes estatales y federales aplicables.

Sección B - Sus empleadores:

En la Sección B, ingrese el nombre, la dirección, el número de teléfono y otra información del empleador para el que trabajaba al momento de la lesión/enfermedad.
Nota: Su empleador es la compañía o agencia que emite su cheque de pago. Si es un contratista en un sitio de trabajo o una oficina, la agencia de dotación de personal o el proveedor que lo contrató es su empleador, no el sitio de trabajo ni la oficina a la que se presenta a trabajar.

Sección C - Su trabajo en la fecha de la lesión o enfermedad:

En la Sección C, ingrese su puesto, actividades laborales e información salarial.

Sección D - Su lesión o enfermedad:

En la Sección D, ingrese la información sobre su lesión o enfermedad.
Punto 1: Ingrese la fecha en que se lesionó o la primera fecha en que notó que estaba enfermo.
Si se trata de una enfermedad ocupacional, saltee el punto 2. La fecha en que se lesionó debe estar en formato mes/día/año. El año se debe escribir como cuatro cifras, por ejemplo, 2015.
Punto 2: Ingrese la hora en que ocurrió el accidente. Marque si fue AM o PM.
Punto 3: Indique el lugar donde ocurrió la lesión/enfermedad, incluida la dirección del edificio y la ubicación física en el edificio donde sucedió la lesión/enfermedad.
Punto 4: Marque si este era su lugar de trabajo normal. Si no lo era, indique por qué se encontraba en esta ubicación.
Punto 5: Describa detalladamente qué estaba haciendo al momento de la lesión/enfermedad (por ejemplo, descargando cajas de un camión manualmente).
Esto explica los eventos que llevaron a la lesión.
Punto 6: Describa detalladamente cómo ocurrió la lesión/enfermedad (por ejemplo, "Estaba levantando una caja pesada del camión"). Esto debe incluir a todas las personas y los eventos involucrados en la lesión/enfermedad.
Punto 7: Indique plenamente la naturaleza y extensión de su lesión/enfermedad, incluidas todas las partes del cuerpo lesionadas. Sea lo más específico posible (por ejemplo, "Me lastimé la espalda intentando levantar una caja pesada. Ahora me duele doblarme, agacharme o siquiera sostener objetos más livianos").
Punto 8: Indique si hubo algún objeto involucrado en el accidente, **que no sea** un vehículo motorizado con licencia. Otros objetos pueden involucrar una herramienta (por ejemplo, un martillo), un producto químico (por ejemplo, ácido), maquinaria (por ejemplo, un montacargas o un taladro de columna), etc.
Punto 9: Indique si hubo un vehículo motorizado con licencia involucrado en el accidente. Si la respuesta es sí, maque si el vehículo involucrado era suyo, de su empleador o de un tercero. Incluya el número de patente (si lo sabe). Si su vehículo estuvo involucrado, indique el nombre y la dirección de su aseguradora automotriz.
Punto 10: Marque si le dio a su empleador o supervisor aviso sobre su lesión o enfermedad. Si lo hizo, indique a quién notificó, así como también si fue verbalmente o por escrito. Incluya la fecha de notificación.
Punto 11: Marque si alguien más vio el accidente. Si alguien lo vio, incluya sus nombres.

Sección E - Regreso al trabajo:

Punto 1: Si dejó de trabajar como resultado de su lesión/enfermedad relacionada con el trabajo, marque Sí e indique la fecha en que dejó de trabajar. Si no dejó de trabajar, marque No y pase a la sección siguiente.
Punto 2: Si ha regresado a trabajar desde entonces, marque Sí. Además, indique en qué fecha volvió a trabajar, y si regresó a sus tareas normales o si está realizando tareas limitadas o restringidas. (Si no ha regresado a sus tareas laborales completas previas a la lesión, entonces está realizando tareas limitadas).
Punto 3: Si ha regresado a trabajar, indique para quién trabaja ahora.
Punto 4: Ingrese su salario bruto (paga antes de los impuestos) por período de pago para el puesto en el que trabaja ahora. Indique con qué frecuencia recibe un cheque de pago (semanal, quincenal, etc.).

Sección F - Tratamiento médico para esta lesión o enfermedad:

Punto 1: Si no recibió tratamiento médico por esta lesión/enfermedad, marque No recibió tratamiento y pase al punto 5. De lo contrario, ingrese la fecha en que recibió tratamiento por primera vez por esta lesión/enfermedad y complete el resto de esta sección.

Punto 2: Marque si primero recibió tratamiento en el trabajo por esta lesión o enfermedad.

Punto 3: Marque el lugar donde recibió su primer tratamiento médico fuera del sitio por su lesión o enfermedad. Incluya el nombre y la dirección del centro, así como también el número de teléfono (incluido el código de área).

Punto 4: Si aún está recibiendo tratamiento por la misma lesión o enfermedad, marque Sí e indique el nombre y la dirección de los médicos que brindan tratamiento, así como también el número de teléfono (incluido el código de área). De lo contrario, marque No.

Punto 5: Si ya sufrió una lesión en la misma parte del cuerpo o una enfermedad similar, marque Sí e indique si recibió tratamiento de un doctor por esta lesión o enfermedad. Si recibió tratamiento de un doctor, indique los nombres y las direcciones de los doctores que lo trataron y **complete y presente el Formulario C-3.3 junto con este formulario.**

Punto 6: Si sufrió una lesión o enfermedad anterior, marque si su lesión o enfermedad anterior fue relacionada con el trabajo. Si la respuesta es sí, marque si la lesión o enfermedad sucedió mientras trabajaba para su empleador actual.

Firme el Formulario C-3 en el lugar brindado para la Firma del empleado en la página 2, indique su nombre en letra de imprenta e ingrese la fecha en que firmó el formulario. Si un tercero firma en nombre del empleado, esa persona debe firmar en la segunda línea de firmas. Si tiene un representante legal, el representante debe completar y firmar la sección de certificación del abogado/representante al pie de la página 2.

Qué deben hacer los trabajadores en case de una lesión en el trabajo o enfermedad ocupacional:

1. Dígale de inmediato a su empleador o supervisor cuándo, dónde y cómo se lesionó.
2. Obtenga atención médica de inmediato.
3. Dígale a su médico que presente informes médicos a la Junta y a su empleador o la aseguradora de su empleador.
4. Complete este reclamo de compensación y envíelo a la Oficina de la Junta de Compensación Obrera más cercana. (Consulte más adelante). Si no realiza la presentación dentro de los dos años siguientes a la fecha de la lesión, su reclamo podría ser denegado. Si necesita ayuda para completar este formulario, llame o visite a la Oficina de la Junta de Compensación Obrera más cercana indicada más adelante.
5. Preséntese a todas las ausencias cuando reciba notificación de comparecencia.
6. Regrese a trabajar lo antes posible; la compensación nunca es tan alta como su salario.

Sus derechos:

1. En general, tiene derecho a recibir tratamiento de un médico que usted elija, siempre y cuando esté autorizado por la Junta. Si su empleador está involucrado en un arreglo con una organización de proveedores preferenciales (preferred provider organization, PPO), debe obtener tratamiento inicial de la organización de proveedores preferenciales que ha sido designada para prestar servicios de atención médica para lesiones de compensación obrera.
2. NO le pague a su médico u hospital. La aseguradora pagará sus facturas si su caso no se disputa. Si su caso se disputa, el médico u hospital debe esperar para recibir el pago hasta que la Junta tome una decisión sobre su caso. En caso de que no procese su caso, o de que la Junta se pronuncie en su contra, deberá pagarle al médico u hospital.
3. También tiene derecho a recibir un reembolso por medicamentos, muletas o cualquier aparato que le rece correctamente un médico, y por los costos de traslado en auto u otros gastos necesarios para ir desde y hasta el consultorio de su médico o el hospital. (Pida recibos para estos gastos).
4. Tiene derecho a recibir compensación si su lesión no le permite trabajar durante más de siete días, requiere que trabaje por un salario inferior, o causa una discapacidad permanente en cualquier parte de su cuerpo.
5. La compensación es pagadera directamente y sin esperar a una adjudicación, excepto cuando el reclamo se disputa.
6. Los trabajadores lesionados o dependientes de trabajadores fallecidos se pueden autorrepresentar en causas ante la Junta, o pueden contratar a un abogado o representante licenciado que los represente. Si se contratan los servicios de un abogado o representante licenciado, sus honorarios por servicios legales serán revisados por la Junta y, si se aprueban, serán pagados por el empleador o la aseguradora además de los beneficios de compensación pagaderos. Los trabajadores lesionados o dependientes de trabajadores fallecidos no deben realizar ningún pago directo al abogado o representante licenciado que los representa en un caso de compensación.
7. Si necesita ayuda para regresar a trabajar, o con problemas financieros en su familia a causa de su lesión, comuníquese con la oficina de la Junta de Compensación Obrera más cercana y pida un asesor de rehabilitación o trabajador social.

Este formulario se debe presentar enviándolo directamente a la dirección que figura a continuación:
New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Número gratuito de atención al cliente: 877-632-4996

NEW YORK STATE | Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:__________________________

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/ illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:______________________________ 2. Social Security Number:______-_____-______
3. Mailing Address: ______________________________
4. Date of Birth: ______/______/______ 5. Date of the current injury/illness: ______/_______/_______
6. Current injury/illness, including all body parts injured:______________________________
7. Your legal representative's name and address (if any):______________________________

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S) (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:______________________________ 2. Phone Number: (______)______________
3. Mailing Address: ______________________________
4. Other provider (if any):______________________________ 5. Phone Number: (______)______________
6. Mailing Address:______________________________

C. READ AND SIGN BELOW. I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

____
Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

____
Your name | Relationship to Claimant | Signature (ink only -- use blue ballpoint pen, if possible.) | Date

Versión en español al reverso de la forma.

Workers' Compensation Board

Divulgación limitada de información sobre la salud (HIPAA)

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

C-3.3

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe]*)

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre)
2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento)
5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

Check here if you allow your health provider(s) to release ***mental health care*** *information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre* ***tratamientos de salud mental****.)*

B. YOUR HEALTH CARE PROVIDERS

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud)
2. Phone Number (Nº de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde])
5. Phone Number (Nº de teléfono)
6. Mailing Adress (Dirección postal)

C. READ AND SIGN BELOW

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) use solo tinta - preferiblemente azul — Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre) — Relationship to Claimant (Relación con el reclamante) — Signature(Firma) — Date(Fecha)

NEW YORK STATE | Workers' Compensation Board

EMPLOYER'S STATEMENT OF WAGE EARNINGS (Preceding the Date of Injury/Illness)

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: __________ WCB Case #: __________ Claim Administrator Claim (Carrier Case) #: ____________________

Injured Worker Information

Last Name: ______________________ First Name: ______________________ MI: __

Mailing Address: ______________________ Line 2: ______________________

City: ______________ State: ________ Zip Code: __________

Job Title: ______________________________ Social Security #: ______________

Insurer Information

Insurer Name: ______________________________ Insurer ID (W#): __________

Mailing Address: ______________________ Line 2: ______________________

City: ______________ State: ________ Zip Code: __________

Insurer Phone #: ______________ Insurer Fax #: __________ Email Address: ______________

Employer Information

Employer Name: ______________________________

Mailing Address: ______________________ Line 2: ______________________

City: ______________ State: ________ Zip Code: __________

Employer Phone #: ______________ Federal Tax ID #: ______________ The Tax ID # is the (check one): ☐ SSN ☐ EIN

To determine Average Weekly Wage, the Board needs the gross weekly earnings for the 52 weekly periods immediately preceding the date of the injury/ illness. This information can be provided by 1) attaching detailed payroll information that indicates days paid and gross weekly earnings; 2) if injured worker is paid by salary and his or her weekly pay does not change from week-to-week, attach document(s) providing their salary information for the previous 52 weeks; or 3) by completing and submitting the **Injured Worker Payroll** section on page 2 of this form.

If the injured worker has not worked at the same employment for one year or a substantial part of the year, also attach detailed payroll information for an employee of the same class, or complete and submit the **Employee of the Same Class Payroll** section on page 2 of this form. "Substantial part of the year" does not require any particular number of days worked but as a guideline 234 days at 5 days per week and 270 days at 6 days per week .

1. Payroll information is: ☐ attached ☐ completed on page 2

2. Did the injured worker's compensation include board, rent, housing, tips and/or gratuities, in addition to gross weekly earnings? ☐ Yes ☐ No

   If Yes, what was the weekly value: ______________

   Nature of the compensation:

3. Basis for the injured worker pay rate is: ☐ hourly ☐ daily ☐ weekly ☐ monthly ☐ annually

4. The injured worker works a: ☐ 5 ☐ 6 ☐ 7 ☐ Other day week. If Other, Explain: ______________________

5. Total days paid in the preceding 52 weeks: ____ 6. Total gross amount paid including overtime in the preceding 52 weeks: __________

7. Was there any wage adjustment made that affected the 52-week period? (If injured worker was in military service, please indicate and provide date of discharge.) ☐ Yes ☐ No

   If "Yes", explain:

8. Was the injured worker laid off during the preceding 52 weeks? ☐ Yes ☐ No

   If Yes, provide dates of layoff : ______________________________

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Prepared By - The above information is true and to the best of my knowledge and belief.

Last Name: ______________________ First Name: ______________________ MI: __

Employer Name: ______________________________

Official Title: ______________________ Daytime Phone #: ______________

Email Address: ______________________ Date of this Report: ______________

Injured Worker's Name: ______________________________ Date of Injury/Illness: __________ WCB Case #: __________

INJURED WORKER PAYROLL Enter the injured worker's gross weekly earnings for the 52 weekly periods immediately preceding the date of injury/illness. In the "**Days Paid**" column enter the number of days compensated, including paid time off.

Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

EMPLOYEE OF THE SAME CLASS PAYROLL. If the injured worker has not worked at the same employment for one year or a substantial part of the year, enter the gross weekly earnings for an employee of the same class. "Substantial part of the year" does not require any particular number of days worked, but as a guideline 234 days at 5 days per week and 270 days at 6 days per week.

Employee of the Same Class

First Name: ______________________ Last Name: ______________________ MI: ___

Job Title: ____

Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

Instructions for Completing Employer's Statement of Wage Earnings (Form C-240)

CLAIM INFORMATION

Date of Injury/Illness: Enter the date the injured worker was injured or noticed they were ill. Enter the date in month/day/year format. Include the four digit year.
WCB Case #: The Workers' Compensation Board Case number.
Insurer Case #: The Claim Administrator Claim (Carrier Case) number.

INJURED WORKER INFORMATION

Last Name, First Name, MI: Enter the injured worker's full legal name.
Mailing Address: Enter the injured worker's full address, including PO Box, if applicable, city or town, state, zip code.
Social Security #: Enter the injured worker's Social Security Number.

INSURER INFORMATION

Insurer Name: Enter the name of the Workers' Compensation Insurer or Self-Insured Group name.
Mailing Address: Enter the insurer or claims administrator address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the insurer phone number, including area code and extension, if applicable.
Fax #: Enter the insurer fax number, including area code, if applicable.
Email Address: Enter the insurer or claims administrator email address.

EMPLOYER INFORMATION

Employer Name: Enter the name of the injured worker's employer.
Mailing Address: Enter the employer's full address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the employer phone number, including area code and extension, if applicable.
Federal Tax ID #: Enter the employer Federal Tax ID number.

1. **Payroll Information -** Indicate if payroll information is attached to this form or if the information is entered on page 2.
2. **Other Earnings**: If the injured worker received board, rent, housing, tips and/or other gratuities, provide the weekly value and describe the additional earnings. Note: Other earnings does not include accrued time such as vacation.
3. **Wage Information**: Enter the basis for injured worker's pay rate (hourly, daily, weekly, monthly or annually).
4. **Days Worked Per Week:** Check the number of days per week the injured worker's work schedule is based on. If it is other than a 5, 6 or 7 day week, explain.
5. **Total Days Paid**: Enter the total number of days for which the injured worker was paid in the 52 weeks immediately prior to the date of injury/illness, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7. Do not include accrued time such as vacation time.
6. **Total Gross Amount Paid Including Overtime:** Enter the injured worker's total gross pay (prior to taxes) for the 52 weeks immediately prior to the date of injury/illness, including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.
7. **Wage Adjustments**: If any wage adjustments (e.g., if the injured worker was demoted) were made during the 52 weeks prior to the injury/illness, explain. Advise if the injured worker was in military service during the 52 week period, and give date of discharge.
8. **Laid Off**: Indicate if the injured worker was laid off during the 52 week period immediately prior to the date of injury/illness, and provide the dates of layoff.

PREPARED BY

Last Name, First Name, MI: Enter the preparer's full legal name.
Employer Name: Enter the name of the preparer's employer.
Official Title: Enter the preparer's official title.
Phone #: Enter the preparer's phone number, including area code and extension, if applicable.
Email Address: Enter the preparer's email address.
Date of this Report: Enter the date this report was prepared.

INSTRUCTIONS FOR COMPLETING INJURED WORKER PAYROLL AND EMPLOYEE OF SAME CLASS PAYROLL

Injured Worker Payroll

Week Ending Date: Enter the week ending dates for each of the 52 weeks immediately prior to the date of injury/illness.
Days Compensated (including paid time off): In the "**Days Paid**" column, give the number of days worked in the employment for which the worker was paid, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7 on page 1. Do not include accrued time such as vacation time.
Gross Amount Paid including Overtime: Enter the injured worker's average weekly gross pay (prior to taxes), including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.

Employee of the Same Class Payroll: Give the gross weekly wages for an employee of the same class if the injured worker worked less than a substantial part of the year (234 days for a 5-day worker, or 270 days for a 6-day worker). In addition, provide name of employee in the same class and their job title. NOTE: "Number of days worked" is a guideline, and the Board may find that an injured worker has worked a substantial part of the year even if the injured worker did not work 234 days (5-day worker) or 270 days (6-day worker).

If attaching payroll information, do not submit page 2. All attachments should include the Injured Worker's full name, WCB Case # and Date of Injury/Illness.

Submit by mail or electronically directly to:

New York State Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

Fax #: (877) 533-0337
WCB Address for Email Filing: wcbclaimsfiling@wcb.ny.gov
WCB Web Upload Link: https://wcbdoc.services.conduent.com/

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

AmTrust North America
An AmTrust Financial Company

May 26, 2021

Name
Address
City, State, Zip

RE:
Claim#: 1234567-1
WCB#: G1234567
D/A: 1/1/2021

Dear Name,

The New York State Worker's Compensation Act allows you to have your compensation payments deposited directly into your bank account rather than receiving a paper check. If you are interested in this option, kindly complete the enclosed Direct Deposit form. The completed form can be returned via confidential fax at 678.258.8399 or email to ClaimsACH@amtrustgroup.com.

For security purposes, forms are not to be returned to the claims P.O. Box or to the New York State Workers Compensation Board.

Should you have any questions regarding this form, you may contact me directly at the phone number below.

Sincerely,

Adjuster Name
Title
Company
PO Box
City, State, Zip
Phone
Fax

SUBMISSION INFORMATION

Insurer ID (W Number) - Enter the WCB-assigned Insurer Code ("W Number") for the insurer that is responsible for the claim and seeking reimbursement; this entity must be identified as a Party of Interest (POI) on the claim in the WCB case folder in order for reimbursement to be processed [REQUIRED].
Insurer Name - The form will populate the name of the insurer that is responsible for the claim and seeking reimbursement from the name in Groups tab.
Claim Administrator - Enter the name of the entity that is administering the claim and will receive the reimbursement or indicate if claim is self-administered; this entity must be identified as a POI on the claim in the WCB case folder in order for reimbursement to be processed. Payment will be directed to the address the WCB Special Funds Group has on file for the administrator [REQUIRED].
Contact Name - Enter the name of the person that the WCB Special Funds Group can contact with questions about the submission [REQUIRED].
Phone Number - Enter the phone number for the contact [REQUIRED].
E-Mail Address - Enter the e-mail address for the contact [REQUIRED].
Submit Date - Enter the date the form was submitted to the WCB Special Funds Group [REQUIRED].

CLAIM INFORMATION

WCB Case Number - Enter the claim number assigned by WCB; this number should be entered as it appears in eCase with no spaces or extra characters [REQUIRED].
Claim Admin Claim Number - Enter the claim number assigned by the entity that is administering the claim [OPTIONAL].
Claimant Name - Enter the name of the claimant [REQUIRED].

REQUEST SUMMARY

Reference Number - Enter the reference number assigned to the original request by Special Funds Group. This number appears on Form C-251R and Form C-251.1R [REQUIRED].
Begin Date - Enter the begin date of the original request [REQUIRED].
End Date - Enter the end date of the original request [REQUIRED].
Original Amount - Enter the amount of the original request [REQUIRED].
Requested Amount - Enter the amount that reconsideration is being requested for; this amount cannot be greater than the difference between the amount of the original request and the amount that was approved by Special Funds Group for that request [REQUIRED].

EXPLANATION

Provide a brief statement of the particular grounds upon which the request for reconsideration is based. A one-page document may be attached as an addendum, using 12-point font, with one inch margins, on 8.5-inch by 11-inch paper. An addendum longer than one page will not be considered, unless the insurer specifies in writing, why the basis of the request could not have been made within the space provided and the one-page addendum. Additional supporting evidence may be submitted if such evidence has not been submitted previously and is not already available for consideration in the Board's electronic case folder. The number of additional documents submitted shall not exceed the number of medical bills at issue and/or, more than ten pages where the request involves indemnity reimbursement.

Additional information can be found on the WCB website: www.wcb.ny.gov.

DIRECT DEPOSIT AUTHORIZATION FORM

Directions: This is a sample form for illustration purposes only. Please do not complete this form. To begin, change or cancel the transmittal of workers' compensation benefit checks and/or proceeds from a settlement agreement pursuant to WCL § 32 (hereinafter settlement proceeds) directly to a financial institution: fill out the form on your insurer or administrator's website and submit the form directly to them. **Do not send to the Workers' Compensation Board**. If you need a paper copy of the form, please contact your insurer.

CLAIMANT'S RIGHTS TO DIRECT DEPOSIT

- This form is optional, but you have the right to receive your workers' compensation indemnity benefits or death benefits in the form of direct deposit. You also have the right to receive your workers' compensation indemnity benefits or death benefits by paper check in the mail.
- You have the right to cancel the direct deposit at any time by checking the appropriate box on this form and forwarding the completed form to the claim administrator responsible for the workers' compensation claim. The request will be implemented within forty-five days of receipt of notice, and thereafter payment of benefits will be sent by paper check.
- Beginning July 1, 2021, you have the right to have such payments deposited into at least two bank accounts at your request, either as a percentage of the total benefit or a fixed dollar amount for each deposit. The claim administrator may require a minimum amount of up to $20 into each bank account.

AUTHORIZATIONS & UNDERSTANDINGS

- I authorize the claim administrator to directly deposit my workers' compensation indemnity benefits or death benefits into the specified bank account(s).
- I authorize the claim administrator to debit the account in order to recover any credits deposited in error. The claim administrator may recover credits deposited in error by any lawful means. IMPORTANT: This consent does not authorize the claim administrator to recover alleged over payments of established and awarded benefits.
- I understand that any change in my employment status may affect my right to receive benefits.
- I understand that any false statement or failure to disclose a material fact in order to obtain or increase my benefits may result in criminal prosecution, disqualification from benefits, and repayment of any funds deposited to my account.
- I understand that the failure to notify the the insurance carrier, self-insured employer, or third-party administrator (TPA) (claim administrator) of any change in financial institution or account may delay receipt of my benefits or settlement proceeds.
- I understand that in order to change or cancel the direct deposit for my workers' compensation indemnity benefits or death benefits, I need to submit this form to the claim administrator.
    - I understand that I have an obligation to immediately notify the claim administrator if I am no longer entitled to such payments, or of changes in circumstances which affect my entitlement to such payment.
    - I understand that the claim administrator may require me to certify annually that I continue to elect the receipt of such benefits by direct deposit, and that if I fail to do so, the claim administrator may discontinue direct deposit and thereafter provide benefits by paper check.

DIRECT DEPOSIT AUTHORIZATION FORM

Do not send to the Workers' Compensation Board.

☐ NEW ENROLLMENT ☐ CHANGE ☐ CANCEL

SECTION 1 (TO BE COMPLETED BY CLAIMANT)

Depositor/Claimant's Name (last, first):	**WCB Claim Number**:
Phone Number (including area code):	**E-mail Address**:
Address:	

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION
I certify that I am entitled to receive the underlying compensation payments or death benefits and circumstances entitling me to benefits or death benefits have not changed. I understand that the claim administrator may request an annual certification of continued entitlement to such payments or benefits and that such certification must be provided within sixty days in order to continue payments by direct deposit.

Depositor/Claimant Certification Signature	**Date**
Joint Account Holder Certification Signature	**Date**

SECTION 2

Please check with your financial institution to complete the requested information in this section. Direct deposit is only available if your financial institution is part of the New York State Automated Clearinghouse. In addition, the depositor's name MUST appear on the account.

Name of Financial Institution:	**Account Type**: ☐ Checking ☐ Savings Amount or Percentage to be deposited: ____________
Depositor's Account Number (EFT Format):	**Routing Number**:

Name of Second Financial Institution:	**Account Type**: ☐ Checking ☐ Savings Amount or Percentage to be deposited: ____________
Depositor's Account Number (EFT Format):	**Routing Number**:

Workers' Compensation Board

Insurer's Notification of Initial Request for Reimbursement Under WCL Section 14(6) or Section 15(8)

Email completed form to: SpecialFunds@wcb.ny.gov

A form must be fully completed and submitted for each claim where reimbursement is being requested for the first time. The actual reimbursement request should be included on Form C-251 or Form C-251.1, as applicable.

Insurer ID (W Number) / Insurer Name: ______________________________

Claim Administrator: ____________________ Contact Name: ____________________

Phone Number: ____________________ Email: ____________________

Submit Date: ____________________

Claim Information	
Type	
WCB Case Number	
Claim Admin Claim Number	
Claimant Name	
Beneficiary Name	
Gender	
Date of Birth	
ANCR/ODNCR	
Date of Injury	
Date of Classification	
Date of SDF Liability	
Benefit Cap	
Average Weekly Wage	
Overall CCP Rate	
CCP Type	
Apportionment %	
SDF Liability %	
SDF Reimbursable Rate	
State of Residence	
Medicare Status	

Established Sites / Conditions (WCL Section 15(8) Only)

Established Site / Condition	Appt %	SDF %

Retention Period (WCL Section 15(8) Only)

Begin Date	End Date	Weeks
	Total:	

SUBMISSION INFORMATION

Insurer ID (W Number) - Enter the WCB-assigned Insurer Code ("W Number") for the insurer that is responsible for the claim and seeking reimbursement; this entity must be identified as a Party of Interest (POI) on the claim in the WCB case folder in order for reimbursement to be processed [REQUIRED].

Insurer Name - The form will populate the name of the insurer that is responsible for the claim and seeking reimbursement from the name in Groups tab.

Claim Administrator - Enter the name of the entity that is administering the claim and will receive the reimbursement or indicate if claim is self-administered; this entity must be identified as a POI on the claim in the WCB case folder in order for reimbursement to be processed. Payment will be directed to the address the WCB Special Funds Group has on file for the administrator [REQUIRED].

Contact Name - Enter the name of the person that the WCB Special Funds Group can contact with questions about the submission [REQUIRED].

Phone Number - Enter the phone number for the contact [REQUIRED].

E-Mail Address - Enter the e-mail address for the contact [REQUIRED].

Submit Date - Enter the date the form was submitted to the WCB Special Funds Group [REQUIRED].

CLAIM INFORMATION

WCB Case Number - Enter the claim number assigned by WCB; this number should be entered as it appears in eCase with no spaces or extra characters [REQUIRED].

Claim Admin Claim Number - Enter the claim number assigned by the entity that is administering the claim [OPTIONAL].

Claimant Name - Enter the name of the claimant [REQUIRED].

Beneficiary Name - Enter the name of the person receiving the indemnity benefits (if someone other than the claimant). If claim has more than one beneficiary indicate "Multiple" [OPTIONAL].

Gender - Enter the gender of the person receiving the indemnity benefits [REQUIRED].

Date of Birth - Enter the date of birth of the person receiving the indemnity benefits [REQUIRED].

ANCR/ODNCR - Enter whether the claim has a finding of Accident Notice Causal Relationship (ANCR) or Occupational Disease Causal Relationship (ODNCR) [REQUIRED].

Date of Injury - Enter the date of accident/date of disablement for the claim [REQUIRED].

Date of Classification - Enter the effective date of the finding that the claimant has a Permanent Partial Disability (PPD) [REQUIRED].

Date of SDF Liability - Enter the effective date of the finding that the Special Disability Fund is liable for some portion of the claim [REQUIRED].

Benefit Cap - If claim is capped, enter the number of weeks of indemnity benefits allowed under the cap [REQUIRED].

Average Weekly Wage - Enter the average weekly wage found for the claimant [REQUIRED].

Overall CCP Rate - Enter the weekly CCP rate that is currently being paid [REQUIRED].

CCP Type - Enter the type of CCP from the options listed below [REQUIRED]:

- DBF Death Benefits
- PPD Permanent Partial Disability
- TRE Tentative Reduced Earnings

Apportionment % - Enter the percentage of the weekly CCP rate that is currently being paid by the insurer on this claim [REQUIRED - CANNOT BE ZERO].

SDF Liability % - Enter the percentage of the weekly CCP rate that is being paid by the insurer on this claim that is reimbursable from the SDF. For 14(6) Concurrent Employment claims this is equal to the percentage of Average Weekly Wage that is attributable to the concurrent employer [REQUIRED - CANNOT BE ZERO].

SDF Reimbursable Rate - The form will calculate the weekly rate for which reimbursement from the SDF is being requested; based on the Overall CCP Rate, Apportionment % and SDF Liability %.

State of Residence - Enter the state or states where the claimant currently resides [REQUIRED].

Medicare Status - Enter the Medicare eligibility status of the claimant from the options listed below [REQUIRED]:

- ENR Currently Enrolled And Receiving Benefits
- ELG Eligible Within The Next 30 Months
- NOT Not Eligible Within The Next 30 Months

ESTABLISHED SITE / CONDITIONS

The following section is required for 15(8) claims only.

Established Site / Condition - Enter each site (body part) or condition that has been established as related to the claim [AT LEAST ONE REQUIRED].

Appt % - Enter the percentage of the cost of medical treatment related to the established site / condition that is currently being paid by the insurer on this claim [REQUIRED FOR EACH SITE/CONDITION].

SDF % - Enter the percentage of cost of medical treatment related to the established site / condition that is being paid by the insurer on this claim that is reimbursable from the SDF [REQUIRED FOR EACH SITE/CONDITION].

RETENTION PERIOD

The following section is required for 15(8) claims only.

Begin Date - Enter the first day of the period for which benefits were paid as part of the retention period ("From Date") [AT LEAST ONE REQUIRED]

End Date - Enter the last day of the period for which benefits were paid as part of the retention period ("To Date") [REQUIRED FOR EACH BEGIN DATE].

Weeks - The form will calculate the number of weeks within the period based on the Begin Date and End Date.

Additional information can be found on the WCB website: www.wcb.ny.gov.

Insurer's Request for Reimbursement of Medical Payments Under WCL Section 15(8)

Submit Completed Form via Email or Mail:
Attention Special Funds Group
328 State Street, Room 331
Schenectady, NY 12305
SpecialFunds@wcb.ny.gov

Submission of this form is a certification to the Chair of the Workers' Compensation Board that the amount of reimbursement requested is the same as that which was expended, that all payments were made in accordance with the applicable medical fee schedule and Medical Treatment Guidelines, that no part thereof has been previously reimbursed, that the amount stated herein is due and owing, and that the information contained herein is true and correct. Invalid or inaccurate requests may be subject to penalty.

Insurer ID (W Number) / Insurer Name: ______________________________

Claim Administrator: ____________________ Contact Name: ____________________

Phone Number: ____________________ Email: ____________________

Submit Date: ____________________

Claim Information	
WCB Case Number	
Claim Admin Claim Number	
Claimant Name	
State of Residence	

Request Summary			
Service Date Range		-	
Payment Date Range		-	
Total Amount			

Request Details

The following information should be entered for each bill/charge with the actual bill and appropriate supporting documentation attached to the form in the order listed. A separate detail sheet may be attached to the form in lieu of completing this section, provided all of the required information is included.

ID							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

SUBMISSION INFORMATION

Submission by Email - Email submissions must be sent to **SpecialFunds@wcb.ny.gov** with "15(8) Medical Reimbursement" noted in the subject line. Emails received in any other inbox or using any other subject heading may not be considered. All supporting documentation must be included as attachment(s) and may not be submitted separately. Supporting documentation must be in PDF format so that it may be reviewed by Specials Funds Group, and by the Office of the State Comptroller if selected for audit. Failure to follow any of these instructions will result in a rejection of the submission.

Insurer ID (W Number) - Enter the WCB-assigned Insurer Code ("W Number") for the insurer that is responsible for the claim and seeking reimbursement; this entity must be identified as a Party of Interest (POI) on the claim in the WCB case folder in order for reimbursement to be processed [REQUIRED].

Insurer Name - The form will populate the name of the insurer that is responsible for the claim and seeking reimbursement from the name in Groups tab.

Claim Administrator - Enter the name of the entity that is administering the claim and will receive the reimbursement or indicate if claim is self-administered; this entity must be identified as a POI on the claim in the WCB case folder in order for reimbursement to be processed. Payment will be directed to the address the WCB Special Funds Group has on file for the administrator [REQUIRED].

Contact Name - Enter the name of the person that the WCB Special Funds Group can contact with questions about the submission [REQUIRED].

Phone Number - Enter the phone number for the contact [REQUIRED].

E-Mail Address - Enter the e-mail address for the contact [REQUIRED].

Submit Date - Enter the date the form was submitted to the WCB Special Funds Group [REQUIRED].

CLAIM INFORMATION

WCB Case Number - Enter the claim number assigned by WCB; this number should be entered as it appears in eCase with no spaces or extra characters [REQUIRED].

Claim Admin Claim Number - Enter the claim number assigned by the entity that is administering the claim [OPTIONAL].

Claimant Name - Enter the name of the claimant [REQUIRED].

State of Residence - Enter the state or states where the claimant currently resides [REQUIRED].

REQUEST SUMMARY

Service Date Range - Enter the first and last date service was rendered for the bills/charges where reimbursement is being requested [REQUIRED].

Payment Date Range - Enter the first and last date payment was made for the bills/charges where reimbursement is being requested [REQUIRED].

Total Amount - Enter the total amount of reimbursement being requested [REQUIRED].

REQUEST DETAILS

The following information should be entered for each bill/charge with the actual bill and appropriate supporting documentation attached to the form in the order listed. A separate detail sheet may be attached to the form in lieu of completing this section, provided all of the required information is included.

Provider Name - Enter the name of the provider who was paid for the bill/charge [REQUIRED].

Service Date - Enter the date service was rendered for the bill/charge [REQUIRED].

Paid Date - Enter the date payment was made for the bill/charge [REQUIRED].

Appt % - Enter the percentage of medical treatment on this bill/charge that is paid by this insurer on this claim; this percentage should be reflected in the Paid Amount [REQUIRED - CANNOT BE ZERO].

Paid Amount - Enter the amount of the bill/charge that was paid by this insurer on this claim; this amount should reflect the Apportionment % [REQUIRED].

SDF % - Enter the percentage of the amount paid by the insurer for this bill/charge that is eligible for reimbursement from the SDF; this percentage should be reflected in the Requested Amount [REQUIRED - CANNOT BE ZERO].

Requested Amount - Enter the amount of reimbursement being requested for the bill/charge; this amount should reflect the SDF Liability % [REQUIRED].

Additional information can be found on the Workers' Compensation Board website: www.wcb.ny.gov.

Workers' Compensation Board

Insurer's Request for Reconsideration of Reduction Under WCL Section 14(6) or Section 15(8)

Email completed form to: SpecialFunds@wcb.ny.gov

Submission of this form is a certification to the Chair of the Workers' Compensation Board that the amount of reimbursement requested is the same as that which was expended, that all payments were made in accordance with the applicable medical fee schedule and Medical Treatment Guidelines, that no part thereof has been previously reimbursed, that the amount stated herein is due and owing, and that the information contained herein is true and correct. Invalid or inaccurate requests may be subject to penalty.

Insurer ID (W Number) / Insurer Name: ____________________

Claim Administrator: ____________________ Contact Name: ____________________

Phone Number: ____________________ Email: ____________________

Submit Date: ____________________

Claim Information	
WCB Case Number	
Claim Admin Claim Number	
Claimant Name	

Request Summary	
Reference Number	
Begin Date	
End Date	
Original Amount	
Requested Amount	

Explanation

Enter information in support of the request for reconsideration in the space provided. A single page document may be attached as an addendum and, if not previously submitted, relevant supporting evidence may be attached to the form (see instructions for further details). Failure to follow these instructions may result in rejection of the request for reconsideration.

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S RECORD OF MEDICAL AND TRAVEL EXPENSES AND REQUEST FOR REIMBURSEMENT

CLAIMANT'S NAME	WCB CASE NO.	SOCIAL SECURITY NO.

RESIDENTIAL ADDRESS	MAILING ADDRESS (IF DIFFERENT)

In connection with the above workers compensation case, you are entitled to be reimbursed for (1) medications or supplies properly prescribed by your health care provider that you paid for yourself and for (2) fares, automobile mileage or other necessary expenses going to and from your health care provider's office or the hospital.

To help you keep a record of such expenses we have provided this form. In order to help insure that you are properly reimbursed, list each item of expense below -- whether or not you obtained a receipt (wherever possible obtain receipts). **Submit the completed form and copies of all receipts or bills to the workers' compensation insurance carrier (or to your employer, if self-insured) and to the Workers' Compensation Board.** (See Board address on reverse.) It is suggested that you retain a copy of the receipts and bills for your records.

NATURE OF EXPENSE	DATE	AMOUNT

Continue on Reverse.

NATURE OF EXPENSE	DATE	AMOUNT

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

Address for email filing: wcbclaimsfiling@wcb.ny.gov

www.wcb.ny.gov

Estado de Nueva York
JUNTA DE COMPENSACIÓN OBRERA (WORKERS' COMPENSATION BOARD)

REGISTRO DE GASTOS MÉDICOS Y DE VIAJE DEL DEMANDANTE Y SOLICITUD DE REEMBOLSO

NOMBRE DEL DEMANDANTE	NÚMERO DE CASO DE LA WCB:	N.º DEL SEGURO SOCIAL:

DIRECCIÓN RESIDENCIAL	DIRECCIÓN DE CORREO (SI ES DIFERENTE)

En relación con el caso de compensación obrera más arriba, usted tiene derecho a ser reembolsado por (1) medicamento o suministro adecuadamente prescrito por su proveedor de atención de la salud que haya pagado usted mismo y por (2) tarifas, millaje de automóvil u otros gastos necesarios para ir y venir del consultorio de su proveedor de atención de la salud u hospital.

Para ayudarlo a conservar un registro de dichos gastos hemos proporcionado este formulario. Para ayudarlo a asegurarse que se lo reembolsa adecuadamente, enumere cada punto de sus gastos a continuación, ya sea que haya obtenido un recibo o no (siempre que sea posible obtenga recibos). **Envíe el formulario completo y copia de todos los recibos o facturas a la aseguradora de compensación obrera (o a su empleador, si es un asegurado independiente) y a la Junta de Compensación Obrera.** (Ver dirección de la Junta en el reverso). Se sugiere que conserve una copia de los recibos y facturas para sus registros.

NATURALEZA DEL GASTO	FECHA	MONTO

Continúa en el reverso

NATURALEZA DEL GASTO	FECHA	MONTO

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

Dirección para presentación mediante correo electrónico: wcbclaimsfiling@wcb.ny.gov
www.wcb.ny.gov

NEW YORK STATE Workers' Compensation Board

C-8.1B - Notice of Objection to a Payment of a Bill for Treatment Provided

Section A: Claim Information

1. WCB Case Number	2. Claim Admin Claim Number	3. Insurer ID (W#)	4. Date of Injury/Illness	5. Last Four Digits of SSN

	Name	Address to which notices should be sent	Apt. No.
6. Claimant			
7. Employer			
8. Insurer			
9. Claimant's Health Care Provider			
10. WCB Authorization #: ______		11. Provider's NPI #: ______	

Section B: Medical Bill Information

Note: If bill is not in the Board's file, it must be submitted with this form.

1. Date(s) of Treatment: ______ 2. Date of Bill: ______

3. Amount of Bill: ______ 4. Amount in Dispute: ______ 5. WCB Document ID # of Bill: ______

Section C: Objection Reasons - Legal and Medical Treatment Guidelines

☐ **The insurer is raising valuation objections simultaneously on the C-8.4.**

The insurer raises the following legal objections to the above cited bill for treatment rendered:

1. ☐ **Claim has been controverted** by a FROI-04 or SROI-04 dated: ______ and: ☐ establishment is pending [P8], or: ☐ the case has been disallowed [P4]
2. ☐ **Prior authorization** was not granted for: ☐ treatment (for non-MTG, non-emergency, special service) for over $1,000.00 [198] RARC ______, or
   ☐ continuous course of treatment for PT/OT for over $1,000.00 [198] RARC ______, or
   ☐ Medical Treatment Guideline procedure/treatment requiring pre-authorization [198]. RARC ______
3. ☐ **Request for treatment** has been denied, withdrawn, or refused. [39] RARC ______
4. ☐ **Treatment provided was:** ☐ for a non-established body site or for a body site that the employer/insurer has not accepted liability for [P2], or
   ☐ for an established body site, but was not causally related to the compensable injury [50], or
   ☐ for a body site that is the subject of multiple claims and the injury is not related to claim at issue [109] WCB Case #: ______
5. ☐ **Treatment provided** within 30 days of initial treatment was outside of preferred provider organization (PPO). [279]
6. ☐ **Medical Report for treatment was:** ☐ not timely filed [164] RARC ______, or ☐ is incomplete [251] RARC ______
7. ☐ **Medical appliance** or program is not covered under the WCL ☐ letter of medical necessity not included [P13/M60], or
   ☐ insufficient documentation provided [P13/M135]
8. ☐ **Provider is not authorized under the WCL and exceptions under WCL § 13-b do not apply [P16]**
9. ☐ **Bill is not for treatment,** but for an evidentiary opinion/review of records or submission of a report made without physical examination as defined in 12 NYCRR 300.2 (b)(12) [96/N717]
10. ☐ **Pharmacy used** outside of network. [242] Date claimant notified: ______
11. ☐ **Diagnostic test** was performed outside of network. [243] Attach copy of form DT-1, or identify by WCB Doc. ID #: ______ Date Rec'd by WCB: ______
12. ☐ **Other (specify) or explain below:** CARC ______ RARC ______

Compliance with Medical Treatment Guidelines (ONLY applies to an injury and/or condition covered by Medical Treatment Guidelines)**:**

13. ☐ Treatment provided was not based on correct application of the Guidelines. [272]
14. ☐ Treatment not consistent with the approved Variance. [198] RARC ______
15. ☐ Treatment deviates from the Guidelines without securing a Variance. [197]
16. ☐ Urine drug screens: ☐ Insufficient documentation [272/N705]
    ☐ Incorrect testing method [272/N623]
17. ☐ Variance denied without claimant timely requesting review or Variance denied by Board decision. [39]
18. ☐ Exacerbation (exception to variance requirement for continued treatment) Information incomplete. [P30]
19. ☐ Exacerbation (exception to variance requirement for continued treatment) treatment exceeds guidelines. [P31]
20. **Explain Reason(s) and provide MTG Reference:**

IT IS HEREWITH CERTIFIED THAT A COPY OF THIS FORM WAS SENT THIS DATE TO THE HEALTH PROVIDER.

Prepared By: ______ Employer Name: ______ Dated: ______

Official Title: ______ Daytime Phone #: ______ Email Address: ______

Prescribed by Chair Workers' Compensation Board State of New York

Information Concerning Medical Treatment and Bills for Injured Employees, Insurers, and Health Care Providers

Answer all questions fully. Notice of Legal Objection must be filed within 45 days of receipt of the medical bill. Failure to pay the undisputed portion of the bill may subject the insurer to interest on that portion. Attach the Explanation of Benefits (using applicable Claims Adjustment Reason Codes (CARCs) and Remittance Advice Reason Codes (RARCs) with C-8.1B form submission to the Board.

Section A: Claim Information: Fields 1 -11 Enter claim demographic information including: WCB case number, carrier case number, insurer ID, date of injury as well as name and address of claimant, employer, insurer and health care provider. Also enter the WCB Authorization # and NPI # of the health care provider. Note: in volunteer firefighters' and volunteer ambulance workers' benefit cases, the liable political subdivision (or unaffiliated ambulance service as defined in Sec. 30 VAWBL) is deemed to be the “Employer”.

Section B: Medical Bill Information: Fields 1-5 Enter medical bill information including: Date of Service; Date billed; amount of bill; amount in dispute and WCB Document ID#. Note: if bill is not in the Board's file, it must be submitted with this form.

Section C: Objection Reasons - Legal and Medical Treatment Guidelines: Fields 1-20 Payer must identify all objection reasons within one C-8.1B form submission. Select the applicable box for each objection reason. Objection reasons must be identical to Explanation of Benefits sent to provider, using same Claims Adjustment Reason Codes (CARC) and Remittance Advice Reason Codes (RARC). Enter the RARC code, where indicated, for objections where multiple codes may be applicable. Clarifying information for legal objections and CARC/ RARC codes should be included in field 12; this field should only be used to identify valid legal objection reasons not otherwise listed on the form. For Medical Treatment Guideline objections, identify the applicable MTG reference in field 20.

The objections listed are not the CARC descriptions, but are supporting information for the use of the CARC. CARC descriptions may be found at: (https://x12.org/codes/claim-adjustment-reason-codes)

If the insurer is also raising valuation objections simultaneously on the C-8.4, please check the applicable box at the top of Section C.

Fraud

Section 114 of the Workers' Compensation Law provides, in part, that any employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who knowingly makes a false statement or representation as to a material fact for the purpose of avoiding provision of any payment or benefit under this chapter shall be guilty of a felony.

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Read instructions on page 2 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 3 in Part B. Health care providers must complete Part B on page 2.

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Last Name: ______ First Name: ______ MI: __
2. Mailing Address (Street & Apt. #): ______
   City: ______ State: ____ Zip: ______
3. Daytime Phone #: ______ Email Address: ______
4. Social Security #: ____ - ___ - _____ 5. Date of Birth: ___ / ___ / _____ 6. Gender: ☐ M ☐ F ☐ X
7. Describe your disability (if injury, also state how, when and where it occurred): ______
8. Date you became disabled: ___ / ___ / _____ Did you work on that day?: ☐ Yes ☐ No
   Have you recovered from this disability?: ☐ Yes ☐ No If Yes, date you were able to return to work: ___ / ___ / _____
   Have you since worked for wages or profit?: ☐ Yes ☐ No If Yes, list dates: ______
9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

10. My job is or was: ______ (Occupation) 11. Union Member: ☐ Yes ☐ No If "Yes": ______ (Name of Union or Local Number)
12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No
    If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: ______
    If you did receive unemployment benefits, provide all periods collected: ______
13. For the period of disability covered by this claim:
    A. Are you receiving wages, salary or separation pay? ☐ Yes ☐ No
    B. Are you receiving or claiming:
       1. Unemployment Benefits? ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No
       3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
       4. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving third party? ☐ Yes ☐ No
       5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ☐ Yes ☐ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:
    I have: ☐ received ☐ claimed from: ______ for the period: ___ / ___ / _____ to: ___ / ___ / _____
14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If yes, Paid by: ______ from: ___ / ___ / _____ to: ___ / ___ / _____
15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If yes, Paid by: ______ from: ___ / ___ / _____ to: ___ / ___ / _____
16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

______ **Claimant's Signature** ______ **Date**

An individual may sign on behalf of the claimant only if they are legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

______ **On behalf of Claimant** ______ **Address** ______ **Relationship to Claimant**

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Last Name: ______________________ First Name: ______________________ MI: ___

2. Gender: ☐ M ☐ F ☐ X   3. Date of Birth: ____ / ____ / ______

4. Diagnosis/Analysis: ______________________ Diagnosis Code: ____________

a. Claimant's symptoms: ______________________

b. Objective findings: ______________________

5. Claimant hospitalized?: ☐ Yes ☐ No   From: ____ / ____ / ______   To: ____ / ____ / ______

6. Operation indicated?: ☐ Yes ☐ No   a. Type ______________   b. Date ____ / ____ / ______

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
☐ Yes ☐ No   If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife)	**Licensed or Certified in the State of**	**License Number**

Health Care Provider's Printed Name	**Health Care Provider's Signature**	**Date**

Health Care Provider's Address	**Phone #**

IMPORTANT NOTICE TO CLAIMANT - READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be mailed **within thirty (30) days of your first date of disability to your employer or your last employer's insurance carrier**. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-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 insurance 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.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized part, you must file with the Board an original signed Form OC-110A "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (**www.wcb.ny.gov**) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

DB-450 6-22

Estado de Nueva York
NOTIFICACIÓN Y PRUEBA DE RECLAMO POR BENEFICIOS POR DISCAPACIDAD

Lea detenidamente las instrucciones en la página 2 para evitar retrasos en la tramitación. Debe responder todas las preguntas en la Parte A y las preguntas 1 a 3 en la Parte B. Los proveedores de atención médica deben completar la Parte B en la página 2.

PARTE A - INFORMACIÓN DEL DEMANDANTE (Por favor completar en letra de imprenta o a máquina)

1. Apellido:________________________ Primer nombre:________________________ Inicial del segundo nombre:______________
2. Dirección postal (Calle y nro. de apartamento):____
   Ciudad:______________________ Estado:_____ Código postal:__________________________
3. Número de teléfono durante el día:____________ Correo electrónico:________________________________
4. N.º del Seguro Social:_______-_____-__________ 5. Fecha de nacimiento:______/_____/______ 6. Género: ☐ M ☐ F ☐ X
7. Describa su discapacidad (si es una lesión, también describa, cómo, cuándo y dónde ocurrió):____________________________
   ____
8. Fecha en que quedó discapacitado:______/_____/______ ¿Trabajó ese día?: ☐ Sí ☐ No
   ¿Se ha recuperado de esta discapacidad?: ☐ Sí ☐ No Si la respuesta es Sí, fecha en la que pudo volver al trabajo:___/___/___
   ¿Ha trabajado desde entonces por salario o beneficios?: ☐ Sí ☐ No Si la respuesta es sí, enumere las fechas:______________
9. Nombre del último empleador antes de la discapacidad. Si tuvo más de un empleador en las ocho (8) semanas anteriores, nombre a todos los empleadores: El Salario Semanal Promedio se basa en todos los salarios ganados en las últimas ocho (8) semanas trabajadas.

NOMBRE DEL ÚLTIMO EMPLEADOR ANTES DE LA DISCAPACIDAD.			PERÍODO DE EMPLEO		Salario Semanal Promedio (Incluye bonificaciones, propinas, comisiones, valor razonable de alojamiento, renta, etc.)
Compañía o nombre del oficio	Dirección	Teléfono	Primer día	Último día trabajado	
			Mes Día Año	Mes Día Año	
OTRO EMPLEADOR (durante las últimas ocho (8) semanas)			**PERÍODO DE EMPLEO**		**Salario Semanal Promedio** (Incluye bonificaciones, propinas, comisiones, valor razonable de alojamiento, renta, etc.)
Compañía o nombre del oficio	Dirección	Teléfono	Primer día	Último día trabajado	
			Mes Día Año	Mes Día Año	
			Mes Día Año	Mes Día Año	

10. Mi empleo es o era:______________ (Ocupación) 11. Miembro del sindicato: ☐ Sí ☐ No Si la respuesta es "Sí":______________________ (Nombre del sindicato o número local)
12. ¿Reclamaba o recibía beneficios por desempleo antes de esta discapacidad? ☐ Sí ☐ No
    Si **no** reclamaba o si reclamó pero **no** recibe beneficios por seguro de desempleo *luego* del ÚLTIMO DÍA TRABAJADO, explique las razones en detalle:____
    ____
    Si recibió beneficios por desempleo, proporcione todos los períodos cobrados:________________________________
    ____
13. Para el período por discapacidad cubierto por este reclamo:
    A. ¿Está recibiendo sueldos, salarios o pago por separación del empleo? ☐ Sí ☐ No
    B. Recibe o reclama:
       1. ¿Beneficios por desempleo? ☐ Sí ☐ No 2. ¿Permiso Familiar Pagado? ☐ Sí ☐ No
       3. ¿Compensación obrera o relacionada con discapacidad en el trabajo? ☐ Sí ☐ No
       4. ¿Accidente automotor motor sin atribución de culpa? ☐ ¿Sí ☐ No **o** lesión personal que involucra a un tercero? ☐ Sí ☐ No
       5. ¿Beneficios por discapacidad a largo plazo de acuerdo con la Ley Federal del Seguro Social para *esta* discapacidad? ☐ Sí ☐ No

    SI LA RESPUESTA "SÍ" ESTÁ MARCADA EN CUALQUIERA DE LOS PUNTOS DE 13, COMPLETE LO SIGUIENTE:
    He: ☐ recibido ☐ reclamado de:___________________ para el período______/_____/______ al:______/_____/______
14. En el año (52 semanas) antes de que comenzara su discapacidad, ¿ha recibido beneficios por discapacidad para otros períodos de discapacidad? ☐ Sí ☐ No
    Si la respuesta es sí, pagados por:___________ De:______/_____/______ al:______/_____/______
15. En el año (52 semanas) antes de que comenzara su discapacidad, ¿ha recibido Permiso Familiar Pagado? ☐ Sí ☐ No
    Si la respuesta es sí, pagados por:___________ De:______/_____/______ al:______/_____/______
16. Si quedó discapacitado mientras estaba empleado o dentro de las cuatro semanas de su último día trabajado, ¿le brindó su empleador sus derechos de acuerdo con la Ley de Discapacidad dentro de los 5 días de su notificación o solicitud de formularios por discapacidad? ☐ Sí ☐ No

Por medio del presente reclamo Beneficios por Discapacidad y certifico que por el período cubierto por este reclamo estuve discapacitado. He leído las instrucciones en la página 2 de este formulario y las declaraciones anteriores, incluyendo cualquier declaración adicional son, a mi mejor saber y entender, verdaderas y completas.

________________________ ________________________ ________________________
En nombre del Demandante **Dirección** **Relación con el Demandante**

Una persona puede firmar en nombre del demandante solo si están legalmente autorizadas a hacerlo y el demandante es un menor, una persona mentalmente incompetente o incapacitada. Si firma otra persona que no sea el denunciante, complete la información a continuación y presente el Formulario OC-110A, Autorización del Demandante para Divulgar Registros de Compensación Obrera.

________________________ ________________
Firma del Demandante **Fecha**

PARTE B - DECLARACIÓN DEL PROVEEDOR DE ATENCIÓN MÉDICA (Por favor en letra de imprenta o a máquina)

LA DECLARACIÓN DEL PROVEEDOR DE ATENCIÓN MÉDICA DEBE COMPLETARSE EN SU TOTALIDAD. EL PROVEEDOR DE ATENCIÓN MÉDICA QUE BRINDA LA ATENCIÓN DEBERÁ COMPLETAR Y DEVOLVER AL DEMANDANTE DENTRO DE LOS SIETE (7) DÍAS DE RECEPCIÓN DE ESTE FORMULARIO Para el punto 7-d, debe brindar una fecha estimada. Si la discapacidad fue causada o surge de un embarazo, ingrese la fecha estimada de parto en el punto 7-e. **LAS RESPUESTAS INCOMPLETAS PODRÁN DEMORAR EL PAGO DE LOS BENEFICIOS.**

1. Apellido:_________________________ Primer nombre:_________________________ Inicial del segundo nombre:_______________
2. Género: ☐ M ☐ F ☐ X   3. Fecha de nacimiento:______/_____/______
4. Diagnóstico/Análisis:____ Código de diagnóstico:__________________
   a. Síntomas del demandante:____
   ____
   b. Hallazgos objetivos:____
   ____
5. ¿El demandante fue hospitalizado?: ☐ Sí ☐ No   Desde:______/_____/______   Hasta:______/_____/______
6. ¿Se indicó operación? ☐ Sí ☐ No   a. Tipo ______________________________   b. Fecha______/_____/______

7. INGRESE LAS FECHAS PARA LO SIGUIENTE	MES	DÍA	AÑO
a. Fecha de su primer tratamiento para esta discapacidad			
a. Fecha de tratamiento más reciente para esta discapacidad			
c. Fecha en la que el Demandante no pudo trabajar debido a esta discapacidad			
d. Fecha en la que el Reclamante podrá trabajar nuevamente (Incluso si existe duda considerable, estimar una fecha. Evitar usar términos tales como desconocido o indeterminado.)			
e. Si está relacionada con el embarazo, por favor marcar la casilla e ingresar la fecha estimada ☐ de parto O ☐ la fecha real de parto			

8. En su opinión, ¿es esta discapacidad el resultado de una lesión que surge del y en el curso del empleo o una enfermedad ocupacional?:
   ☐ Sí ☐ No   Si la respuesta es “Sí”, ¿Se ha completado el formulario C-4 con la Junta? ☐ Sí ☐ No

Certifico que soy un:

______________________	______________________	______________________
(Médico, Quiropráctico, Dentista, Podiatra, Psicólogo, Enfermero-Partero)	**Licenciado o Certificado en el Estado de**	**Número de licencia**

______________________	______________________	______________________
Nombre en letra de imprenta del Proveedor de Atención Médica	**Firma del Proveedor de Atención Médica**	**Fecha**

______________________	______________________
Dirección del Proveedor de Atención Médica	**N.º de teléfono:**

NOTIFICACIÓN IMPORTANTE AL DEMANDANTE - LEER ESTAS INSTRUCCIONES CON ATENCIÓN

POR FAVOR TENER EN CUENTA: No fecha y presente este formulario antes de su primera fecha de discapacidad. Para que su reclamo pueda ser procesado, deben estar completas las Partes A y B.

1. Si está usando este formulario porque quedó discapacitado mientras estaba empleado o quedó discapacitado **dentro de las cuatro (4) semanas luego de la finalización de su empleo**, su reclamo completo deberá enviarse por correo dentro de los **treinta (30) días de su primera fecha de discapacidad a su empleador o a la aseguradora de su último empleador.** Podrá encontrar la aseguradora por discapacidad de su empleador en el sitio web de la Junta de Compensación Obrera, www.wcb.ny.gov, usando la búsqueda de cobertura del empleador.
2. Si está usando este formulario debido a que quedó discapacitado **luego de haber estado desempleado durante más de cuatro (4) semanas**, su reclamo completo DEBE ser enviado por correo a: **Junta de Compensación Obrera. Disability Benefits Bureau, PO Box 9029, Endicott, NY 137619029** Si respondió "sí" a la pregunta 13.B.3, por favor complete y adjunte el formulario DB-450.1.

Si no recibió una respuesta dentro de los 45 días o si tiene preguntas acerca de su reclamo por beneficios por discapacidad, por favor llame a la aseguradora de su empleador. Para información general acerca de beneficios por discapacidad, por favor visite www.wcb.ny.gov o llame a la Oficina de Beneficios por Discapacidad de la Junta al (877) 632-4996.

Notificación de conformidad con la Ley de Protección de Privacidad de Nueva York (Ley de Funcionarios Públicos, artículo 6-A) y la Ley de Privacidad Federal de 1974 [Título 5 del Código de los Estados Unidos, (United States Code, U.S.C.), sección 552a]. La autoridad de la Junta de Compensación Obrera (Junta) para solicitar que el demandante lesionado proporcione la información personal, incluido su número de seguro social, se deriva de la autoridad investigadora de la Junta de conformidad con la Ley de Compensación Obrera (Worker's Compensation Law, WCL), § 20 y su autoridad administrativa de acuerdo con la WCL, § 142. Esta información es recolectada para ayudar a la junta a investigar y administrar los reclamos de la manera más conveniente posible y para ayudarla a mantener los registros de reclamos precisos. Proporcionar su número de seguro social a la Junta es voluntario. No hay penalidad por no proporcionar su número de seguro social en este formulario; no traerá como consecuencia una denegación de su reclamo o una reducción en los beneficios. La junta protegerá la confidencialidad de toda la información personal en su posesión y la divulgará solo en cumplimiento de sus deberes oficiales de acuerdo con las leyes estatales y federales

NOTIFICACIÓN DE HIPAA (LEY DE TRANSFERENCIA Y RESPONSABILIDAD DE SEGURO MÉDICO (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, HIPAA): Para adjudicar un reclamo de compensación obrera o de discapacidad, la WCL-13-a(4)(a) y 325-1.3 del título 12 de NYCRR requieren que los proveedores de atención médica completen de manera regular informes médicos de tratamiento para la Junta y la aseguradora o empleador. Conforme a 164.512 del título 45 de CFR, estos informes médicos legalmente requeridos están exentos de las restricciones de la HIPPA con respecto a la divulgación de información de salud.

Divulgación de información: La Junta no divulgará ninguna información acerca de su caso a ninguna parte no autorizada sin su consentimiento. Si elige que se divulgue dicha información a una parte no autorizada, deberá presentar con la Junta un Formulario OC-110A original firmado "Autorización del Demandante a Divulgar Registros de Compensación Obrera". Este formulario se encuentra disponible en el sitio web de la WCB (**www.wcb.ny.gov**) y puede accederse haciendo clic en el enlace "Forms" (Formularios). Si no tiene acceso a internet, por favor llame al (877) 632-4996 o visite nuestro Centro de Atención al Cliente más cercano para obtener una copia del formulario. En lugar del Formulario OC-110A, podrá también presentar una carta de autorización firmada y notarizada.

Un empleador o aseguradora, o cualquier empleado, agente o persona que A SABIENDAS REALICE UNA DECLARACIÓN O AFIRMACIÓN FALSA como un dato material en el curso de la información, investigación o ajuste de un reclamo por algún beneficio o pago conforme a este capítulo con el fin de evitar la entrega de dicho pago o beneficio SERÁ CULPABLE DE UN DELITO Y ESTARÁ SUJETA A MULTAS IMPORTANTES Y PRISIÓN.

Claimant's Name: ____________________ Social Security #: ____________

New York State Workers' Compensation Board, Disability Benefits Bureau
Form DB-450.1, Claimant's Statement Regarding No Fault or Personal Injury

Instructions to Claimant: Complete this form if you became disabled after having been **unemployed for more than four (4) weeks** and you have indicated on Form DB-450 that your disability may be the result of an injury due to a no-fault motor vehicle accident or the negligence or wrong doing of a third party, i.e. individual, firm, etc.

Section 227 of the Disability Benefits Law provides that the Chair of the Workers' Compensation Board can take a lien, in the amount of benefits paid to you, against the proceeds of any recovery you may receive from a third party, whether by judgement, settlement or otherwise.

The Law provides that you may lose your rights to Disability Benefits and may be required to refund payments already made to you, if you:

1. Accept settlement from a third party in an amount less than the benefits provided by the Disability Benefits Law, without the written consent of the Chair of the Workers' Compensation Board.
2. Sign any waiver or release of your claim against a third party, regardless of whether or not you received any payment.

You must complete this form and submit it with your completed DB-450 so that there will be no delay in the payment of your Disability Benefits.

CLAIMANT'S STATEMENT ABOUT ACCIDENT

1. Date of Accident	2. Location of Accident (**Give Complete Address, City, State, Zip**)

3. Cause of Accident: ☐ Motor Vehicle ☐ Workers' Compensation ☐ Other

4. a. Have you commenced action against such party? ☐ Yes ☐ No
   b. If "No", do you intend to commence such action? ☐ Yes ☐ No
   If "Yes", please provide the name and address of the party (or parties):

5. If you have retained an Attorney, please provide the following information:

Attorney Name and Address	Phone #:

6. Have you received any settlement for injury? ☐ Yes ☐ No
   If "Yes", please provide: Amount of Settlement ($) Date of Settlement:

7. Have you received payment for medical care other than from your own insurance or health plan? ☐ Yes ☐ No
   If "Yes", please provide Name and Address of Insurance Carrier or other party making payment

Motor Vehicle Accident - Complete this Section and attach MV-104, Report of Accident or Police Report of Accident

8. Are you claiming/receiving or intend to claim/receive No-Fault Insurance Benefits? ☐ Yes ☐ No
   Was a commercial vehicle involved: ☐ Yes ☐ No If Yes, are you taking third party action: ☐ Yes ☐ No If "No", please explain.
   Explanation:

Damages for Other Personal Injury Involving Third Party

9. Was this party insured for such action? ☐ Yes ☐ No

Name and Address of Insurance Carrier:	Policy #

10. Were you insured for this accident? ☐ Yes ☐ No

If "Yes", please provide Name and Address of Insurance Carrier	Policy #

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

Claimant's Signature: ____________________ Date: ____________

Nombre del reclamante: ______________________ Número de Seguro Social: ______________

New York State Workers' Compensation Board, Disability Benefits Bureau
Formulario DB-450.1, Declaración del reclamante respecto a un accidente sin culpa o una lesión personal

Instrucciones para el reclamante: Llene este formulario si quedó discapacitado después de haber estado **desempleado durante más de cuatro (4) semanas** e indicó en el Formulario DB-450 que su discapacidad puede ser el resultado de una lesión debida a un accidente de vehículo motorizado sin culpa o a la negligencia o conducta incorrecta de un tercero, es decir, una persona individual, una firma, etc.

La Sección 227 de la Ley de Beneficios por Discapacidad establece que el Presidente de la Junta de Compensación Obrera puede tener un gravamen por la cantidad de beneficios que se le han pagado a usted, contra el producto de cualquier recuperación que usted pueda recibir de un tercero, ya sea por juicio, acuerdo o de otra manera.

La Ley establece que usted podría perder sus derechos a los Beneficios por discapacidad y posiblemente reembolsar los pagos que ya recibió, si:

1. Acepta un acuerdo de un tercero por un monto menor que los beneficios establecidos por la Ley de Beneficios por discapacidad, sin el consentimiento escrito del Presidente de la Junta de Compensación Obrera.
2. Firma cualquier exención o liberación de responsabilidad de su reclamo contra un tercero, independientemente de que usted haya o no recibido algún pago.

Debe completar este formulario y enviarlo con su formulario DB-450 lleno para que no haya ningún retraso en el pago de sus Beneficios por discapacidad.

DECLARACIÓN DEL RECLAMANTE SOBRE EL ACCIDENTE

1. Fecha del accidente	2. Lugar donde ocurrió el accidente (**Dirección completa, ciudad, estado, código postal**)

3. Causa del accidente: ☐ Vehículo motorizado ☐ Compensación de los trabajadores ☐ Otro

4. a. ¿Inició una acción contra tal parte? ☐ Sí ☐ No
   b. Si la respuesta es "No", ¿tiene intención de iniciar esa acción? ☐ Sí ☐ No
   Si su respuesta es "Sí", proporcione el nombre y la dirección de la parte (o las partes):

5. Si contrató a un abogado, proporcione la siguiente información:

Nombre y dirección del abogado	N.° de teléfono:

6. ¿Ha acordado un monto por la lesión? ☐ Sí ☐ No
   Si su respuesta es sí, proporcione: Monto del acuerdo ($) Fecha del acuerdo:

7. ¿Ha recibido pago por atención médica que no sea de su propio seguro o plan de salud? ☐ Sí ☐ No
   Si la respuesta es "Sí", proporcione Nombre y dirección de la compañía de seguros o de otro tercero pagador

Accidente de vehículo motorizado: Llene esta sección y adjunte el formulario MV-104, Informe del accidente o Informe policíaco del accidente

8. ¿Está presentando/recibiendo un reclamo o tiene intención de presentar un reclamo/recibir beneficios de seguro sin culpa? ☐ Sí ☐ No
   Hubo un vehículo comercial implicado: ☐ Sí ☐ No Si la respuesta es "Sí", está tomando una acción de tercero: ☐ Sí ☐ Si la respuesta es "No", explique.
   Explicación:

Daños por otra lesión personal que implica a un tercero

9. ¿Estaba esta parte asegurada para tal acción? ☐ Sí ☐ No

Nombre y dirección de la compañía de seguros:	N.° de póliza

10. ¿Estaba asegurado para este accidente? ☐ Sí ☐ No

Si la respuesta es "Sí", proporcione el nombre y la dirección de la compañía de seguros	N.° de póliza

Por este medio certifico que las afirmaciones anteriores, incluyendo cualquier declaración adjunta son verdaderas y están completas según mi leal saber y entender.

Firma del solicitante: ______________________ Fecha: ______________

NEW YORK STATE OF OPPORTUNITY. | **Workers' Compensation Board**

VOLUNTEER FIREFIGHTER'S CLAIM FOR BENEFITS

SEE REVERSE FOR FILING INSTRUCTIONS

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? (Check one) ☐ Yes ☐ No

W.C.B. CASE NO. (if known)	CARRIER CASE NO. (if known)	CARRIER CODE NO.	DATE OF INJURY	SOCIAL SECURITY NO.

	First Name / Middle Initial / Last Name	Address (Give Number and Street, City, State, Zip Code)	Apt. No.
1. VOLUNTEER FIREFIGHTER			
2. FIRECOMPANY			
3. POLITICAL SUBDIVISION LIABLE FOR BENEFITS			

INFORMATION, REGULAR WORK

4. (a) Marital Status ______________ (b) Gender ☐ M ☐ F ☐ X (c) Date of Birth ____________ (d) Tel. No. ______________
5. Describe in detail your duties in regular employment ______________________________
6. Your work week at time of injury was (check one) ☐ 5 days ☐ 6 days ☐ 7 days ☐ Other ______________
7. Employer's name and address ______________________________

INJURY

8. (a) Were you injured in the line of duty in the jurisdiction of your own ambulance district or political subdivision? ☐ Yes ☐ No
   (b) If you were injured in the line of duty involving assistance call from another locality, give name of other ambulance district or political subdivision ______________________________

PLACE AND TIME

9. Address where injury occurred ______________________________ County ______________
10. Date of injury ______________________________ at ______________ o'clock ________ M

NATURE AND EXTENT OF INJURY

11. State full nature and cause of injury ______________________________
12. Has injury resulted in amputation? ☐ Yes ☐ No If yes, describe ______________________________
13. On what date did you stop work because of this injury? ______________________________
14. Have you returned to work? ☐ Yes ☐ No If yes, give date ______________________________
15. (a) Does injury keep you from work? ☐ Yes ☐ No (b) Have you done any work during your disability? ☐ Yes ☐ No

MEDICAL CARE

16. (a) Did you receive medical care? ☐ Yes ☐ No (b) Are you now receiving medical care? ☐ Yes ☐ No
17. (a) Are you now in need of medical care? ☐ Yes ☐ No (b) Name and address of attending doctor ______________________________
18. If you were treated in a hospital, give name and address ______________________________

VOLUNTEER FIREFIGHTERS' BENEFITS

19. Have you received volunteer firefighters' benefits payments for the injury reported above? ☐ Yes ☐ No
20. Are you now receiving volunteer firefighters' benefits payments? ☐ Yes ☐ No
21. Do you claim further volunteer firefighters' benefits payments? ☐ Yes ☐ No If yes, explain ______________________________

NOTICE

22. Have you given Notice to Liable Political Subdivision of Volunteer Firefighter Injury or Death (Form VF-1) to the political subdivision liable for the payment of your volunteer firefighter benefits? ☐ Yes ☐ No If yes, was such Notice delivered personally? ☐ Yes ☐ No or sent by Registered Mail? ☐ Yes ☐ No If yes, to whom was Notice delivered/sent ______________________________

______________________________ Date ______________
Name of Officer and Political Subdivision

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.

I certify that copy of this was filed with ______________________________
Name of Officer / Title of Officer

______________________________ on ______________________________
Political Subdivision or Ambulance Service Liable for Benefits

Dated ______________________________ Signed by ______________________________ or
Volunteer Firefighter

Signed ______________________________
A person on their behalf, or in case of death, by any one or more of their dependents, or person on their behalf. / Relationship / Telephone No.

THIS CLAIM SHOULD BE FILED WITH THE CHAIR, WORKERS' COMPENSATION BOARD, AS SOON AS POSSIBLE AFTER INJURY IS INCURRED. DO NOT DELAY FILING THIS CLAIM.

WHAT EVERY VOLUNTEER FIREFIGHTER SHOULD KNOW IN CASE OF INJURY IN LINE OF DUTY

A. The law requires every county, city, town, village or ambulance district to:

1. Provide Volunteer Firefighters' Benefits in case of accident or injury in the line of duty.
2. Post a notice of compliance:(a) Giving the name of the insurance carrier, if the community is insured, or (b) Stating that the community is self-insured. *(Look for this notice at your ambulance company headquarters. Advise the Workers' Compensation Board if it is not posted in a conspicuous place. Note: Ambulance Services unaffiliated with a political subdivision are not required to provide coverage under the VAWBL. However, if coverage is provided, a notice of compliance must be posted.)*

B. What You Must Do

1. You must give written notice of injury on Form VF-1 or this Form VF-3 by personal delivery or registered mail WITHIN NINETY DAYS after injury to the designated officer of the political subdivision liable for benefits as follows:

If the political subdivision liable for benefits is a	Then deliver to
a. County ______	a. Clerk of Board of Supervisors
b. City ______	b. Comptroller or Chief Financial Officer
c. Town ______	c. Town Clerk
d. Village ______	d. Village Clerk
e. Fire District ______	e. Secretary

The home county, city, town, village or fire district is liable for the payment of benefits, regardless of whether service was rendered for the home area or for another area under contract or in response to a call for assistance.

2. **Form VF-1 is only a notice of injury or death and not a claim for benefits**. In order to claim benefits, you must file this Form VF-3 no later than two years after injury with: (a) Chair, Workers' Compensation Board (see address below) and (b) The same officer to whom a notice of injury was sent (item B1 above). **If you file Form VF-3 WITHIN NINETY DAYS, it serves as both a notice of injury and a claim for benefits, and you do not need to file Form VF-1**.
3. You should secure medical attention promptly (see item 2 below regarding choice of doctor).
4. Attend the hearing on your case if you are notified to appear before the Workers' Compensation Board.
5. Go back to work as soon as you are able.

C. Your Rights

1. As a volunteer firefighter, you are entitled to benefits if you suffer injury in the line of duty.
2. Generally, you are entitled to be treated by a doctor of your choice, provided they are authorized by the Board. If the political subdivision is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the certified preferred provider organization which has been designated to provide health care services for volunteer firefighters' injuries.
3. You are entitled to be paid for drugs, crutches or any apparatus such as belts, if they are prescribed by your doctor; also for carfares and other necessary expenses going to and from your doctor's office or hospital. You are to secure a bill or receipt for such expenses and present it to the clerk of the county's board of supervisors, comptroller or chief financial officer of the city, clerk of the town or village, secretary of the fire district which is liable for providing volunteer firefighters' benefits, or its insurance carrier for payment. If payment is refused, the bill or receipt should be sent to the Workers' Compensation Board with a statement of fact that payment has been refused.
4. You are entitled to benefits from the first day of disability if your injury keeps you from work, compels you to work at lower wages, or leaves you with impaired eyesight or hearing, serious facial scars, or any permanent injury or stiffness of a finger, hand, toe, foot, leg or arm.
5. You are entitled to an opportunity to be heard on your claim before the Workers' Compensation Board.
6. You are entitled to the repair or replacement of prosthetic devices which are damaged as a result of services performed in the line of duty as a volunteer firefighter. Prosthetic devices include an artificial limb, artificial eye, eyeglasses, contact lens, hearing aid, denture or dental appliance or any surgical appliance required to be worn or used by the volunteer firefighter, but does not include articles considered to be ordinary wearing apparel.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. Sec. 552a).

The Workers' Compensation Board's ("Board") authority to request personal information from claimants is derived from Sections 20 and 142 of the Workers' Compensation Law. This information is collected to assist the Board in processing claims in an efficient manner and to help it maintain accurate claim records.

The Board is strongly committed to protecting the confidentiality of all personal information that it collects. Such information will be disclosed within the agency only to Board personnel and agents in furtherance of their official duties. Personal information will be disclosed outside the agency only in accordance with applicable state and federal law.

The Board's Director of Operations, located at 328 State Street, Schenectady, NY 12305, is primarily responsible for the maintenance of agency records containing personal claimant information.

Failure to provide the information requested on this form will not result in the denial of your claim, but may delay the processing of your claim. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your claim.

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.

Claims 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

IF YOU HAVE QUESTIONS OR NEED ADVICE ABOUT YOUR CLAIM, YOU MAY CALL OR VISIT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.	SI TIENE PREGUNTAS O NECESITA CONSEJO SOBRE SU RECLAMACION, PUEDE LLAMAR O VISITAR LA OFICINA DE LA JUNTA DE COMPENSACION MAS CERCANA A USTED.

BE SURE TO NOTIFY THE APPROPRIATE OFFICE OF THE WORKERS' COMPENSATION BOARD OF ANY CHANGE IN YOUR ADDRESS.

Workers' Compensation Board

VOLUNTEER AMBULANCE WORKER'S CLAIM FOR BENEFITS

SEE REVERSE FOR FILING INSTRUCTIONS

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? (Check one) ☐ Yes ☐ No

W.C.B. CASE NO. (if known)	CARRIER CASE NO. (if known)	CARRIER CODE NO.	DATE OF INJURY	SOCIAL SECURITY NO.

	First Name / Middle Initial / Last Name	Address (Give Number and Street, City, State, Zip Code)	Apt. No.
1. VOLUNTEER AMBULANCE WORKER			
2. AMBULANCE COMPANY			
3. POLITICAL SUBDIVISION			

INFORMATION, REGULAR WORK

4. (a) Marital Status ______ (b) Gender ☐ M ☐ F ☐ X (c) Date of Birth ______ (d) Tel. No. ______
5. Describe in detail your duties in regular employment ______
6. Your work week at time of injury was (check one) ☐ 5 days ☐ 6 days ☐ 7 days ☐ Other ______
7. Employer's name and address ______

INJURY

8. (a) Were you injured in the line of duty in the jurisdiction of your own ambulance district or political subdivision? ☐ Yes ☐ No
   (b) If you were injured in the line of duty involving assistance call from another locality, give name of other ambulance district or political subdivision ______

PLACE AND TIME

9. Address where injury occurred ______ County ______
10. Date of injury ______ at ______ o'clock ______ M

NATURE AND EXTENT OF INJURY

11. State full nature and cause of injury ______
12. Has injury resulted in amputation? ☐ Yes ☐ No If yes, describe ______
13. On what date did you stop work because of this injury? ______
14. Have you returned to work? ☐ Yes ☐ No If yes, give date ______
15. (a) Does injury keep you from work? ☐ Yes ☐ No (b) Have you done any work during your disability? ☐ Yes ☐ No

MEDICAL CARE

16. (a) Did you receive medical care? ☐ Yes ☐ No (b) Are you now receiving medical care? ☐ Yes ☐ No
17. (a) Are you now in need of medical care? ☐ Yes ☐ No (b) Name and address of attending doctor ______
18. If you were treated in a hospital, give name and address ______

VOLUNTEER AMBULANCE WORKERS' BENEFITS

19. Have you received volunteer ambulance workers' benefits payments for the injury reported above? ☐ Yes ☐ No
20. Are you now receiving volunteer ambulance workers' benefits payments? ☐ Yes ☐ No
21. Do you claim further volunteer ambulance workers' benefits payments? ☐ Yes ☐ No If yes, explain ______

NOTICE

22. Have you given Notice to Liable Pol. Subdivision of Vol. Ambulance Worker's Injury or Death (Form VAW-1) to the political subdivision liable for the payment of your vol. ambulance workers' benefits? ☐ Yes ☐ No If yes, was such Notice delivered personally? ☐ Yes ☐ No or sent by Registered Mail? ☐ Yes ☐ No If yes, to whom was Notice delivered/sent ______
______ Date ______
Name of Officer and Political Subdivision

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.

I certify that copy of this was filed with ______
Name of Officer / Title of Officer

______ on ______
Political Subdivision or Ambulance Service Liable for Benefits

Dated ______ Signed by ______ or
Volunteer Ambulance Worker

Signed ______
A person on their behalf, or in case of death, by any one or more of their dependents, or person on their behalf. / Relationship / Telephone No.

THIS CLAIM SHOULD BE FILED WITH THE CHAIR, WORKERS' COMPENSATION BOARD, AS SOON AS POSSIBLE AFTER INJURY IS INCURRED. DO NOT DELAY FILING THIS CLAIM.

WHAT EVERY VOLUNTEER AMBULANCE WORKER SHOULD KNOW IN CASE OF INJURY IN LINE OF DUTY

A. The law requires every county, city, town, village or ambulance district to:

1. Provide Volunteer Ambulance Workers' Benefits in case of accident or injury in the line of duty.
2. Post a notice of compliance:(a) Giving the name of the insurance carrier, if the community is insured, or (b) Stating that the community is self-insured. *(Look for this notice at your ambulance company headquarters. Advise the Workers' Compensation Board if it is not posted in a conspicuous place. Note: Ambulance Services unaffiliated with a political subdivision are not required to provide coverage under the VAWBL. However, if coverage is provided, a notice of compliance must be posted.)*

B. What You Must Do

1. You must give written notice of injury on Form VAW-1 or this Form VAW-3 by personal delivery or registered mail WITHIN NINETY DAYS after injury to the designated officer of the political subdivision liable for benefits as follows:

If the political subdivision liable for benefits is a	Then deliver to
a. County	a. Clerk of Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Ambulance District	e. Secretary

   If a political subdivision is not liable for benefits, file this form with the head of the unaffiliated ambulance service. The home county, city, town, village or ambulance district is liable for the payment of benefits, regardless of whether service was rendered for the home area or for another area under contract or in response to a call for assistance.
2. Form VAW-1 is only a notice of injury or death and not a claim for benefits.
   In order to claim benefits, you must file this Form VAW-3 no later than two years after injury with: (a) Chair, Workers' Compensation Board (see address below) and (b) The same officer to whom a notice of injury was sent (item B1 above). If you file Form VAW-3 WITHIN NINETY DAYS, it serves as both a notice of injury and a claim for benefits, and you do not need to file Form VAW-1.
3. You should secure medical attention promptly (see item 2 below regarding choice of doctor).
4. Attend the hearing on your case if you are notified to appear before the Workers' Compensation Board.
5. Go back to work as soon as you are able.

C. Your Rights

1. As a volunteer ambulance worker, you are entitled to benefits if you suffer injury in the line of duty.
2. Generally, you are entitled to be treated by a doctor of your choice, provided they are authorized by the Board. If the ambulance service or political subdivision is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the certified preferred provider organization which has been designated to provide health care services for volunteer ambulance workers' injuries.
3. You are entitled to be paid for drugs, crutches or any apparatus such as belts, if they are prescribed by your doctor; also for carfares and other necessary expenses going to and from your doctor's office or hospital. You are to secure a bill or receipt for such expenses and present it to the clerk of the county's board of supervisors, comptroller or chief financial officer of the city, clerk of the town or village, secretary of the ambulance district or to the ambulance service which is liable for providing volunteer ambulance workers' benefits, or its insurance carrier for payment. If payment is refused, the bill or receipt should be sent to the Workers' Compensation Board with a statement of fact that payment has been refused.
4. You are entitled to benefits from the first day of disability if your injury keeps you from work, compels you to work at lower wages, or leaves you with impaired eyesight or hearing, serious facial scars, or any permanent injury or stiffness of a finger, hand, toe, foot, leg or arm.
5. You are entitled to an opportunity to be heard on your claim before the Workers' Compensation Board.
6. You are entitled to the repair or replacement of prosthetic devices which are damaged as a result of services performed in the line of duty as a volunteer ambulance worker. Prosthetic devices include an artificial limb, artificial eye, eyeglasses, contact lens, hearing aid, denture or dental appliance or any surgical appliance required to be worn or used by the volunteer ambulance worker, but does not include articles considered to be ordinary wearing apparel.

Notification Pursuant to the New York Personal Privacy Protection Law
(Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).
The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

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.

INSTRUCTIONS: Claims 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

IF YOU HAVE QUESTIONSOR NEED ADVICE ABOUT YOUR CLAIM,YOU MAY CALL OR VISIT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.	SI TIENE PREGUNTAS O NECESITA CONSEJO SOBRE SU RECLAMACION, PUEDE LLAMAR O VISITAR LA OFICINA DE LA JUNTA DE COMPENSACION MAS CERCANA A USTED.

BE SURE TO NOTIFY THE APPROPRIATE OFFICE OF THE WORKERS' COMPENSATION BOARD OF ANY CHANGE IN YOUR ADDRESS.

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

CHECK ONE
☐ **NOTICE OF RETAINER AND APPEARANCE** ☐ **NOTICE OF RETAINER AND APPEARANCE - APPELLATE ATTORNEY**
☐ **NOTICE OF SUBSTITUTION AND APPEARANCE** (For substitutions, item C MUST also be completed.)

WCB Case No.	Social Security No.	Date of Injury/Illness, Paid Family Leave ("PFL") Start Date, or PFL Discrimination Complaint Date		Interpreter Required at Hearing ☐ / Specify Language

	Name	Address
Claimant		
Employer*		
Insurer		
Attorney or Representative		

Representative's ID No.	Telephone No. of Atty/Rep.	*If claim is made under the Volunteer Firefighters' Benefit Law or the Volunteer Ambulance Workers' Benefit Law, show as EMPLOYER the liable political subdivision and enter "X" in the appropriate box.. ☐ VFBL ☐ VAWBL

A. CLAIMANT COMPLETE THIS SECTION

CHECK ONE:

☐ Please take notice that I have retained the above-named firm/individual to represent me in all proceedings concerning my claim.

☐ Please take notice that I have retained the above-named firm/individual to represent me in my appeal to the Supreme Court, Appellate Division, Third Department, or the Court of Appeals.

☐ Please take notice that in place of ________________________________ I have retained the above-named to represent and appear for me in all proceedings concerning my claim.

My claim is under the ☐ Workers' Compensation Law ☐ Volunteer Firefighter's Benefit Law ☐ Volunteer Ambulance Workers' Benefit Law ☐ Disability Benefits Law ☐ Section 120/241 WCL - Discharge or Discrimination Complaint ☐ Paid Family Leave Law

I hereby authorize the above-named attorney/representative to request and obtain copies of any necessary medical records connected with the Workers' Compensation Board (WCB) case indicated above. In addition, I consent to the transmittal of all medical reports in this case from my health provider(s) to my attorney/representative. I understand and agree that a licensed representative may appear on my behalf at the request of my attorney.

I have also attached a fully executed Form OC-110A (Claimant's Authorization to Disclose Workers' Compensation Records) authorizing the above-named attorney/representative to access the following workers' compensation case file(s) maintained by the NYS WCB (list by number):

____

Claimant's Signature (Ink Only - Use Blue Ink If Possible)________________________________ Date ________________

B. ATTORNEY/REPRESENTATIVE COMPLETE THIS SECTION

I agree to represent the above-named claimant in compliance with the aforementioned Law and Rules and Regulations promulgated thereunder and hereby notice my retention in the above case. All notices, decisions and other documents are to be sent to the undersigned unless otherwise indicated below. It is understood that the only fees to be paid in this case are those fixed by the WC Law Judge, the Board, the Conciliator or designated employee of the Chair.

I am (CHECK ONE):

☐ An Attorney at Law ☐ A Licensed Representative with Fee--License No.__________ ☐ A Licensed Representative without Fee--License No.__________

Signature of Attorney/Representative ________________________________ Date ________________

ATTORNEY OR REPRESENTATIVE WHO IS TO APPEAR, IF OTHER THAN YOURSELF

Name____________________Address____________________________Tel.No.______________will appear in this case. All notices, decisions and other documents should be sent to (him, her or them). Fees, if any should be made payable to:

Name____________________ Address____________________________Tel. No.______________

C. FOR SUBSTITUTION ONLY - ATTORNEY/REPRESENTATIVE COMPLETE THIS SECTION

A copy of this notice of substitution was served on the ______________day of ______________________,20__________, on

________________________________ ________________________________

Name of Former Attorney or Representative — Address

D. REQUEST AND NOTICE TO HEALTH PROVIDER

Pursuant to Section 13(f) of the Workers' Compensation Law, please transmit copies of all your medical reports to me as the claimant's representative.

Signature of Attorney or Representative appearing for claimant ________________________________

Please Note: A photocopy of this notice shall be deemed as effective as an original.

E. CERTIFICATION OF TRANSMITTAL OF THIS NOTICE TO INSURANCE CARRIER/SELF-INSURED EMPLOYER/EMPLOYER

I hereby certify that a copy of this notice was transmitted to the insurance carrier, self-insured employer or employer named above as required by law (see instructions below).

________________________________ ________________

Signature of Attorney or Representative — Date

NOTICE TO ATTORNEY OR REPRESENTATIVE:

1. This form may be used by an **original, substituted or additional** attorney or representative. Check appropriate box on top of form.
2. Send a copy of this form to **all** of the claimant's health providers, if applicable.
3. A copy of this form **must** be sent to the workers' compensation insurance carrier, self-insured employer or employer (see section E above).

RULES AND PROCEDURE OF THE WORKERS' COMPENSATION BOARD

12NYCRR 300.17 Notices of Retainer, Appearance and Substitution, and Fees of Claimant's Attorney or Licensed Representative

§ 300.17 Notices of retainer, appearance, substitution and withdrawal, and fees of claimant's attorney or licensed representative.

In the representation of a claimant before the board or a Workers' Compensation Law Judge in any case:

a. An attorney or licensed representative shall file a notice of retainer and appearance, and, when appropriate, a notice of substitution, in the format prescribed by the chair, immediately upon being retained. The attorney or licensed representative shall also transmit a copy of such notice to the insurance carrier, self-insured or other representative of the employer at the time of filing.

b. 1. An attorney or licensed representative, substituted for a former attorney or licensed representative, shall immediately upon being retained serve the former attorney or licensed representative with a copy of the notice of substitution.

   2. An attorney or licensed representative may withdraw from representation of a claimant when (i) a notice of substitution has been filed; or (ii) a withdrawal of representation completed in the format prescribed by the Chair has been filed and approved by a Workers' Compensation Law Judge or conciliator. Failure to obtain the approval of a Workers' Compensation Law Judge or conciliator prior to ceasing representation of a claimant, when a notice of substitution has not been filed, will constitute the basis of a referral for a violation of Rule 1.16 of the Rules of Professional Conduct (22 NYCRR 1200.0) for an attorney, and may be the basis for license revocation of a licensed representative.

c. No fee shall be approved or fixed, in accordance with subdivision (f) of this section, for the services of any such attorney or licensed representative who has failed or neglected to serve and file the required notice of retainer and appearance, the required notice of substitution, or obtained approval of a withdrawal of representation as required in subparagraph (2) of subdivision (b) herein.

d. 1. An attorney or licensed representative shall file an application]in the format prescribed by the Chair in each instance where a fee is requested pursuant to sections 24 and 24-a of the Workers' Compensation Law, except that where the fee requested is not more than $1000, the attorney or licensed representative may, in lieu of such written application, make an oral statement on the record as to the services rendered and the time spent for the performance of such services. Notwithstanding the foregoing, the board may require an application in the format prescribed by the Chair for a fee of $1000 or less. Any fee application shall be accurately completed.

   2. All fees awarded at a hearing are to be made in the presence of the claimant, except that the Workers' Compensation Law Judge may, in his or her discretion, waive this requirement if the amount of the fee requested is not more than $1000, provided that the attorney or licensed representative makes a statement on the record as to the services rendered and the time spent for the performance of such services.

   3. In any case where the claimant is not present and the amount of the fee requested is more than $1000, the claimant must be advised of the amount requested by the attorney or licensed representative 10 days in advance of the awarding of a fee. The fee application shall contain a statement signed by the claimant indicating that he or she has reviewed the fee request with the attorney or licensed representative, has no objection to the requested fee, and understands that any approved fee will be deducted from the award, or the attorney or licensed representative shall, together with the fee application, submit written explanation as to why the signature was not obtained. If the board finds insufficient excuse for failure to obtain the written signature, the fee application may be considered defective. Proof of service by mail or otherwise on the copy of the fee application prescribed by the chair and filed with the board, may be accepted as evidence that the claimant has been so advised.

e. Whenever a fee is requested in excess of $1000 for services rendered in conciliation, administrative determination, agreement pursuant to section 32 of the Workers' Compensation Law, or conference calendar processing, the request is to be made in the format prescribed by the Chair in each instance where a fee is requested. Such fee request shall be itemized as to the services performed in the time since any prior fee request was submitted and the time spent for each service, with a total amount of time spent. Failure to sufficiently itemize services or time spent on services may be the basis for reducing or denying the fee request. The claimant must be advised of the amount requested, the service rendered and the time spent for the performance of the services by the attorney or licensed representative 10 days prior to the awarding of a fee. Proof of service by mail or otherwise on the copy of the fee request filed with the board, may be acceptable as evidence that the claimant has been so advised. Fees awarded in conciliation, administrative determination, agreement pursuant to section 32 of the Workers' Compensation Law, or conference calendar processing, may be approved by a conciliator or designee of the chair.

f. Whenever an award is made to a claimant who is represented by an attorney or a licensed representative, and a fee is requested, the board in such case shall approve a fee in an amount commensurate with the services rendered and having due regard for the financial status of the claimant and whether the attorney or licensed representative engaged in dilatory tactics or failed to comply in a timely manner with board rules. Unbecoming or unethical conduct by an attorney or licensed representative may result in reduction or denial of a fee request. In no case shall the fee be based solely on the amount of the award.

g. Whenever an attorney or licensed representative is notified, by notice of substitution or otherwise, that the claimant has terminated his or her retainer, the attorney or licensed representative, in each instance where a fee is requested for services rendered for which no previous fee has been approved, shall file an application for such final fee in the format prescribed by the Chair, within thirty days of the filing of the notice of substitution, and serve a copy upon the claimant. The claimant must be advised of the amount requested, the service rendered and the time spent for the performance of the services by the attorney or licensed representative, 10 days prior to the awarding of a fee. Proof of service by mail or otherwise on the copy of a fee request filed with the board, may be acceptable as evidence that the claimant has been so advised. Where the fee requested is not more than $1000, the attorney or licensed representative may make an oral statement on the record as to the services rendered and the time spent for the performance of such services, at the first hearing held following notice to such attorney or licensed representative that the retainer has been terminated.

h. No fee shall be awarded to a claimant's attorney or licensed representative unless the attorney or licensed representative has complied with the requirements of this section.

i. The Chair may require that an attorney or licensed representative with access via the internet to his or her client's electronic case folder receive Board notices via an electronic mailbox.

It is unlawful to disclose individually identifiable information from Workers' Compensation Board records to any person who is not otherwise lawfully authorized to obtain these records. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates Workers' Compensation Law Section 110-a shall be guilty of a Class A misdemeanor and shall be subject upon conviction to a fine of not more than one thousand dollars.

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

Customer Service: (877) 632-4996

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

APPLICATION FOR REOPENING OF CLAIM, MORE THAN SEVEN YEARS AFTER ACCIDENT

NOTICE: This form must be filed immediately with the Chair, Workers' Compensation Board, together with attending doctor's report (Form C-27) if required, at the district office where the case was closed. Information on reverse side must be completed.

ANSWER ALL QUESTIONS FULLY - PRINT OR TYPE CLEARLY

WCB Case No. ____________ Date of Accident ____________ Claimant's Social Security No. ____________

1. Name of injured ____________ Gender ◯ M ◯ F ◯ X Date of Birth ____________

   Present address ____________ Apt. No. ____________

2. Employer (at time of accident) ____________

   Address ____________

3. When did you last work for this employer? ____________

4. Name of present attending doctor ____________

   Address ____________

5. If injured employee is deceased, give date of death ____________

6. Nature of injury ____________

7. State specific reasons why you desire reopening of your case ____________

8. RECORD OF MEDICAL TREATMENT SINCE THE ACCIDENT (List all doctors and hospitals):

Doctor or Hospital	Address	Period	
		From	To
		From	To
		From	To

9. Were you originally provided with any apparatus or appliances for your injury or furnished with treatment at the time of the accident? .... ☐ Yes ☐ No

   (a) If "Yes," who provided and paid for it? ____________

   (b) Has such apparatus been replaced or repaired? .... ☐ Yes ☐ No

   (c) If "Yes," by whom and on what date? ____________

10. Has any medical or surgical treatment or hospital care been furnished to you by employer or insurance carrier within the last 8 years? .... ☐ Yes ☐ No

11. Has apparatu sor artificial appliance been furnished or repaired by employer or insurance carrier within the last 8 years? .... ☐ Yes ☐ No

12. Did you sue anyone other than filing for compensation as a result of your accident?.......... ☐ Yes ☐ No
    If "Yes," provide the following:

    Name and address of attorney ____________

    Date settled ____________ Amount of Settlement: $ ____________
    Submit copy of settlement papers, if available.

(Complete the information on the reverse side)

13. Has any compensation been paid to you within the past 8 years?... ☐Yes ☐No
If "Yes," give the following information:
(a) When was last payment made? ______
(b) By whom? ______
(c) Were you given lighter duties?... ☐Yes ☐No
(d) If Yes to (c), were benefits received for reduced earnings?... ☐Yes ☐No

14. Have you sustained any other injury since the closing of your case?... ☐Yes ☐No
If "Yes," state the following:
(a) Nature of such injury ______
(b) Date of accident ______
(c) Name of the employer ______
(d) W .C.B. Case Number ______
(e) Last date of hearing ______

15. Are you currently working?.. ☐Yes ☐No
If If you **are not** currently working, are you retired?... ☐Yes ☐No
you **are** currently working, give the following information:
(a) Name of latest employer ______
Address ______
Employer's NYS U.I.Registration No. (if known) ______
(b) When did present period of disability begin? ______ (Date)
(c) Give first and last date you worked on the job immediately preceding present disability:
First day worked ______ Last day worked ______
(d) Are you receiving disability benefits for your present period of disability?.................................. ☐Yes ☐No
If "Yes," from whom? ______

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.

Claimant's Signature ______ Telephone No. ______ Dated ______

Mail Address ______

IMPORTANT
Authorization must be received from the Chair, Workers' Compensation Board, before securing medical treatment or supplies. Otherwise, claimant will be responsible for said medical treatment or supplies.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).
The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

IF YOU HAVE QUESTIONS OR NEED ADVICE ABOUT YOUR CLAIM, YOU MAY CALL OR VISIT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.
SI USTED TIENE ALGUNAS PREGUNTAS O NECESITA CONSEJO SOBRE SU RECLAMACION, USTED PUEDE LLAMAR O VISITAR LA OFICINA DE LA JUNTA DE COMPENSACION MAS CERCANA A USTED.

Atención al cliente: (877) 632-4996

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACIÓN OBRERA

ESTA AGENCIA EMPLEA Y SIRVE A PERSONAS CON DISCAPACIDADES SIN DISCRIMINACIÓN.

SOLICITUD PARA LA REAPERTURA DE UN RECLAMO, MÁS DE SIETE AÑOS DESPUÉS DEL ACCIDENTE

NOTIFICACIÓN: Este formulario deberá presentarse de inmediato ante el Presidente, la Junta de Compensación Obrera Workers' Compensation Board, WCB), junto con el informe del médico tratante (Formulario C-27) si se requiere, en la oficina de distrito en donde se cerró el caso. Se debe completar la información en el reverso.

RESPONDA TODAS LAS PREGUNTAS DE MANERA COMPLETA - IMPRIMA O TIPEE CON CLARIDAD

Nro. de caso de la WCB ______ Fecha del accidente ______ N.º del Seguro Social del Demandante ______

1. Nombre de la persona lesionada ______ Género ○M ○F ○X Fecha de nacimiento ______

   Dirección actual ______ Depto. N.º ______

2. Empleador (al momento del accidente) ______

   Dirección ______

3. ¿Cuándo trabajó por última vez para este empleador? ______

4. Nombre del médico tratante actual ______

   Dirección ______

5. Si el empleado lesionado falleció, indique la fecha de defunción ______

6. Naturaleza de la lesión ______

7. Establezca razones específicas por las que desea reabrir su caso ______

8. REGISTRE EL TRATAMIENTO MÉDICO DESDE EL ACCIDENTE (Enumere todos los médicos y hospitales):

Médico u Hospital	Dirección	Período
		Desde ______ hasta ______
		Desde ______ hasta ______
		Desde ______ hasta ______

9. ¿Se le suministró algún aparato o dispositivo para su lesión o se le entregó con el tratamiento al momento de su accidente? ☐Sí ☐No

   (a) Si responde "Sí", ¿quién lo suministró y quién lo pagó? ______

   (b) ¿Se ha reemplazado o reparado dicho aparato? ☐Sí ☐No

   (c) Si responde "Sí", ¿quién y en qué fecha? ______

10. ¿Su empleador o aseguradora le suministraron algún tratamiento médico o quirúrgico u atención en el hospital durante los últimos 8 años? ☐Sí ☐No

11. ¿Su empleador o aseguradora le suministraron o repararon algún aparato o dispositivo artificial durante los últimos 8 años? ☐Sí ☐No

12. ¿Demandó a alguien más además de presentar un reclamo por compensación como resultado de su accidente? ☐Sí ☐No
    Si responde "Sí", indique lo siguiente:

    Nombre y dirección del abogado ______

    Fecha de conciliación ______ Importe de la conciliación: $ ______

    Presente copia de los documentos de la conciliación, si los tiene disponibles.

(Complete la información en el reverso)

13. ¿Se le pagó alguna compensación durante los últimos 8 años? ☐Sí ☐No
Si responde "Sí", brinde la siguiente información:
(a) ¿Cuándo se hizo el último pago? ____________
(b) ¿Quién lo hizo? ____________
(c) ¿Se le asignaron tareas más livianas? ☐Sí ☐No
(d) Si responde Sí a (c), ¿recibió beneficios por la reducción en sus ingresos? ☐Sí ☐No

14. ¿Sufrió alguna otra lesión desde que su caso se cerró? ☐Sí ☐No
Si responde "Sí", indique lo siguiente:
(a) Naturaleza de la lesión ____________
(b) Fecha del accidente ____________
(c) Nombre del empleador ____________
(d) Número de caso de la Junta de Compensación Obrera ____________
(e) Fecha de la última audiencia ____________

15. ¿Trabaja actualmente? ☐Sí ☐No
Si **no** trabaja actualmente ¿está retirado? ☐Sí ☐No
Si **trabaja** actualmente, brinde la siguiente información:
(a) Nombre de su último empleador ____________
Dirección ____________
N.º de registro U.I de NYS del Empleador (si lo conoce) ____________
(b) ¿Cuándo comenzó el período de discapacidad actual? ____________ (Fecha)
(c) Indique la primera y última fecha en la que trabajó en ese puesto antes de la discapacidad actual:
Primer día trabajado ____________ Último día trabajado ____________
(d) ¿Recibe beneficios por discapacidad por su período de discapacidad actual? ☐Sí ☐No
Si responde "Sí", ¿de quién? ____________

CUALQUIER PERSONA QUE DELIBERADAMENTE TENGA INTENCIÓN DE DEFRAUDAR A LAS CAUSAS A SER PRESENTADAS O PREPARE CON CONOCIMIENTO O CREENCIA DE QUE SERÁ PRESENTADA POR UNA ASEGURADORA O AUTOASEGURADORA, CUALQUIER INFORMACIÓN QUE CONTENGA DECLARACIONES MATERIALMENTE FALSAS U OCASIONE CUALQUIER HECHO MATERIAL SERÁ CULPABLE DE UN DELITO Y ESTARÁ SUJETO A MULTAS IMPORTANTES Y PRISIÓN.

Firma del Demandante ____________ N.º de teléfono ____________ Fecha ____________

Dirección de correo ____________

IMPORTANTE

Se debe recibir autorización del Presidente de la Junta de Compensación Obrera antes de obtener tratamiento médico o suministros. De lo contrario, el demandante será responsable por dichos tratamientos médicos o suministros.

Notificación de conformidad con la Ley de Protección de Privacidad de Nueva York (Ley de Funcionarios Públicos, artículo 6-A) y la Ley de Privacidad Federal de 1974 (Art. 441a del título 5 del U.S.C.).
La autoridad de la Junta de Compensación Obrera (Junta) para solicitar que el demandante lesionado proporcione la información personal, incluido su número de seguro social, se deriva de la autoridad investigadora de la Junta de conformidad con la Ley de Compensación Obrera (Worker's Compensation Law, WCL), § 20 y su autoridad administrativa de acuerdo con la WCL, § 142.
Esta información es recolectada para ayudar a la junta a investigar y administrar los reclamos de la manera más conveniente posible y para ayudarla a mantener los registros de reclamos precisos. Proporcionar su número de seguro social a la Junta es voluntario.
No hay penalidad por no proporcionar su número de seguro social en este formulario; no traerá como consecuencia una denegación de su reclamo o una reducción en los beneficios. La junta protegerá la confidencialidad de toda la información personal en su posesión y la divulgará solo en cumplimiento de sus deberes oficiales de acuerdo con las leyes estatales y federales

IF YOU HAVE QUESTIONS OR NEED ADVICE ABOUT YOUR CLAIM, YOU MAY CALL OR VISIT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.
SI TIENE ALGUNA PREGUNTA O NECESITA CONSEJO CON RESPECTO A SU RECLAMO, PUEDE LLAMAR O VISITAR LA OFICINA MÁS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA

REQUEST FOR ASSISTANCE BY INJURED WORKER

This form is not to be used to report an injury. To file a claim, use Form C-3.

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: __________ WCB Case #: ______________

Injured Worker Information

☐ Check if new address

Last Name: ______________________ First Name: ______________________ MI: __

Mailing Address: ______________________ Line 2: ______________________

City: ______________ State: __________ Zip Code: ________ Country: __________

Daytime phone #: ______________________ Email Address: ______________________

Social Security #: ______________ Date of Birth: __________ Gender: ☐ M ☐ F ☐ X

Employer Information

Employer Name: ____

Mailing Address: ______________________ Line 2: ______________________

City: ______________ State: __________ Zip Code: ________ Country: __________

Employer Phone: ______________ Federal Tax ID #: __________ The Tax ID # is the (check one): ☐ SSN ☐ EIN

Reason for this Request - Instructions:

Instructions: Check all boxes that apply. Be sure to attach additional forms, medical reports, letters, etc. as required for each checkbox. If the additional information was already submitted do not attach it, but try to identify it in the space at the bottom of this form** by giving the form number or title and the date it was submitted to the Board. Sign and date the form below**.**

Compensation Payments:

☐ a. I am not working as of ______________ and not receiving payments. **Medical documentation indicating disability required.**
Check all that apply:
- ☐ I have filed a claim for a work related injury.
- ☐ My employer is not paying my wages.
- ☐ My claim has not been denied.
- ☐ I have not received a decision barring me from compensation.
- ☐ I have attempted to resolve the issue with the insurer.

☐ b. My payments have been stopped or reduced.

☐ c. I have returned to work as of ______________at full pay.

☐ d. I am making less money than I was before I got hurt. **Attach current pay stub and medical reports from your doctor.**

☐ e. I had two or more employers on the date of accident/injury (concurrent employment).
Attach weekly gross pay before your injury and statement from second employer regarding lost time.

☐ f. I was released from incarceration on ______________ and am not receiving payments.
Attach medical report that shows a medical disability and release from custody papers.

☐ g. I have not been paid as directed in the decision filed on ______________

Medical Issues:

☐ h. My Prior Authorization Request (PAR) was denied by the insure**r. Attach PAR denial**.
Review by WCB Adjudication can only be requested if:
- ☐ Denial category was Administrative or No Jurisdiction.
  Attach any documents that show why the denial was incorrect.
- ☐ MTG Special Services or MTG Variance PAR was denied for Medical reasons. (medical provider is not seeking MDO review)
- ☐ Non-MTG Over $1,000 PAR was granted in part.

☐ i. My Prior Authorization Request (PAR) was denied by the Medical Director's Office and my health care provider is not permitted to request review. **Attach "Notice of Resolution" regarding treatment.**

☐ j. My disability is now permanent. **Attach Doctor's Report of MMI/Permanent Impairment (Form C-4.3).**
- ☐ Check this box if you were under 25 years of age at time of accident.

☐ k. My medical condition has changed. **Attach medical forms.**

☐ l. My request for medical and transportation reimbursement was denied or has not been addressed. **Attach receipts and Form C-257**.

This form and any attachments must be mailed or emailed to the Workers' Compensation Board.

Other Issues:

☐ m. I have new information and/or information requested by the Board regarding (**Attach documents**):

☐ n. Other (Explain in the space provided below):

****Document reference information (date, name/title, form ID):** ______________________________

Injured Worker Signature: ______________________________ **Date:** ______________

This form and any attachments must be mailed or emailed to the Workers' Compensation Board.

To the Injured Worker - General Information On Using This Form

You may file this form (RFA-1W) and any attachments with the Workers' Compensation Board when you want the Board to take a specific action in your claim, or if you need to alert the Board to any problem or situation that is affecting your claim. Many of the most frequently requested actions/situations are listed as either compensation payment issues (items a through g), or medical issues (items h through l), but you are not limited to those listed. Check all that apply and/or add additional information or explanation in the space provided (m or n).

Complete the identifying information at the top of Form RFA-1W and send the form, WITH ALL APPLICABLE INFORMATION ATTACHED*, to:

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

Address for Email Filing: wcbclaimsfiling@wcb.ny.gov

The Board will contact you and all parties when it takes action on your claim.

*After each check box you will see the information needed in bold letters. For example, if you are letting the Board know that your disability is now permanent (box j), the information required is, Doctor's Report of MMI/Permanent Impairment (Form C-4.3).

YOU MUST SEND A COPY OF THIS FORM TO THE INSURER(S), OR DIRECTLY TO THE EMPLOYER OR ITS THIRD PARTY ADMINISTRATOR IF THE EMPLOYER IS SELF-INSURED.

If you have any other concerns, you may contact the Board's **ADVOCATE FOR INJURED WORKERS at (800) 580-6665.** Additional information about other Board services may be obtained at the Board's website: **www.wcb.ny.gov.** If you would like to follow your claim online, you can register for eCase using the registration instructions available on the Board's website under the eCase link.

You have the right to legal representation. A lawyer cannot charge you directly for representation in a workers' compensation claim. If there is an award in your claim, any legal fee request must be approved by the Board and will be deducted from the award to you by the insurer and paid directly to the lawyer.

Medical Treatment - Medication/Durable Medical Equipment/Treatment/Test - This form is to be used when a medical request has been denied and you are requesting assistance from the Board regarding one of the reasons listed in box h. If prior authorization has not been requested yet and is required, your health care provider must submit a Prior Authorization Request (PAR). Information regarding submitting Prior Authorization Requests or unpaid medical bills can be found on the WCB website **www.wcb.ny.gov**.

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.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that injured worker's provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

NEW YORK STATE | Workers' Compensation Board

SOLICITUD DE ASISTENCIA PARA TRABAJADOR LESIONADO

Este formulario no se debe usar para informar sobre una lesión.
Para presentar un reclamo, use el Formulario C-3.

Información del reclamo - TODA COMUNICACIÓN DEBE INCLUIR ESTOS NÚMEROS

Fecha de la lesión o enfermedad: ____________ Número de caso WCB: ____________________

Información del trabajador lesionado

☐ Marcar si tiene una nueva dirección

Apellido: ______________________ Primer nombre: ______________________ Inicial del segundo nombre: ______

Dirección de correo: ______________________ Línea 2: ______________________

Ciudad: ______________ Estado: ____________ Código postal: ________ País: EE. UU.

Número telefónico durante el día: ______________________ Correo electrónico: ______________________

N.º del Seguro Social: ________________ Fecha de nacimiento: ______________ Género: ☐ M ☐ F ☐ X

Información del empleador

Nombre del empleador: ____

Dirección de correo: ______________________ Línea 2: ______________________

Ciudad: ______________ Estado: ____________ Código postal: ________ País: EE. UU.

Número telefónico del empleador: ______________________ Número de identificación fiscal: ______________

El número de identificación fiscal es el (seleccione uno):

☐ Número del Seguro Social (Social Security Number, SNN) ☐ Número de Identificación del Empleador (Employer Identification Number, EIN)

Motivo de esta solicitud - **Instrucciones:** Marque todas las opciones que correspondan. Asegúrese de adjuntar los formularios adicionales, informes médicos, correspondencias, etcétera, según se requiera en cada casilla. Si la información adicional ya se envió, no la adjunte, pero procure identificarlo en el espacio al final de este formulario** mediante el número de formulario o título y la fecha en la que se le envió a la Junta. Firme y feche el formulario abajo.

Pagos por compensación:

☐ a. No trabajo desde el __________ y no estoy recibiendo pagos. **Documentación médica que indique que se requiere discapacidad. Marque todo lo que corresponda:**
- ☐ He presentado un reclamo por una lesión relacionada con el trabajo.
- ☐ Mi empleador no está pagando mis salarios.
- ☐ Mi reclamo no ha sido denegado.
- ☐ No he recibido una decisión que me impida recibir una compensación.
- ☐ He intentado resolver el problema con la aseguradora.

☐ b. He dejado de recibir mis pagos o han sido reducidos.

☐ c. He regresado a trabajar desde el ________________ con el salario completo.

☐ d. Estoy ganando menos dinero del que ganaba antes de lesionarme. **Adjunte el talón de pago actual y los informes médicos de su médico.**

☐ e. Tuve dos o más empleadores en la fecha del accidente o lesión (empleo concurrente).
Adjunte el pago bruto semanal antes de su lesión y la declaración del segundo empleador con respecto al tiempo perdido.

☐ f. Fui liberado de prisión el ________________ y no estoy recibiendo pagos.
Adjunte el informe médico que muestre una discapacidad médica y la liberación de los documentos de custodia.

☐ g. No me han pagado como se indicó en la decisión presentada el ______________

Gastos médicos:

☐ h. Mi Solicitud de Autorización Previa (PAR) fue rechazada por la aseguradora. **Adjunte el rechazo de la PAR.**
Solo se puede solicitar la revisión de la WCB si:
- ☐ La categoría de rechazo fue Administrativa o Sin Jurisdicción.
  Adjunte los documentos que prueben por qué el rechazo fue incorrecto.
- ☐ La PAR para servicios especiales de la Guía de Tratamientos Médicos (Medical Treatment Guidelines, MTG) o para la Variación de la MTG fue rechazada por motivos Médicos. (el proveedor médico no busca una revisión de la MDO)
- ☐ La PAR no correspondiente a la MTG de más de $1,000 fue otorgada en parte.

☐ i. Mi Solicitud de Autorización Previa (PAR) fue rechazada por la Oficina del Director Médico (Medical Director' s Office, MDO) y mi proveedor de atención médica no tiene permitido solicitar una revisión. **Adjunte la "Notificación de Resolución" en relación con el tratamiento.**

Este formulario y sus anexos se deben enviar por correo o correo electrónico a la Junta de Compensación Obrera.

☐ j. Mi discapacidad ahora es permanente. **Adjunte el Informe de Mejoría Médica Máxima (Maximum Medical Improvement, MMI)/Discapacidad Permanente del Médico (Formulario C-4.3).**

☐ Seleccione esta casilla si era menor de 25 años de edad al momento del accidente.

☐ k. Mi condición médica ha cambiado. **Adjunte los formularios médicos.**

☐ l. Mi solicitud para reembolso médico y de transporte fue denegada o no ha sido tratada. **Adjunte los recibos y el Formulario C-257.**

Otros asuntos:

☐ m. Tengo información nueva o información solicitada por la Junta relacionada con (**Adjunte los documentos**):

☐ n. Otro (explique en el espacio proporcionado abajo):

****Información de referencia del documento (fecha, nombre y título, identificación del formulario):** ______________________

Firma del trabajador lesionado: ______________________ **Fecha:** ______________

Este formulario y sus anexos se deben enviar por correo o correo electrónico a la Junta de Compensación Obrera.

Para el trabajador lesionado: Información general sobre el uso de este formulario

Puede presentar este formulario (RFA-1W) y cualquier documento adjunto con la Junta de Compensación Obrera cuando desee que la Junta tome una medida específica en su reclamo o si necesita alertar a la Junta sobre cualquier problema o situación que afecte su reclamo. Muchas de las acciones o situaciones más frecuentemente solicitadas se enumeran como problemas de pago de compensación (elementos desde la a hasta la g) o problemas médicos (elementos desde la h hasta la l), pero no están limitadas a dichos elementos enumerados. Seleccione todo lo que corresponda o agregue información o explicaciones adicionales en el espacio proporcionado (m o n).

Complete la información de identificación en la parte superior del Formulario RFA-1W y envíe el formulario CON TODA LA INFORMACIÓN QUE CORRESPONDE ADJUNTA*, a:

Junta de Compensación Obrera
PO Box 5205
Binghamton, NY 13902-5205

Dirección para presentación por correo electrónico: wcbclaimsfiling@wcb.ny.gov

La Junta lo contactará a usted y a todas las partes cuando tome una medida sobre su reclamo.

*Después de cada casilla, verá la información necesaria en negrita. Por ejemplo, si usted le está informando a la Junta que su discapacidad ahora es permanente (casilla j), la información requerida es el Informe de MMI/Discapacidad Permanente del Médico (Formulario C-4.3).

DEBE ENVIAR UNA COPIA DE ESTE FORMULARIO A LA ASEGURADORA O DIRECTAMENTE AL EMPLEADOR O A SU ADMINISTRADOR EXTERNO SI EL EMPLEADOR ES AUTOASEGURADO.

Si tiene otras inquietudes, puede contactar al **ABOGADO PARA TRABAJADORES LESIONADOS de la Junta al (800) 580-6665**. La información adicional sobre otros servicios de la Junta se puede obtener el sitio web de la Junta: **www.wcb.ny.gov**. Si desea hacer seguimiento de su reclamo en línea, puede registrarse en eCase mediante las instrucciones de registro disponibles en el sitio web de la Junta a través del enlace de eCase.

Usted tiene derecho a representación legal. Un abogado no puede cobrarle directamente por la representación en un reclamo por compensación laboral. Si hay una adjudicación en su reclamo, cualquier solicitud de tarifa legal debe ser aprobada por la Junta y la aseguradora la deducirá de la adjudicación y se le pagará directamente al abogado.

Tratamiento médico: Medicamento/Equipo Médico Durable/Tratamiento/Prueba- Este formulario se utiliza cuando se rechazó una solicitud médica y usted solicita asistencia a la Junta en relación con uno de los motivos enumerados en la casilla h. Si aún no se ha solicitado la autorización previa y es un requisito, su proveedor de atención médica debe presentar una Solicitud de Autorización Previa (PAR). Puede encontrar información sobre la presentación de Solicitudes de Autorización Previa o facturas médicas impagas en el sitio web de la WCB **www.wcb.ny.gov**.

CUALQUIER PERSONA QUE DELIBERADAMENTE TENGA INTENCIÓN DE DEFRAUDAR A LAS CAUSAS A SER PRESENTADAS O PREPARE CON CONOCIMIENTO O CREENCIA DE QUE SERÁ PRESENTADA POR UNA ASEGURADORA O AUTOASEGURADORA, CUALQUIER INFORMACIÓN QUE CONTENGA DECLARACIONES MATERIALMENTE FALSAS U OCASIONE CUALQUIER HECHO MATERIAL SERÁ CULPABLE DE UN DELITO Y ESTARÁ SUJETO A MULTAS IMPORTANTES Y PRISIÓN.

Notificación de conformidad con la Ley de Protección de Privacidad de Nueva York (Ley de Funcionarios Públicos, artículo 6-A) y la Ley de Privacidad Federal de 1974 [Título 5 del Código de los Estados Unidos, (United States Code, U.S.C.), sección 552a].
La autoridad de la Junta de Compensación Obrera (Junta) para solicitar que el trabajador lesionado proporcione la información personal, incluido su número de seguro social, se deriva de la autoridad investigadora de la Junta de conformidad con la Ley de Compensación Obrera (Worker' s Compensation Law, WCL), sección 20 y su autoridad administrativa de acuerdo con la WCL, sección 142. Esta información es recolectada para ayudar a la Junta a investigar y administrar los reclamos de la manera más conveniente posible y para ayudarla a mantener los registros de reclamos precisos. Proporcionar su número de seguro social a la Junta es voluntario. No hay penalidad por no proporcionar su número de seguro social en este formulario; no traerá como consecuencia una denegación de su reclamo o una reducción en los beneficios. La Junta protegerá la confidencialidad de toda la información personal en su posesión y la divulgará solo en cumplimiento de sus deberes oficiales de acuerdo con las leyes estatales y federales aplicables.

State of New York
WORKERS' COMPENSATION BOARD

REQUEST FOR FURTHER ACTION BY INSURER/EMPLOYER

This form is submitted by ☐ insurer ☐ self-insurer ☐ Special Funds Group

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS

1. WCB CASE NO.	2. CLAIM ADMIN CLAIM NUMBER	3. INSURER CODE	4. DATE OF INJURY (MM/DD/YY)

	NAME	ADDRESS TO WHICH NOTICES SHOULD BE SENT	
5. CLAIMANT		Check if new address: ☐	APT. NO.
6. EMPLOYER			
7. INSURER			
8. ATTORNEY / LICENSED REP.			ATTY/REP ID NO.

9. **INSTRUCTIONS:** The insurer/employer seeks Board action regarding the claim identified above for the following reasons (**check all that apply**). Please note that the **required documentation** identified below **must be attached** to the form and submitted to the Board or **must be referenced** in the space provided below** (by date, name or title of document, and form ID) if it is already in the Board's electronic file. This form must be submitted to the Workers' Compensation Board by mail, email or Web Upload. Information can be found on the Forms page of the Board's website. A copy of this form and the attachments must be sent to the claimant and claimant's representative if one has been retained. A copy of this form and the attachments must also be sent to the health care provider if item a or b is checked.

Compensation:

☐ a. Continuing payments directed by the Board should be suspended as of ________________ pursuant to 12 NYCRR 300.23(b). *(medical or payroll documentation supporting suspension required)*

☐ b. Continuing payments directed by the Board should be reduced to _________/wk as of ______________ pursuant to 12 NYCRR 300.23(b). *(medical or payroll documentation supporting reduction required)*

☐ c. Payments should be modified as claimant is working at full or reduced earnings as of _________________. *(payroll documentation supporting modification required)*

☐ d. Payments should be suspended as of ________________ as claimant has voluntarily removed him/herself from or is no longer attached to the labor market. *(documentation supporting suspension required)*

☐ e. Payments should be suspended as of _________________ because of disqualification pursuant to WCL § 114-a. *(list of documents or evidence to be produced required)*

Medical Issues:

☐ f. Claimant's disability is now amenable to a facial award or schedule loss of use award. *(medical documentation indicating permanency required)*

☐ g. Claimant's disability is now amenable to a non-schedule award. *(medical documentation indicating permanency required)*

☐ h. Claimant has made an application to reopen a previously established claim seeking additional benefits, and pursuant to 12 NYCRR 300.22 the insurer contends ____
(statement as to the insurer's position on the payment of further benefits required)

☐ i. Opioid Weaning under Non-Acute Pain Guidelines. *(medical documentation indicating weaning goals and recommended weaning program/resource is required)*

☐ j. Request review of MTG Special Services or MTG Variance Prior Authorization that was granted or granted in part by the Medical Director's Office. *(attach "Notice of Resolution" regarding treatment)*

☐ k. Request denial of future treatment that insurer contends is not related to an established site or condition *(insurer must state what treatment is not related, and why)*

____

Other:

☐ l. Parties have entered into a stipulation. (*Form C-300.5 or written stipulation required)*

☐ m. Parties have reached an agreement and seek a Proposed Conciliation Decision. (*Form C-312.5 or proposed findings required)*

☐ n. Claimant has discontinued or settled a lawsuit pertaining to the accident/injury of this claim. *(documents indicating discontinuance, settlement, or closing statement required)*

☐ o. Insurer seeks desk review of Special Funds Group reimbursement decision *Form C-251.6R*. (*Form C-251.6R and all related forms and emails to and from SFG required per SN046-1063R. New evidence may not be submitted*)

☐ p. Insurer has new or requested documentation regarding ______________________ *(documents required)*

Other. (Explain fully in space provided below.)

____

****Document reference information (date, name/title, form ID):** ______________________

I certify that this request for Board action is based upon reasonable grounds, and that this form with attachment(s) has been provided to the opposing party(ies). I also certify that (check one box below):

☐ **I have discussed the issue(s) above with the opposing party(ies) or its representative(s).**
(give name of person contacted) ______________ ***(on date)*** __________ **and that (check one):**
☐ no settlement of the issue(s) could be reached. ☐ settlement of the issue(s) was reached *(documentation required).*

☐ **I attempted to contact *(give name)*** ______________ **(*on date*)** __________
to discuss the issue(s) above, that I have waited a reasonable time for a response, but that no discussion was forthcoming.

CERTIFIED BY (Please Print Name)	WCB ID NO.	DATE PREPARED (MM/DD/YY)	AREA CODE	TELEPHONE NUMBER

Please note: Failure to check either the "I have discussed" or "I attempted to contact" boxes will result in no action on the RFA-2.

TO THE INSURER/EMPLOYER

This form may be filed by the insurance carrier or employer in a workers' compensation case when it wants the Workers' Compensation Board to take action in the case. ATTACH ALL APPLICABLE EVIDENCE FOR CONSIDERATION BY THE BOARD. A copy of this form and the attachments must also be sent to the claimant, and his/her representative, if any. If item a or b is checked, a copy of this form and the attachments must also be sent to the claimant's attending doctor. If you would like online access to the case, you can register for eCase using the registration instructions available on the Board website under the eCase link.

MTG Special Services or MTG Variance Prior Authorization - This form is to be used when a Prior Authorization Request has been granted/ granted in part by Notice of Resolution regarding treatment and you are requesting assistance from the Board regarding one of the reasons listed. Information regarding the Prior Authorization Request process can be found on the WCB website www.wcb.ny.gov.

Regarding Items a and b - Board Rule 12 NYCRR 300.23

This is to notify the Board of the insurer/employer's intention to reduce or suspend the claimant's payments in accordance with Board Rule 12 NYCRR 300.23. This notice may be filed in any case where there has been an award and a direction for continuation of payments and evidence is presented to support the suspension of payments or reduction in rate.

The Board, upon receipt of this notice and attachments, may either schedule a WC LAW JUDGE HEARING on this issue within 20 days during any period in which regular hearings are scheduled, or refer the matter to the Administrative Review Division for a determination of whether a reopening is warranted. In the event that the Administrative Review Division directs that the case be reopened, a WC Law Judge Hearing will be scheduled in an expeditious manner. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, THE CASE WILL NOT BE SCHEDULED FOR A HEARING.

Cases at hearing points which do not have regularly scheduled hearings within 20 days may be scheduled at another hearing point. At the time a WC Law Judge hearing is held, either immediately after the Board's receipt of this notice and attachments or at the direction of the Administrative Review Division, the WC Law Judge will consider all available evidence and decide whether or not payments may be suspended or reduced.

PAYMENTS SHALL CONTINUE, AS DIRECTED, until there is a determination by the WC Law Judge that such payments may be suspended or reduced.

TO THE CLAIMANT

If you have any questions regarding the action being requested by the insurer/employer, please contact the Board's **ADVOCATE FOR INJURED WORKERS at (877) 632-4996**. If you have retained legal counsel to represent you, you may contact him/her for assistance. Please remember to always use the WCB Case Number shown on the other side of this form when corresponding with the Board. If you would like to follow your claim online, you can register for eCase using the registration instructions available on the Board website under the eCase link.

AL RECLAMANTE

Si tiene alguna pregunta en relación a la acción solicitada por el patrono ó el seguro favor de **llamar al Defensor de los trabajadores lesionados (877) 632-4996.** Si está representado legalmente, debe comunicarse con sú representante para asesoramiento. Cuando se comunique con la Junta, siempre use el número de caso WCB que aparece en el otro lado de esta notificación. Si desea realizar un seguimiento en línea de su reclamo, puede registrarse para ingresar a eCase utilizando las instrucciones para registro que están disponibles en el sitio web de la WCB en el enlace eCase.

TO THE CLAIMANT - Regarding Items a and b

Please read this notice and attachments carefully. If item a or b is checked, this notice means that your employer (if self-insured) or its insurance company wants to suspend or reduce your compensation payments, for the reason indicated.

As explained above, your case may be scheduled for a hearing on this issue. Be sure to BE PRESENT, if you disagree with your employer or his/her insurance company. If you are NOT PRESENT, the W.C. Law Judge will make a decision based on available evidence. If your employer or his/her insurance company contends that your compensation payments should be suspended or reduced because your medical condition has improved (not because your earnings have increased), BRING TO YOUR HEARING THE MOST RECENT MEDICAL REPORT FROM YOUR DOCTOR THAT DESCRIBES YOUR CURRENT MEDICAL CONDITION.

PARA EL RECLAMANTE - Respecto de los puntos a y b

Lea atentamente esta notificación y los documentos adjuntos. Si están marcados los puntos a o b, esta notificación significa que el empleador (en caso de estar auto asegurado) o su compañía aseguradora, desea suspender o reducir los pagos de su indemnización, por el motivo que se indica.

Tal como se explica anteriormente, es posible que se fije una fecha para una audiencia sobre su caso en relación a este asunto. Asegúrese de ESTAR PRESENTE, en caso de que usted esté en desacuerdo con su empleador o su compañía aseguradora. Si usted NO ESTÁ PRESENTE, el juez que dirime sobre cuestiones laborales tomará una decisión a partir de la evidencia disponible. En caso de que su empleador o su compañía aseguradora aleguen que se deben suspender o reducir los pagos de su indemnización debido a una mejoría de su condición médica (no debido a un aumento de sus ingresos), PRESENTE EN LA AUDIENCIA EL INFORME MÉDICO MÁS RECIENTE QUE DESCRIBA SU CONDICIÓN MÉDICA ACTUAL, ESCRITO POR SU MÉDICO.

Section 114 of the Workers' Compensation Law provides, in part, that any employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who knowingly makes a false statement or representation as to a material fact for the purpose of avoiding provision of any payment or benefit under this chapter shall be guilty of a felony.

Workers' Compensation Board

PO Box 5205
Binghamton, NY 13902-5205

Address for Email Filing: wcbclaimsfiling@wcb.ny.gov
www.wcb.ny.gov

State of New York
WORKERS' COMPENSATION BOARD

VF/VAW ADJUSTMENTS

INSURER'S REQUEST FOR BENEFIT INCREASE REIMBURSEMENT UNDER SECTION 51 VOLUNTEER FIREFIGHTERS' & VOLUNTEER AMBULANCE WORKERS' BENEFIT LAWS

WCB Case No. ______________ Claim Admin Claim Number ______________ Insurer ID W# ______________

Claimant ____ Social Sec. No. ______________

Insurer ____ ☐ Vol. Fire Claim ☐ Vol. Ambulance Claim

Insurer Address ____

Original weekly benefit rate in this claim: $_________ Increased benefit rate effective Jan. 1, 1999: $_________

Original weekly benefit rate in this claim: $_________ Increased benefit rate effective July 27, 2004: $_________(VAW ONLY)

Original weekly benefit rate in this claim: $_________ Increased benefit rate effective Jan. 2, 2006: $_________

Insurer requests reimbursement for benefits paid, as follows:

A. Compensation/Death Benefits

_______ Weeks from ___________ To ___________ at $ __________/wk $ ______________

_______ Weeks from ___________ To ___________ at $ __________/wk $ ______________

_______ Weeks from ___________ To ___________ at $ __________/wk $ ______________

B. Lump Sum .... $ ______________

C. Re-marriage Award .... $ ______________

TOTAL OF THIS CLAIM FOR REIMBURSEMENT $ ______________

1. Does this represent an initial request for reimbursement in this claim? ☐ Yes ☐ No
2. If this is the initial request for reimbursement, or re-marriage award, you must attach the following:
   a. A copy of the Notice of Decision establishing the classification and benefit rate or award.
   b. A copy of SROI-02 verifying the rate change.

INSURER STATEMENT

I hereby certify that this request for reimbursement made to the Chair of the Workers' Compensation Board is true and correct; that no part thereof has been previously paid and that the amount stated therein is due and owing.

By (Print or Type): ______________________________ Signature: ______________________________

Title: ____________________ Phone No. ______________ Email: ____________________ Date: __________

INSTRUCTIONS:

1. Claims for compensation reimbursement should be submitted for 52-week periods.
2. Send your request along with any required documentation to SpecialFunds@wcb.ny.gov.
3. Retain one copy for your records.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

VOLUNTEER'S NOTIFICATION OF EXECUTIVE OFFICER OF FIRE/AMBULANCE COMPANY OF SIGNIFICANT RISK OF TRANSMISSION OF HIV

PER VFBL/VAWBL SECTION 11-c(1)

Notice to the Executive Officer of a Fire Company/Ambulance Company that a volunteer firefighter/volunteer ambulance worker has been exposed to a significant risk of transmission of the Human Immunodeficiency Virus (HIV) while performing services in the line of duty.

VFBL/VAWBL Section 11-c(1) requires the Executive Officer of a Volunteer Fire/Ambulance Company to authorize a volunteer firefighter/volunteer ambulance worker to obtain an appropriate medical examination to determine if such volunteer firefighter/ambulance worker has been exposed to or infected with HIV within 8 hours of receipt of the notice of an incident that has created an exposure risk to the volunteer firefighter/ambulance worker to HIV while performing services in the line of duty.

INSTRUCTIONS TO VOLUNTEER: PRESENT THIS FORM TO THE EXECUTIVE OFFICER OF FIRE/AMBULANCE COMPANY. SEND A COPY TO THE WORKERS' COMPENSATION BOARD (SEE MAILING ADDRESS AND PERSONAL PRIVACY PROTECTION NOTIFICATION ON REVERSE).

NAME OF VOLUNTEER FIREFIGHTER/AMBULANCE WORKER	DATE OF BIRTH	SOCIAL SECURITY NO.	TELEPHONE NUMBER	GENDER
				☐ M ☐ F ☐ X

RESIDENTIAL ADDRESS	MAILING ADDRESS, IF DIFFERENT

NAME AND ADDRESS OF FIRE/AMBULANCE COMPANY	TELEPHONE NUMBER

DATE AND TIME OF EXPOSURE	SPECIFIC PARTS OF BODY EXPOSED
ADDRESS WHERE EXPOSURE OCCURRED	**WITNESSES, IF ANY**

HOW DID EXPOSURE OCCUR?

Signature of Volunteer Firefighter/Ambulance Worker ______ Date Signed ______ Time of Submission to Executive Officer ______

FOR USE BY EXECUTIVE OFFICER OF FIRE/AMBULANCE COMPANY

The volunteer firefighter/ambulance worker named above is authorized to obtain an appropriate medical examination to determine if they have been exposed to or infected with the human immunodeficiency virus (HIV).

Name of Executive Officer ______ **Signature of Executive Officer** ______ **Date** ______ **Time of Approval** ______

Reports should be sent directly to the Workers' Compensation Board address listed below:

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

Customer Service Toll-Free Line: 877-632-4996

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).

The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

NEW YORK STATE | Workers' Compensation Board

Doctor's Report of MMI/Permanent Partial Impairment

C-4.3

Use this form: 1. When rendering an opinion on MMI and/or permanent partial impairment; or 2. In response to a request by the Workers' Compensation Board to render a decision on MMI and/or permanent partial impairment.

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 patient, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date of Examination: ____________ WCB Case #: ____________ Claim Admin Claim Number: ____________

A. Patient's Information

1. Name: ______________________ (Last, First, MI) 2. Date of Birth: ________ 3. SSN: ________

4. Address (if changed from previous report): ______________________ (Number and Street, City, State, Zip Code)

5. Home phone #: ________ 6. Date of injury/illness: ________ 7. 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. Insurer ID: W________

3. Insurance carrier's address: ______________________ (Number and Street, City, State, Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)		
(2)		
(3)		
(4)		

5. Billing (CPT) Code: ________ 6. Charge ($): ________ 7. Zip Code: ________

Patient Name: ______________________________ Date of injury/illness: ____________

Last First MI

D. Maximum Medical Improvement

1. Has the patient reached Maximum Medical Improvement? ☐ Yes ☐ No If yes, provide the date patient reached MMI: ____________

   If No, describe why the patient has not reached MMI and the proposed treatment plan (attach additional documentation, if necessary).

E. Permanent Partial Impairment

1. Is there permanent partial impairment? ☐ Yes ☐ No

2. List the body parts and conditions you treated the patient for related to the date of injury listed in Section A, Question 6.

Complete Permanent Partial Disability, Attachment A and/or Attachment B, as indicated based on the patient's condition. Attachment A and/or Attachment B must be completed for each body part and/or condition which you treated the patient for on the date of injury listed in Section A, Question 6.

- For a permanent partial impairment where schedule award (schedule loss of use) is appropriate, complete Attachment A, except for serious facial disfigurement, vision, or hearing loss.

  Hearing Loss:
  - Occupational Loss of Hearing - C-72.1 should be utilized, and/or
  - Traumatic Hearing Loss - C4.3 with an attached narrative.

  Vision Loss:
  - Attending Ophthalmologist's Report (Form C-5), or
  - C-4.3 with an attached narrative.

  Serious Facial Disfigurement
  - C-4.3 with an attached narrative.

- For a non-schedule award (classification), complete Attachment B.

Sign below and submit to the Board only the pages of the form that apply to this report.

This form is signed under penalty of perjury.

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date

Patient Name: ____ Date of injury/illness: ____________________
Last First MI

Permanent Partial Disability - Attachment A
Schedule Loss of Use of Member

If the patient has a permanent partial impairment, complete Attachment A for all body parts and conditions for which a schedule award is appropriate (schedule loss of use). You must complete this attachment for all body parts and conditions for which you treated the patient for the date of injury listed in Section A, Question 6. Attach additional sheets if needed.

Body Part

Please include all the information in the bullet points below in the table on this page or attach a medical narrative with your report. The medical narrative should include the following information:

- Affected body part (include left or right side) and identify Guideline chapter (when special consideration exist)
- Measured Active Range of Motion (ROM) (3 measurements for injured body part, and use the greatest ROM). If not, please explain why
- Measurement of contralateral body part ROM, or explain why inapplicable
- Previously received scheduled losses of use to same body part(s), if known, stating with specificity the percentage loss of use you believe to be attributable solely to the injury being evaluated (and why), versus the percentage(s) of loss of use to the same body part(s) attributed to prior injury(ies)
- Special considerations
- Loading for Digits and Toes

	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement
	1	2	3	4	5	6
	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right
Range of Motion (3 measures)						
Contralateral Applicable Y/N If No, please, explain below						
Contralateral ROM						
Special Considerations (Chapter)						
Impairment %						

Details:

Patient Name: ______________________________ Date of injury/illness: ____________

Last First MI

Permanent Partial Disability - Attachment B
Non-Schedule Award (Classification)

1. Non-Schedule Permanent Partial Disability:
(Identify impairment class according to the latest Workers' Compensation Guidelines for Determining Impairment. Attach separate sheet for additional body parts.)

Body Part: ____________ Impairment Table: ____________ Severity Ranking: ____________

Body Part: ____________ Impairment Table: ____________ Severity Ranking: ____________

Body Part: ____________ Impairment Table: ____________ Severity Ranking: ____________

State the basis for the impairment classification (attach additional narrative, if necessary):

History: ______________________________

Physical Findings: ______________________________

Diagnostic Test Results: ______________________________

2. Patient's Work Status: ☐ At the pre-injury job ☐ At other employment ☐ Not working

3. Functional Capabilities/Exertion Abilities:

a. Please describe patient's residual functional capacities for any work at this time (not limited to the at-injury job activities):

	Never	Occasionally	Frequently	Constantly
Lifting/carrying	☐	☐ ____ lbs.	☐ ____ lbs.	☐ ____ lbs.
Pulling/pushing	☐	☐ ____ lbs.	☐ ____ lbs.	☐ ____ lbs.
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Bending/stooping/squatting	☐	☐	☐	☐
Simple grasping	☐	☐	☐	☐
Fine manipulation	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Reaching at/or below shoulder level	☐	☐	☐	☐
Driving a vehicle	☐	☐	☐	☐
Operating machinery	☐	☐	☐	☐
Temp extremes/high humidity	☐	☐	☐	☐
Environmental	☐	☐	☐	☐

Specify: ______________________________

Patient's Residual Functional Capacities
- **Occasionally**: can perform activity up to 1/3 of the time.
- **Frequently**: can perform activity from 1/3 to 2/3 of the time.
- **Constantly**: can perform activity more than 2/3 of the time.

Psychiatric/neuro-behavioral (attach documentation describing functional limitations)

b. Please check the applicable category for the patient's exertional ability:

☐ **Very Heavy Work** - Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Heavy Work.

☐ **Heavy Work** - Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Medium Work.

☐ **Medium Work** - Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Light Work.

☐ **Light Work** - Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may only be a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

☐ **Sedentary Work** - Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Patient Name: ____ Date of injury/illness: ________________

Last First MI

Functional Capabilities/Exertion Abilities (continued):

c. Other medical considerations which arise from this work related injury (including the use of pain medication such as narcotics):

d. Could this patient perform his/her at-injury work activities with restrictions? ☐ Yes ☐ No

If Yes, specify:

e. Could this patient perform any work activities with or without restrictions? ☐ Yes ☐ No

Explain:

f. If patient is not working, could reasonable accommodations be made to enable the patient to perform work? ☐ Yes ☐ No

If Yes, explain:

4. Has the patient had an injury/illness since the date of injury which impacts residual functional capacity? ☐ Yes ☐ No

If Yes, explain. Attach additional sheets if necessary.

5. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

If Yes, explain

<u>IMPORTANT - TO THE ATTENDING DOCTOR</u>

The C-4.3 has been modified to accommodate the 2018 Workers' Compensation Guidelines for Determining Impairment, while continuing to reflect the 2012 Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity. The 2018 Guidelines replace chapters in the existing 2012 Medical Impairment Guidelines Introduction and with respect to SLU. The 2012 Guidelines should continue to be used for determining non-schedule permanent impairments. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefits cases as follows: 1. When rendering an opinion on MMI and/or permanent partial impairment; or 2. In response to a request by the Workers' Compensation Board to render a decision on MMI and/or permanent partial impairment.

MEDICAL REPORTING

This form must be signed by the attending doctor and must contain his/her authorization certificate number, code letters and NPI number.

A CHIROPRACTOR, PODIATRIST, PSYCHOLOGIST, NURSE PRACTITIONER OR LICENSED CLINICAL SOCIAL WORKER FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY LAWFULLY BE TREATED BY THE FILING PROVIDER, AS DEFINED IN THE EDUCATION LAW AND, WHERE IT DOES NOT, THE FILING PROVIDER HAS ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS/HER CHOICE.

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 insurer or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Ask the patient if he/she has retained a legal representative. If they have retained legal representation, you are required to send copies of all reports to the patient's representative.

Instructions for Completing Section D, E, Attachment A and Attachment B

Section D. Maximum Medical Improvement

Section D includes questions regarding maximum medical improvement (MMI). For the definition of MMI, see Chapter 1.2 of the 2018 Guidelines and 2012 Guidelines. A provider who finds that the patient has met MMI should so indicate and provide the approximate date of such finding (Question 1). If the patient has not yet reached MMI so indicate (Question 1) and provide an explanation as to why additional improvement is expected and the proposed treatment plan.

Section E. Permanent Partial Impairment

Section E includes questions regarding permanent partial impairment. If there is no permanent partial impairment (Question 1) do not file this form, instead use Form C-4.2 (Dr's. Progress Report), unless requested by the Workers' Compensation Board to render a decision on MMI and/or permanent partial impairment. For more information on evaluating impairment, see Chapter 1.5 and 1.6 of the 2018 Guidelines and Chapter 9.2 of the 2012 Guidelines.

List all the body parts and/or conditions that the patient was treated for with regards to the workers' compensation claims identified in Section A of the form (Question 2).

Complete either Attachment A and/or Attachment B for each body part and/or condition for which permanency exists.

Permanent Partial Disability

Attachment A and Attachment B includes questions about schedule loss of use of member or facial disfigurement (1) or Non-Schedule Permanent Partial Impairment (2). Complete Attachment A and/or Attachment B for each body part and condition for which the patient was treated. If the patient injured body parts that receive a schedule and do not receive a schedule, then complete both Attachment A and Attachment B for the appropriate body parts/conditions.

Attachment A. Schedule loss of use of member

Determine impairment % using the 2018 Workers' Compensation Guidelines for Determining Impairment. If a scheduled loss is appropriate under the 2018 Impairment Guidelines do not complete any questions in Attachment B. Attach additional sheets or narrative, if necessary. The provider should sign the Board Authorization at the bottom of page 2 and return to the Workers' Compensation Board.

Attachment B. Non-Schedule Permanent Partial Impairment

If the patient was treated for a body part and condition that is not amendable to a schedule loss of use award, record the body part, impairment table and severity letter grade for each body part or system (Question 1) using the 2012 Guidelines. Also state the history, physical findings, and diagnostic test results that support the impairment finding. If the patient has a non-schedule impairment of a body part or system that is not covered by an impairment guideline, follow Chapter 17 of the 2012 Guidelines and include the relevant history, physical findings, and diagnostic test results, but no severity letter grade.

Complete the questions regarding the patient's work status (2).

Complete the Functional Capabilities/Exertion Abilities (Question 3. a - f). Attachment B should be completed based on the patient's current condition if the provider believes there is MMI and/or permanent partial impairment or in a response to a request by the Board to render a decision on MMI and/or permanent partial impairment.

Question 3. includes questions applicable to a patient who has reached MMI and has a permanent, non-schedule impairment. For more information on evaluating functional capabilities, see Chapter 9.2 of the 2012 Guidelines. Measure and record the specific functional abilities and losses caused by the work-related medical impairment on Questions 3, a through f as follows:

Question 3a - Rate whether the patient can perform each of the fifteen functional abilities: never, occasionally, frequently, or constantly. Note the specific weight tolerances for the categories lifting/carrying and pulling/pushing. There is also room to describe any functional limitations in connection with environmental conditions (e.g., occupational asthma). Attach documentation when describing Psychiatric/neuro-behavioral functional limitations, if applicable to a patient.

Question 3b - Check the applicable category for the patient's exertional ability.

Question 3c - Note any other medical considerations arising from the permanent injury that are not captured elsewhere in Attachment B. This includes any restrictions or limitations that may be imposed as a result of medications (e.g., narcotics) taken by the patient or other relevant medical considerations that impact work function.

Question 3d - With knowledge of the patient's at-injury work activities, indicate whether the patient can perform his/her at-injury work activities with restrictions. If Yes, specifically assess the patient's ability to perform his/her at-injury work activities with restrictions.

Question 3e. Indicate whether the patient can perform any work activities with or without restrictions. Explain by providing what activities can be performed with restrictions and what work activities can be performed without restrictions.

Question 3f - Provide an explanation whether reasonable accommodations can be made for the patient.

Question 4 - Explain or attach a detailed explanation if the patient has had an intervening injury or illness that may account for any of the functional restrictions noted in Question 3a.

Question 5 - Indicate if the patient would benefit from vocational rehabilitation and if so, provide detailed explanation.

BILLING INFORMATION

Complete all billing information contained on this form. Use additional forms or narrative, if necessary. The workers' compensation carrier has 45 days to pay the bill or to file an objection to it. Contact the workers' compensation carrier if neither payment nor an objection are received within this time period. After contacting the carrier, if necessary, file Health Provider's Request for Decision on Unpaid Medical Bill(s) (Form HP-1). If you have questions, please contact the NYS Workers' Compensation Board at 1-800-781-2362.

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.

All reports are to 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

NEW YORK STATE | Workers' Compensation Board

C-8.4 - Notice to Health Care Provider and Claimant of an Insurer's Refusal to Pay All (or a portion) of a Medical Bill Due to Valuation Objection(s)

Section A: Claim Information

1. WCB Case Number	2. Claim Admin Claim Number	3. Insurer ID (W#)	4. Date of Injury/Illness	5. Last Four Digits of SSN

	Name	Address to which notices should be sent	
6. Claimant			Apt. No.
7. Employer			
8. Insurer			
9. Claimant's Health Care Provider			
10. WCB Authorization #: ______		11. Provider's NPI #: ______	

Section B: Medical Bill Information

Note: If bill is not in the Board's file, it must be submitted with this form.

1. Date(s) of Treatment: ______ 2. Date of Bill: ______ 3. Date Bill Received: ______

4. Amount of Bill: ______ 5. Amount Paid: ______ 6. Amount in Dispute: ______ 7. WCB Document ID # of Bill: ______

Section C: REASON(S) FOR OBJECTION TO MEDICAL BILL: Please check all that apply.

Amount of Bill:

1. ☐ is excessive or not in accordance with pertinent Medical Fee Schedule [P12]
2. ☐ has not been properly pro-rated or apportioned between providers [B20]
3. ☐ uses improper CPT codes [P13/M51]
4. ☐ is not in accordance with Ground Rules limitation [P13/N130]
5. ☐ for dental treatment or treatment outside NYS exceeds community standard [P5]

Treatment:

6. ☐ is inappropriate for the clinical situation [150]
7. ☐ involves concurrent or overlapping services [59]
8. ☐ is duplicative, excessive or rendered too frequently [151]
9. ☐ involves unnecessary or excessive hospitalization [151]
10. ☐ involves a provider treating outside scope of practice [185]

FAILURE TO PAY UNDISPUTED PORTION OF BILL WITH THIS NOTIFICATION SHALL NOT BE CONSIDERED A TIMELY NOTIFICATION.

IT IS HEREWITH CERTIFIED THAT A COPY OF THIS FORM WAS SENT THIS DATE TO THE HEALTH CARE PROVIDER AND THE WORKERS' COMPENSATION BOARD.

______ Dated

______ Prepared By

______ Tel. No. & Ext.

______ Official Title

Information Concerning Medical Treatment and Bills For Claimant, Insurers, and Health Care Providers

This form must be used for all valuation objections to medical bills*. Notice of Valuation Objection must be filed within 45 days of receipt of the medical bill. Failure to pay the undisputed portion of the bill may subject the insurer to interest on that portion. Attach the Explanation of Benefits (using applicable Claims Adjustment Reason Codes (CARCs) and Remittance Advice Reason Codes (RARCs) with Form C-8.4 submission to the Board.

Valuation Objection Issues - Valuation issues relate to the dollar amount of the medical bill or the medical appropriateness of the treatment provided. Applicable valuation issues and the associated CARCs/RARCs are listed on the front of this form. This form cannot be used for objections relating to Forms FROI-04/SROI-04 or C-8.1B legal issues.

Section A: Claim Information: Fields 1 -11 Enter the claim information including: WCB Case Number, Claim Admin Claim number, Insurer ID, Date of Injury as well as the name and address of the claimant, employer, insurer and health care provider. Also enter the WCB Authorization # and NPI # of the health care provider. Note: in volunteer firefighters' and volunteer ambulance workers' benefit cases, the liable political subdivision (or unaffiliated ambulance service as defined in Sec. 30 VAWBL) is deemed to be the "employer".

Section B: Medical Bill Information: Fields 1-7 Enter the medical bill information including: Date of Service, Date of Bill, Date Bill Received, amount of medical bill, amount paid, amount in dispute and WCB Document ID#. Note: if bill is not in the Board's file, it must be submitted with this form. If a legal objection has been simultaneously filed on Form C-8.1B, the amount entered in item 5 ("amount paid") should be the proposed payment amount to be paid by the carrier, in the event that the legal objection is resolved in favor of the provider. If the legal issue is resolved in favor of the carrier, the payable amount will be $0.

Section C: Valuation Objection Reasons: Fields 1-10 The insurer must identify <u>all</u> valuation objection reasons within one Form C-8.4 submission. Select the applicable box for each objection reason. Valuation objection reasons must be identical to the Explanation of Benefits sent to the provider, using the same CARCs and RARCs.

The objections listed are not the CARC descriptions, but are supporting information for the use of the CARC. CARC descriptions may be found at: (https://x12.org/codes/claim-adjustment-reason-codes)

*Note: valuation objections should <u>not</u> be submitted by the insurer in the following scenarios:

1) the amount billed for the particular CPT code is in excess of the amount designated by the applicable medical fee schedule, and the insurer pays the bill at the appropriate medical fee schedule amount;

2) the insurer reduces the amount of the bill to 12, 15 or 18 relative value units for evaluation services and modalities, as set forth in the applicable medical fee schedule; or

3) the insurer reduces the amount of the bill pursuant to a contractual agreement with the provider (i.e., network or PPO discount). Such reductions should be included on the Explanation of Benefits and may be provided to an arbitrator in the event an HP-1 is filed.

Information for Health Care Providers: Form HP-1.0 Health Provider's Request For Decision On Unpaid Medical Bill(s) - If no legal issues relating to the medical bill are pending, and the medical provider or hospital has received a valuation issue objection, the provider may request arbitration by proper submission of Form HP-1.0. Details of the Form HP-1.0 process can be obtained by telephoning 1(800) 781-2362 or by visiting the Board's website at www.wcb.ny.gov.

Information for Claimant: Workers' Compensation insurance provides medical, surgical, optometric or other attendance or treatment necessitated by the work-related injury or illness without cost to the claimant. The cost is paid by the employer or its insurance carrier, and the health care provider may not collect a fee from the patient. Sometimes, the insurance carrier may object to the length or type of treatment or to the amount the provider has billed for treatment. The claimant should not pay the provider for services rendered until the Board rules that the services are not covered by workers' compensation.

Fraud

Section 114 of the Workers' Compensation Law provides, in part, that any employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who knowingly makes a false statement or representation as to a material fact in the course of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit shall be guilty of a felony.