IMPORTANT:

PLEASE READ CAREFULLY THE FOLLOWING INFORMATION FOR DETERMINING HOW TO FIND INSURER/SELF-INSURER CONTACTS

C-4 AUTH, ATTENDING DOCTOR'S REQUEST FOR AUTHORIZATION AND INSURER'S RESPONSE
This form requires the name and fax number or email address of the insurer's designated contact listed on the Workers' Compensation Board's website.

Insurer/Self-Insurer's designated contact information is available online at:
wcb.ny.gov/attending-doctors-request-authorization

NEW YORK STATE | Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR AUTHORIZATION AND INSURER'S RESPONSE

Answer all questions fully on this report

C-4 AUTH

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

A. Patient's Name: _____ (First / MI / Last) Social Security No.: _____

Address: _____ (Number and Street / City / State / Zip Code)

Employer Name: _____

Address: _____ (Number and Street / City / State / Zip Code)

Insurer Name: _____

Address: _____ (Number and Street / City / State / Zip Code)

B. Attending Doctor's Name: _____

Address: _____ (Number and Street / City / State / Zip Code)

Individual Provider's WCB Authorization No.: ☐☐☐☐☐☐ - ☐☐ NPI No.: _____

Telephone No.: _____ Fax No.: _____

C. AUTHORIZATION REQUEST

*The undersigned requests written authorization for the following **special service(s) costing over $1,000** or requiring pre-authorization pursuant to the Medical Treatment Guidelines. Do NOT use this form for injuries/illnesses involving the Mid and Low Back, Neck, Knee, Shoulder, Carpal Tunnel Syndrome and Non-Acute Pain, except for the treatment/procedures listed below under Medical Treatment Guideline Procedures Requiring Pre-Authorization. Please use the appropriate Medical Treatment Guideline form if any other procedure/test is being requested.*

Authorization Requested:	**Insurer Response: if any service is denied, explain on reverse.**
Diagnostic Tests:	
☐ Radiology Services (X-Rays, CT Scans, MRI) indicate body part: _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ Other _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
Therapy (including Post Operative):	
☐ Physical Therapy: _____ ___ times per week for ___ weeks	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ Occupational Therapy: _____ ___ times per week for ___ weeks	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ Other _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
Surgery:	
☐ Type of Surgery (Describe, include use of hardware/surgical implants) _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
_____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
Treatment:	
☐ Other _____	☐ Granted ☐ Granted w/o Prejudice ☐ Denied

Medical Treatment Guidelines Procedures Requiring Pre-Authorization *(Complete Guideline Reference for each item checked, if necessary. 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.)*

☐ 1. Lumbar Fusions	B-E4a	1.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 2. Artificial Disk Replacement	-E	2.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 3. Vertebroplasty	B-E7ai	3.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 4. Kyphoplasty	B-E7ai	4.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 5. Electrical Bone Growth Stimulators	-Ea	5.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 6. Osteochondral Autograft	K-D1f	6.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 7. Autologous Chondrocyte Implantation	K-D1f	7.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 8. Meniscal Allograft Transplantation	K-D	8.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 9. Knee Arthroplasty (total or partial knee joint replacement)	K-F2	9.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 10. Spinal Cord Stimulators	P-G1	10.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 11. Intrathecal Drug Delivery (pain pumps)	P-G2	11.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied
☐ 12. Second or Subsequent Procedure	-	12.	☐ Granted ☐ Granted w/o Prejudice ☐ Denied

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STATEMENT OF MEDICAL NECESSITY

Pursuant to 12 NYCRR 325-1.4(a)(1), it is the treating provider's burden to set forth the medical necessity of the special services required. Failure to do so may delay the authorization process. Your explanation of medical necessity must provide the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time.

_____

_____

_____

Date of service of supporting medical in WCB Case File: _____ **(Attach if not already submitted.)**

Pursuant to 12 NYCRR 325.1(a)(3), the treating provider shall submit this form to the Workers' Compensation Board and insurer.

*Providers **must** complete Part A below indicating that the request was sent to the insurer/self-insurer's designated fax or email address (see Board's URL address below*), unless the provider is not equipped to send or receive email or fax (complete "C" below). If the request was **also** sent to an additional fax or email address provided by the insurer, complete Part B below.*

A. *Insurer's designated fax # or email address as provided on the Board's website:* _____

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* _____

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:* _____

If you called the insurer and spoke with an individual, provide the date of the call: _____
and name of person contacted: _____

**Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/attending-doctors-request-authorization*

☐ ***Designated contact information not available.***

I certify I am making the above request for certification. This request was made to the insurance carrier/self-insurer on: _____

A copy of this form was sent to the Board on the date below.

Provider's Signature: _____ Date: _____

D. **SELF-INSURED EMPLOYER / INSURER RESPONSE TO AUTHORIZATION REQUEST**

Response Time and Notification Required:
The self-insured employer/insurer must respond to the authorization request orally and in writing via email, fax or regular mail with confirmation of delivery within 30 days. The 30 day time period for response begins to run from the completion date of this form if emailed or faxed, or the completion date plus five days if sent via regular mail. The written response shall be on a copy of this form completed by the treating provider seeking authorization and shall clearly state whether the authorization has been granted, granted without prejudice, or denied. *Authorization can only be granted without prejudice when the compensation case is controverted or the body part has not yet been accepted(with or without prejudice). Authorization without prejudice shall not be construed as an admission that the condition for which these services are required is compensable or the employer/insurer is liable. The employer/insurer shall not be responsible for the payment of such services until the question of compensability and liability is resolved.* Written response must be sent to the treating provider, claimant (patient), claimant's legal counsel, if any, the Workers' Compensation Board and any other parties of interest.

Denial of the Request for Authorization of a Special Service: A denial of authorization of a special service **must** be based upon and accompanied by a **conflicting second opinion** rendered by a physician authorized to conduct IMEs, or record review, or qualified medical professional, or a physician authorized to treat workers' compensation claimants. (If authorization is denied in a controverted case, the conflicting second opinion must address medical necessity only.) Failure to file timely the conflicting second opinion will render the denial defective. If denial of an authorization is based upon claimant's failure to attend an IME examination scheduled within the 30 day authorization period, contemporaneous supporting evidence of claimant's failure must be attached.

Failure to Timely Respond to Form C-4 AUTH: The special service(s) for which authorization has been requested will be ***deemed authorized*** by Order of the Chair if the self-insured employer/insurer fails to respond within 30 days (35 days if C-4AUTH is mailed with return receipt requested). An Order of the Chair is not subject to an appeal under Section 23 of the Workers' Compensation Law.

REASON FOR DENIAL(S), IF ANY. (ATTACH OR REFERENCE CONFLICTING SECOND MEDICAL OPINION AS EXPLAINED ABOVE.)

_____

_____

_____

_____

Date of service of supporting medical in WCB case file: _____

*I certify that the self-insured employer/insurer **telephoned** the office of the health care provider listed above within the response time-frame indicated above and advised that the self-insured employer/insurer had either granted or denied approval for the special services for which authorization was sought, as indicated above, on the date below:*

and

*I certify that copies of this form were emailed, faxed, or mailed to the treating provider**,** the claimant (patient), the claimant's legal representative, if any, the Workers' Compensation Board and all parties of interest on the date below:*

By: (print name) _____ Title: _____

Signature: _____ Date: _____

REQUEST FOR WRITTEN AUTHORIZATION **IMPORTANT TO ATTENDING DOCTOR**

AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY

1. This form is used for a workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit case to request written authorization for special service(s) costing over $1,000 in a non-emergency situation or requiring pre-authorization pursuant to the Medical Treatment Guidelines.

2. This form must be signed by the attending doctor and must contain her/his authorization number and code letters. Out-of-State medical providers must enter their 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.

3. Please ask your patient for his/her WCB case # and the claim administrator claim (carrier case) number and show these numbers on this form. In addition, ask your patient if he/she has retained a representative. If represented, ask for the name and address of the representative.
This request must be sent to the Workers' Compensation Board, and the the workers' compensation insurance carrier, self-insured employer, or Special Fund. If patient is not represented, a copy must be sent to the patient.

4. The attending doctor must submit this form with the Board and on the same day serve a copy on the self-insured employer or the insurer by one of the following methods of service: a) the insurer's designated fax number, b) the insurer's designated email address, or c) by regular mail with confirmation of delivery. The insurer's designated fax and email address can be found at: wcb.ny.gov/attending-doctors-request-authorization. Failure to submit the request to the designated contact identified on the WCB's website may result in your request being denied. If there is no designated contact listed on the WCB website, check the "Designated contact information not available" box which is located at the bottom of Section C of this form.

5. If authorization or denial is not forthcoming within 30 calendar days, (or 35 days if C-4AUTH is mailed return receipt requested), the treatment is deemed authorized and the attending physician may provide the requested treatment.

6. SPECIAL SERVICES - Services for which authorization must be requested are as follows:
Physicians - To engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than $1,000.
Podiatrists - In treating the foot, to provide physiotherapeutic procedures, X-ray examinations, or special diagnostic laboratory tests costing more than $1,000.
Chiropractors - In treating a condition as provided in Section 6551 of the Education Law, to engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than $1,000.
Occupational/Physical Therapists - In treating a condition as provided in Article 136 or 156 of the Education Law, in the Workers' Compensation Law, and the Rules of the Chair relative to Occupational/Physical Therapy Practice to provide occupational/physical therapy procedures costing more than $1,000.
Psychologists - Prior authorization for procedures enumerated in section 13-a(5) of the Workers' Compensation Law costing more than $1,000 must be requested from the self-insured employer or insurer. In addition, authorization must be requested for any biofeedback treatments, regardless of the cost, or and special diagnostic laboratory tests which may be performed by psychologists. Where a patient has been referred by an authorized physician to a psychologist for evaluation purposes only and not for treatment, prior authorization must be requested if the cost of consultation exceeds $1,000.
Medical Treatment Guidelines - Lumbar Fusions, Artificial Disk Replacement, Vertebroplasty, Kyphoplasty, Electrical Bone Growth Stimulators, Spinal Cord Stimulators, Osteochondral Autograft, Autologus Chondrocyte Implantation, Meniscal Allograft Transplantation, Knee Arthroplasty (total or partial knee joint replacement), Intrathecal Drug Delivery (pain pumps).

7. If the insurer has checked "GRANTED WITHOUT PREJUDICE" in Section C, the liability for this claim has not yet been determined. This authorization is made pending final determination by the Board. Pursuant to 12 NYCRR § 325-1.4(b)(2), this authorization is limited to the question of medical necessity only and is not an admission that the condition for which the services are required is compensable. This authorization does not represent an acceptance of this claim by the insurer, self-insured employer, employer or Special Fund or guarantee payment for the services authorized. When a decision is rendered regarding liability, you will receive a Notice of Decision by mail. The insurer, self-insured employer, employer or Special Fund will only provide payment for these services if the claim is established and the insurer, self-insured employer, employer or Special Fund is found to be responsible for the claim.

8. It is the attending doctor's burden to set forth the medical necessity of the special services required. Be sure to provide this information in the Statement of Medical Necessity section of this form.

9. 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.

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.

This form must be served on the insurer/self-insurer's designated contact identified on the Board's website: www.wcb.ny.gov by fax, email or mailed, return receipt requested. Failure to submit the form to the designated contact identified on the Board's website may result in your request being denied. A copy of the form must also be filed with the Board.

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

Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: (877) 632-4996 • Statewide Fax: (877) 533-0337