CONTINUATION TO FORM MG-1, ATTENDING DOCTOR'S REQUEST FOR OPTIONAL PRIOR APPROVAL

MG-1.1

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

Patient's Name: _____ Social Security No.: _____

Doctor's Name: _____ WCB Authorization No.: _____ NPI No.: _____

INSTRUCTIONS TO ATTENDING DOCTOR: **This form must be filed attached to a completed Form MG-1** if requesting optional prior approval for additional treatment(s) or procedure(s) in the same case.

A. *The undersigned requests additional optional approval under the WCB Medical Treatment Guidelines as indicated below:*

2. Treatment/Procedure Requested _____ Guideline Reference: ☐ - ☐☐☐☐ *(In first box, indicate injury and/or condition: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck, C = **C**arpal Tunnel, P = Non-Acute **P**ain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)* Date of service of supporting medical in WCB case file, if not attached: _____ Comments:	INSURER'S/EMPLOYER'S RESPONSE *(Insurer/employer must complete certification on reverse of this form)* ☐ Granted ☐ Granted without Prejudice ☐ Denied
3. Treatment/Procedure Requested _____ Guideline Reference: ☐ - ☐☐☐☐ *(In first box, indicate injury and/or condition: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck, C = **C**arpal Tunnel, P = Non-Acute **P**ain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)* Date of service of supporting medical in WCB case file, if not attached: _____ Comments:	INSURER'S/EMPLOYER'S RESPONSE *(Insurer/employer must complete certification on reverse of this form)* ☐ Granted ☐ Granted without Prejudice ☐ Denied
4. Treatment/Procedure Requested _____ Guideline Reference: ☐ - ☐☐☐☐ *(In first box, indicate injury and/or condition: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck, C = **C**arpal Tunnel, P = Non-Acute **P**ain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)* Date of service of supporting medical in WCB case file, if not attached: _____ Comments:	INSURER'S/EMPLOYER'S RESPONSE *(Insurer/employer must complete certification on reverse of this form)* ☐ Granted ☐ Granted without Prejudice ☐ Denied
5. Treatment/Procedure Requested _____ Guideline Reference: ☐ - ☐☐☐☐ *(In first box, indicate injury and/or condition: K = **K**nee, S = **S**houlder, B = Mid and Low **B**ack, N = **N**eck, C = **C**arpal Tunnel, P = Non-Acute **P**ain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)* Date of service of supporting medical in WCB case file, if not attached: _____ Comments:	INSURER'S/EMPLOYER'S RESPONSE *(Insurer/employer must complete certification on reverse of this form)* ☐ Granted ☐ Granted without Prejudice ☐ Denied

I certify that I am making the above request for optional prior approval and my affirmative statements are true and correct.

A copy was sent to the Workers' Compensation Board, and copies were provided to the claimant's legal representative, if any, and to any other parties of interest on the date below.

Provider's Signature: _____ Date: _____

B. INSURER'S / EMPLOYER'S RESPONSE (Response is due within 8 business days of receipt of this request or medical care is deemed approved (12 NYCRR 324 (c)). IF ANY REQUESTS ARE DENIED, GIVE REASON(S) IN THE SPACE PROVIDED BELOW. Identify reasons according to Request No. 2-5 on the front of this form.

Name of the medical professional who reviewed the denial(s): _____

I certify that copies of this form were sent to the Treating Medical Provider requesting optional prior approval, the Workers' Compensation Board (see mailing and email addresses and fax number on Form MG-1), the claimant's legal representative, if any, and any other parties of interest, on the date below.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

C. MEDICAL PROVIDER'S REQUEST FOR BOARD REVIEW OF DENIAL

☐ I hereby request review by a medical arbitrator designated by the Chair of the insurers decision to deny optional prior approval of the request(s) checked below. I understand that resolution by the medical arbitrator is binding and is not appealable under Workers' Compensation Law Section 23. (Request is due within 14 calendar days of the date of denial.) Supporting medical report(s) dated _____ is/are attached or is/are available in the WCB case file.

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

Provider's Signature: _____ Date: _____

D. INSURER / EMPLOYER IS APPROVING ADDITIONAL REQUEST(S) FOR OPTIONAL PRIOR APPROVAL AFTER AN INITIAL DENIAL

☐ I certify that the provider's request for optional prior approval given above, **which was initially denied on** _____ , is now granted for the following request(s):

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name) _____ Title: _____

Signature: _____ Date: _____