

Doctor's Initial Report

C-4

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

A. Patient's Information 1. Name:			2. Social Security	#:	
Last	First 4. WCB Case # (if known):	MI	= Coolai Coolain, 5. Carrier Case #:		
3. Home phone #: ()	4. WOD Case # (II KIIOWII)	`	D. Carrier Case #		
6. Mailing address:	Number and Street		O'th :		7:- 01-
7. Date of injury/onset of illness:		1 1	City 9. Gender:	State Male	Zip Code Female
10. On the date of injury/illness what was					
11. On the date of injury/illness what were	e the patient's usual work activities:				
12. Patient's Account #:					
B. Employer Information					
Employer when injury occurred:			2. Phone #	! : ()_	
3. Employer Address:	Company/Agency Name				
o. Employor Address.	Number and Street		City	State	Zip Code
C. Doctor's Information					
1. Your name:			2. WCB Authorizat	ion #:	
3. WCB Rating Code:	First4. Federal Tax ID #:	MI	The Tax ID # is the	(check one)	:□ssn □e
5. Office address:					
Billing group or practice name:	Number and Street	Cit	•	State	Zip Code
33 34 7 7 3333 3 ====					
7. Billing address:	Number and Street	Cit		State	Zip Code
8. Office phone #: ()			^y). Treating Provider's		•
11. You are a (select one): Physician			-		
B. Billion Information					
D. Billing Information1. Employer's insurance carrier:			2. Carrier Cod	e#: W	
3. Insurance carrier's address:	Number and Street	_	City	State	Zip Code
4. Diagnosis or nature of disease or injur			,		,
•)10 Descriptor:				
	•				
(1)					
(2)					
(3)					
141					

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.

'atient's Name:							First MI			Date of injury/onset of illness:				
From			of Servi	ce		Place of Service	Leave Blank		NCB Codes Services or Supplies IMODIFIER	Diagnosis Code	\$ Charges	Days/ Units	СОВ	Zip code where service was rendered
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atient's Name:	Date of injury/onset of illness:/
Last First 4. Physical examination: Check all relevant objective fi	МІ
None at present	□ N
Bruising	Neuromuscular Findings: Abnormal/Restricted ROM
Burns	
Crepitation	Active ROM
Deformity	Passive ROM
Edema	Galt
Hematoma/Lump/Swelling	Palpable Muscle Spasm
Joint Effusion	Retiexes
Laceration/Sutures	Camaatian
Pain/Tenderness	01
Scar	
Other findings:	
3. Describe any diagnostic test(s) rendered at this visit.	
7. Describe prognosis for recovery: 8. Does the patient's medical history reveal any pre-exist lf yes, list and describe: 6. Doctor's Opinion	sting condition(s) that may affect the treatment and/or prognosis? Yes No
7. Describe prognosis for recovery: 8. Does the patient's medical history reveal any pre-exis If yes, list and describe: 6. Doctor's Opinion 1. In your opinion, was the incident that the patient describe	sting condition(s) that may affect the treatment and/or prognosis?
7. Describe prognosis for recovery: 8. Does the patient's medical history reveal any pre-exis If yes, list and describe: 9. Doctor's Opinion 1. In your opinion, was the incident that the patient describe 2. Are the patient's complaints consistent with his/her h	sting condition(s) that may affect the treatment and/or prognosis?
7. Describe prognosis for recovery:	sting condition(s) that may affect the treatment and/or prognosis?
7. Describe prognosis for recovery: 8. Does the patient's medical history reveal any pre-exist If yes, list and describe: 6. Doctor's Opinion 1. In your opinion, was the incident that the patient describes. 2. Are the patient's complaints consistent with his/her had been described. 3. Is the patient's history of the injury/illness consistent. 4. What is the percentage (0-100%) of temporary impations.	sting condition(s) that may affect the treatment and/or prognosis?
7. Describe prognosis for recovery: 8. Does the patient's medical history reveal any pre-exist If yes, list and describe: 6. Doctor's Opinion 1. In your opinion, was the incident that the patient describes. 2. Are the patient's complaints consistent with his/her had been described. 3. Is the patient's history of the injury/illness consistent. 4. What is the percentage (0-100%) of temporary impations.	sting condition(s) that may affect the treatment and/or prognosis? Yes No scribed the competent medical cause of this injury/illness? Yes No nistory of the injury/illness? No with your objective findings? Yes No No N/A (no findings at this time) irment?%
7. Describe prognosis for recovery: 8. Does the patient's medical history reveal any pre-exist If yes, list and describe: 6. Doctor's Opinion 1. In your opinion, was the incident that the patient destalling 2. Are the patient's complaints consistent with his/her had 3. Is the patient's history of the injury/illness consistent 4. What is the percentage (0-100%) of temporary impated 5. Describe findings and relevant diagnostic test results. 1. Plan of Care	sting condition(s) that may affect the treatment and/or prognosis?
7. Describe prognosis for recovery: 8. Does the patient's medical history reveal any pre-exist If yes, list and describe: 6. Doctor's Opinion 1. In your opinion, was the incident that the patient destalling 2. Are the patient's complaints consistent with his/her had 3. Is the patient's history of the injury/illness consistent 4. What is the percentage (0-100%) of temporary impated 5. Describe findings and relevant diagnostic test results. 1. Plan of Care	sting condition(s) that may affect the treatment and/or prognosis? Yes No scribed the competent medical cause of this injury/illness? Yes No nistory of the injury/illness? No with your objective findings? Yes No No N/A (no findings at this time) irment?%
7. Describe prognosis for recovery:	sting condition(s) that may affect the treatment and/or prognosis?
7. Describe prognosis for recovery:	sting condition(s) that may affect the treatment and/or prognosis?

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atient's Name: Last First	Date of injury/onset of illness://
3. Does the patient need diagnostic tests or referrals? Yes No	If yes, check all that apply:
Tests:	Referrals:
CT Scan	Chiropractor
☐ EMG/NCS	☐ Internist/Family Physician
MRI (Specify):	Occupational Therapist
Labs (Specify):	Physical Therapist
X-rays (Specify):	Specialist in
Other (Specify):	Other (Specify):
4. Assistive devices prescribed for this patient: Cane Ci Other (specify):	rutches Orthotics Walker Wheelchair
Important: Form C-4 AUTH should be used to request any s	special medical service costing over \$1000 or for those services requinent Guidelines for the back, neck, knee and shoulder.
5. When is the patient's next follow-up appointment?	ient Guidennes for the back, fleck, knee and shoulder.
☐ Within a week ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks	7-8 weeks Months Return as needed
. Work Status	
I. Has the patient missed work because of the injury/illness? $\ $ Yes $\ $	No If yes, date patient first missed work://
Is the patient currently working?	ient return to: usual work activities limited work activities
2. Can the patient return to work? (check only one):	
a.	
b. The patient can return to work without limitations on	<u></u>
c. The patient can return to work with the following limitations ((check all that apply) on / /
☐ Bending/twisting ☐ Lifting	Sitting
	eavy equipment Standing
Environmental conditions Operation of	motor vehicles Use of public transportation
☐ Kneeling ☐ Personal pro	tective equipment Use of upper extremities
Other (explain):	
How long will these limitations apply? 1-2 days 3-7 da	ays 🔲 8-14 days 🔲 15+ days 🔲 Unknown at this time 🔲 N/.
,	•
B. With whom will you discuss the patient's return to work and/or limitation	is? with patient with patient's employer N/A
This form is signed under penalty of perjury.	
Board Authorized Health Care Provider - Check one:	
I provided the services listed above.	
I actively supervised the health-care provider named below who prov	ided these services.
Provider's name	Specialty
Board Authorized Health Care Provider signature:	
	1 1
Name Signature	Specialty Date

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MEDICAL REPORTING

IMPORTANT-TO THE ATTENDING DOCTOR

- 1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:
 - 48 HOUR INITIAL REPORT Prepare and submit this form, complete in all details, within 48 hours after you first render treatment.

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

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

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

- 2. Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.
- 3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.
- 4. AUTHORIZATION FOR SPECIAL SERVICES Form C-4 AUTH should be used to request any special medical service over \$1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY

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

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

BILLING INFORMATION

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

IMPORTANT TO THE PATIENT

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

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

<u>IMPORTANTE PARA EL PACIENTE</u>

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

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

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

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

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

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