Doctor's Initial Report

State of New York - Workers' Compensation Board

C-4

Use this form 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 necesary, 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 testiony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.state.ny.us.

A. Patient's Information

1. Name: **LastName** (Last) **FirstName** (First) **M** (M) 2. Social Security #: **123-45-6789**

3. Home phone #: **(555)555-5555** 4. WCB Case # (if known) **WCB Case 55555** 5. Carrier Case # **C42 Carrier code**

6. Mailing Address: **12345 main Street** (Number and Street) **New York** (City) **NY** (State) **12345** (Zip)

7. Date of injury/onset of illness: _____ 8. Date of Birth: **04/20/1960** 9. Gender: [ ] Male [X] Female

10. On the date of injury/illness what was the patient's job title or description: **Job Title test test**

11. On the date of injury/illness what were the patient's usual work activities: **A Work TEST test**

12. Patient Account # **DSFDF000**

B. Employer Information

1. Employer when injury occured _____ 2. Phone # _____

3. Employer Address: _____ (Number and Street) (City) (State) (Zip Code)

C. Doctor's Information

1. Your name: **Provider** **FirstName** 2. WCB Authorization #: **TEST TEST test**

3. You are a (check one): [X] Physician [X] Podiatrist [X] Chiropractor 4. WCB Rating Code: _____

5. Office Address: **54321 Medical Drive** **Medical** **NY** **54321**

6. Billing address: _____

7. Office phone: **(555)555-5555** 8. Billing Phone: _____ 9. NPI #: **9876543214**

10. Federal Tax ID#: _____ The Tax ID # is the (check one): [ ] SSN [X] EIN

D. Billing Information

1. Employer's insurance carrier: **Insurance Company** 2. Carier Code #: **W**

3. Insurance carrier's address: **9999 Does Not Pay Street** **New York** **NY** **12345**

4. Diagnosis or nature of disease or injury:

	Enter ICD9 Code:	ICD9 Description:
(1)	**123.11**	**Diagnosis1**
(2)	**2222.22**	**Diagnosis 2**
(3)	**333.33**	**Diagnosis 3**
(4)	**444.44**	**Diagnosis 4**

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

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

Patient's Name: FirstName (Last) FirstName (First) M (MI) Date of Injury/onset of illness: _____

From Date of Service MM	DD	YY	To Date of Service MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was performed
04	20	09	04	20	09	11		99999		1 2 3 4	190.00	11		54321
04	20	09	04	20	09	11		99888		1 2 3 4	400.00	11		54321
04	20	09	04	20	09	11		888999		1 2 3 4	550.00	11		54321
04	20	09	04	20	09	11		888999		1 2 3 4	550.00	11		54321

☐ Check here if services provided by a WCB preferred provider organization (PPO)

Total Charges 1,690.00 | Amount Paid Carrier Use Only | Balance Due (Carrier Use Only)

E. History

1. Based on the patient's history, where and how did the injury/illness happen: **Injury Details test**
Line2 Test rtrtrtrrtrtrtrtrtrtrr
Line 3 TEST reeeeeeeeeeeeeeeeeeeeeeeeeeeeeeeeeeeeee
2. How did you learn about the injury/illness (check one): [X] Patient [ ] Medical Records [ ] Other (specify) _____
3. Did another health provider treat this injury/illness including hospitalization and/or surgery? [X] Yes [ ] No If yes, give details:
_____
4. have you previously treated this patient for a similar work-related injury/illness? [X] Yes [ ] No No If yes, when: _____

F. Exam Information

1. Date(s) of Examination: _____
2. Patient's subjective complaints: Check all that apply and identify specific affected body part(s):

[X] Numbness/Tingling _____ [X] Swelling _____
[ ] Pain _____ [ ] Weakness _____
[X] Stiffness _____ [X] Other (specify) _____

3. Type nature of injury: Check all that apply and identify specific affected body part(s):

[X] Abrasion _____ [X] Infectious Disease _____
[X] Amputation _____ [ ] Inhalation Exposure _____
[X] Avulsion _____ [X] Laceration _____
[X] Bite _____ [ ] Needle Stick _____
[X] Burn **Burned test test** [ ] Poisoning/Toxic Eff. _____
[ ] Contusion/Hematoma _____ [ ] Phychological _____
[X] Crush Injury _____ [X] Puncture Wound _____
[ ] Dermatitis _____ [ ] Repetitive Strain Injury _____
[ ] Dislocation _____ [ ] Spinal Cord Injury _____
[ ] Fracture _____ [ ] Sprain/Strain _____
[ ] Hearing Loss _____ [ ] Torn Ligament, Tendon or Muscle _____
[ ] Hernia _____ [ ] Vision Loss _____
[X] Other (specify) _____

Patient's Name: LastName (Last) FirstName (First) M (M) Date of injury/illness: _____

4. Physical examination: *Check all relevant objective findings and identify specific affected body part(s).*

- [X] None at present
- [X] Bruising Test test test
- [ ] Burns Test test test
- [X] Crepitation
- [X] Deformity Test test
- [X] Edema
- [X] Hematoma/Lump Swelling Test test test rrrrrrrrrrrrrr
- [ ] Joint Effusion
- [X] Laceration/Sutures Test test test
- [X] Pain/Tenderness
- [ ] Scar terrerererererere
- [X] Other findings: Other Findings test

- [ ] Neuromuscular findings:
- [ ] Abnormal/Restricted ROM
- [X] Active ROM wqeqwwqe
- [ ] Passive ROM
- [ ] Gait wewqe
- [ ] Palpable Muscle Spasm
- [ ] Reflexes
- [X] Sensation
- [X] Stregnth (Weakness) qwewqeqwee
- [ ] Wasting/Muscle Atrophy

5. Describe any diagnostic test(s) rendered at this visit
eqweqwe

6. Describe any treatment(s) rendered at this visit

7. Describe prognosis for recovery:

8. Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? [ ] Yes [X] No
If yes, describe

G. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [X] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [ ] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [ ] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the precentage (0-100%) of temporary impairment? 90 %
5. Describe findings and relevant diagnostic test results:

H. Plan of Care

1. What is your proposed treatment?

2. Medication(s):(a) list medications prescribed:
(b) list over-the-counter medications advised:

Medication restrictions: [ ] None [ ] May affect patient's ability to return to work, make patient drowsy, or other issue. Explain below:

Patient's Name: FirstName (Last) FirstName (First) M (M) Date of injury/illness: _____

3. Does the patient need diagnostic tests or referrals? [ ] Yes [ ] No If yes, check all that apply:

Tests:

- [X] CT Scan
- [ ] EMG/NCS
- [X] MRI (Specify): _____
- [ ] Labs (Specify): _____
- [X] X-rays (Specify): _____
- [X] Other (Specify): _____

Referrals

- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapist
- [ ] Physical Therapist
- [ ] Specialist in _____
- [X] Other (Specify): _____

4. Assistive devices prescribed for this patient [ ] Cane [ ] Crutches [ ] Orthodics [ ] Walker [ ] Wheelchair

Important: *You must fill out a C-4 AUTH to request any special medical service over $1000 that is not on the pre-authorized procedure list.*

[X] Other (Specify): _____

5. When is the patient's next follow-up appointment?

[ ] Within a week [X] 1-2 weeks [ ] 3-4 weeks [ ] 5-6 weeks [ ] 7-8 weeks [ ] _____ months [ ] Return as needed

I. Work Status

1. Has the patient missed work because of the injury/illness? [ ] Yes [ ] No If yes, date patient first missed work: _____

Is the patient currently working? [ ] Yes [ ] No If yes, did the patient return to: [ ] Usual work activities [ ] limited work activities

2. Can the patient return to work? *(check only one):*

a. [X] The patient cannot return to work because (explain): _____

b. [X] The patient can return to work without limitations on _____

c. [X] The patient can return to work with the following limitations (check all that apply) on _____

- [ ] Bending/twisting
- [ ] Climbing stairs/ladders
- [ ] Environmental conditions
- [ ] Kneeling
- [ ] Lifting
- [ ] Operating heavy equipment
- [ ] Operation of motor vehicle
- [ ] Personal protective equipment
- [ ] Sitting
- [ ] Standing
- [ ] Use of public transportation
- [ ] Use of upper extremities

[X] Other (explain): **Explain Other Test etst**

Describe/quantify the limitations: _____

How long will these limitations apply? [ ] 1-2 days [ ] 3-7 days [X] 8-14 days [X] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom did you discuss the patient's return to work and/or limitations? [ ] with patient [ ] with patient's employer [ ] N/A

This form is signed under penalty or perjury.

Board Authorized Health Care Provider - Check one:

[ ] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these services.

Provider's name _____

Board Authorized Health Care Provider signature:

_____

Signature Specialty Date

Doctor's Progress Report

C-4.2

State of New York - Worker's Comensation Board

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

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

Date(s) of Examination: **4/1/2009** **4/3/2009** **4/4/2009**

WCB Case Number (if known): **WCB Case 55555** Carrier Case Number (if known): _____

A. Patient's Information

1. Name: **LastName** (Last) **FirstName** (First) **M** (MI) 2. Date of Injury/Illness: _____ 3. Soc. Sec. # **123-45-6789**

4. Address (if changed from previous report): **12345 main Street** (Number and Street) **New York** (City) **NY** (State) **12345** (Zip Code)

5. Patient's Account # **DSFDF000**

B. Doctor's Infomation

1. Your Name: **Provider** (Last) **FirstName** (First) (MI) 2. WCB Authorization #: _____

3. WCB Rating Code: **WCB Rating 666666**

4. Office address: **54321 Medical Drive** (Number and Street) **Medical** (City) **NY** (State) **54321** (Zip Code)

5. Billing address: **54321 Medical Drive** (Number and Street) **Medical** (City) **NY** (State) **54321** (Zip Code)

6. Office phone #: **(555)555-5555** 7. Billing phone #: **(555)555-5555** 8. NPI # **9876543214**

9. Federal Tax ID#: **555-55-5555** 10. The Tax ID# is the (check one) [ ] SSN [X] EIN

C. Billing Information

1. Employer's insurance carrier: **Insurance Company** 2. Carrier Code #: **W C42 Carrier code**

3. Insurance carrier's address: **9999 Does Not Pay Street** (Number and Street) **New York** (City) **NY** (State) **12345** (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD9 Code:	ICD9 Descriptor:
(1)	**123.11**	**Diagnosis1**
(2)	**2222.22**	**Diagnosis 2**
(3)	**333.33**	**Diagnosis 3**
(4)	**444.44**	**Diagnosis 4**

Relate ICD9 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

From Date of Service MM	DD	YY	To Date of Service MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip Code where service was performed
04	20	09	04	20	09	11		99999		1 2 3 4	190.00	11		54321
04	20	09	04	20	09	11		99888		1 2 3 4	400.00	11		54321
04	20	09	04	20	09	11		888999		1 2 3 4	550.00	11		54321
04	20	09	04	20	09	11		888999		1 2 3 4	550.00	11		54321

[X] Check here if services were provided by a WCB preferred organizaion (PPO)

Total Charges **1,690.00** | Amount Paid Carrier use Only | Balance Due (Carrier Use Only)

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit **TEST TEST TEST**

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

C-4 AUTH

State of New York - Worker's Compensation Board

Answer all questions fully on this report

WCB Case Number: WCB	Carrier Case Number: Carrier Case 444444	Date of Injury:

Patient's Name: FirstName (First) M (MI) LastName (Last)

Social Security Number: 123-45-6789

Employer' Name:

Insurance Carrier's Name: Insurance Company

Address: 9999 Does Not Pay Street (Number and Street) New York (City) NY (State) 12345 (Zip Code)

Attending Doctor's Name FirstName Provider

Provider Authorization Number: PROVAUTH333333

Address: 54321 Medical Drive (Number and Street) Medical (City) NY (State) 54321 (Zip Code)

Telephone Number: (555)555-5555 Fax Number:

AUTHORIZATION REQUEST

The undersigned requests written authorization for the following special service(s) costing over $1,000.

Authorization Request:

Diagnostic Tests (indicate body part)

		Carrier Response: If any service is denied, explain on reverse.
[X]	X-Rays XRAYaaaaaaaaaaaaaaaaaa	☐ Granted ☐ Denied
[X]	CT Scat CTSCAN33333333333333333333333333	☐ Granted ☐ Denied
[X]	MRI MRI TESTttttttttttttttttttttttttttttttttt	☐ Granted ☐ Denied
[X]	EMG/NCV UE ewewewqeqwewqewq (L, R, or B)	☐ Granted ☐ Denied
	LE ewqweeqw (L, R, or B)	☐ Granted ☐ Denied
[X]	Nerve Blocks Nerve Block	☐ Granted ☐ Denied
[X]	Orthopedic Evaluation Orthopedic rererere	☐ Granted ☐ Denied
[X]	Neurological Evaluation Neuro NNNNNNNNN	☐ Granted ☐ Denied
[X]	Other Other TTTTTT	☐ Granted ☐ Denied

Treatment

[X]	Physical Therapy (_____ times per week for _____ weeks)	☐ Granted ☐ Denied
[X]	Occupational Therapy (_____ times per week for _____ weeks)	☐ Granted ☐ Denied
[X]	Other (_____ times per week for _____ weeks)	☐ Granted ☐ Denied

Surgery

[X]	Type of Surgery trrtrtrtrtrtr	☐ Granted ☐ Denied
		☐ Granted ☐ Denied
[X]	Surgical Implants	☐ Granted ☐ Denied
[X]	Post-OP Physical Therapy (_____ times per week for _____ weeks)	☐ Granted ☐ Denied

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

OCCUPATIONAL THERAPIST'S REPORT
PHYSICAL THERAPIST'S REPORT

STATE OF NEW YORK
WORKER'S COMPENSATION BOARD

SERVICES PROVIDED UNDER WCB PREFERRED PROVIDER ORGANIZATION (PPO) PROGRAM? YES [ ] NO [X]

[ ] 48 HR. INITIAL [ ] 15 DAY INITIAL [ ] 45 DAY SEE ITEM 1 ON REVERSE FOR PROGRESS FILING INSTRUCTIONS

PLEASE TYPE ALL INFORMATION COMPLETE ALL ITEMS

WCB CASE NO	CARRIER CASE NO. (IF KNOWN)	DATE OF INJURY AND TIME	ADDRESS WHERE INJURY OCCURED (CITY TOWN OR VILLAGE)	INJURED PERSON'S SOC. SEC. NO.
CASE	Carrier Case	4-1-2009	1234 Injury Street Accident NY	123-45-6789

INJURED PERSON	(First Name) FirstName (Middle Initial) M (Last Name) LastName	12345 main Street New York, NY 12345	TELEPHONE NO. 5555555555
EMPLOYER			PATIENT'S DATE OF BIRTH 04201960
INSURANCE CARRIER	Insurance Company	9999 Does Not Pay Street New York, NY 12345	
REFERRING PHYSICIAN/ PODIATRIST			TELEPHONE NO.

"If treatment was rendered under the VFBL OR VAWBL show as "Employer" the liable political subdivision and enter check here: [ ] VFBL [ ] VAWBL

If you have filed a previous report, setting forth the history of the injury, enter the date and complete items 3 to 16. If not, complete all items.

HISTORY

1. DIAGNOSIS OF REFERRING PHYSICIAN/PODIATRIST
Broken Leg

2. If patient has given any history of pre-existing injury, disease or physical impairment, describe specifically
None

EVALUATION / TREATMENT

3. Referral was for: [X] Evaluation Only (Complete item a) [ ] Treatment Only (Complete item b-1,2,3) [ ] Evaluation and Treatment (complete Items a and B-1,2,3)

a. Your Evaluation:
Evaluation

b. (1) Patient's condition and progress

b. (2) Treatment and planned future treatment. If an authorization request is required (see items 4 & 5 on reverse), check box [ ] and explain below. If additional space is necessary, please attach request.

b. (3) Was such treatment plan upon prescription or referral of claimant's attending physician or, in the case of physical therapy, authorized physician or podiatrist?
[ ] Yes [X] No if yes, frequency of tratment ordered: Period of treatment ordered:

4. Date(s) of visits on which this report is based | Date of First Visit | Will Patient be seen again? [ ] Yes [X] No If yes, when? If no, was patient referred back to attending doctor? [ ] [X]

5. Is patient working? [ ] Yes [X] No If yes, date(s) patient resumed limited work of any kind resumed regular work

BILLING

6. Diagnosis or nature of disease or injury (Relate items 1,2,3 or 4 to item 7E by line). Enter code and describe nature of injury
1. | 123-11 Diagnosis1 3. | 333-33 Diagnosis 4
2. | 2222- Diagnosis 2 4. | 444-44 Diagnosis 3

A Dates of Service MM DD YY MM DD YY	B Place of Service	C Leave Blank	D (USE WCB CODES) Procedures, Services or Supplies CPT/HCPCS	MODIFIER	E Diagnosis Code	F $ Charges	G Days or Units	H COB	I Zip Code where Service was Rendered

SEE C4.1 CONTINUATION PAGE(s) FOR BILLING INFORMATION

Federal Tax I.D. Number	SSN	EIN	9. NYS License Number	10. Patient's Account Number	11. Total Charges	12. Amt paid (carrier use only)	13. Bal. Due (carrier use only)
555-55-5555		X		DSFDF000	1,690.00		

Affirmed Under Penalty of Perjury

14. Signature of Treating Therapist Date

15. Therapist's Name, Address & Phone No.
FirstName Provider (555)555-5555
54321 Medical Medical- NY 54321

16. Therapist's Billing Name, Address & Phone No. -555-555-5555
FirstName Provider
54321 Medical Drive Medical- NY 54321

SEE REVERSE SIDE FOR IMPORTANT INSTRUCTIONS

CONTINUATION TO CARRIER/EMPLOYER BILLING PORTION OF FORMS C-4, C-5, PS-4, or OT/PT-4

Doctor's Name	WCB Case Number	Carrier Case Number	Date of Accident or Injury
FirstName Provider			

Patient	Patient's Social Security Number
LastName, FirstName M	123-45-6789

A		B	C	D (USE WCB CODE)		E	F	G	H	I
Dates of Service From MM DD YY	MM DD YY	Place of Service	Leave Blank	Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HPCS	MODIFIER	Diagnosis Code	$ Charges	Days or Units	COB	Zip Code Where Service was Rendered
04 20 09	04 20 09	11		99999		1 2 3 4	190 00	1		54321
04 20 09	04 20 09	11		99888		1 2 3 4	400 00	1		54321
04 20 09	04 20 09	11		888999		1 2 3 4	550 00	1		54321
04 20 09	04 20 09	11		888999		1 2 3 4	550 00	1		54321

THE INJURED WORKER SHOULD NOT PAY THIS BILL.