Doctor's Narrative Report

EC-4NARR

State of New York - Workers' Compensation Board

THIS FORM MAY ONLY BE SUBMITTED ELECTRONICALLY. DO NOT MAIL.

This form may be used to report the *first* time you treated the patient or to report *continuing* services. (To report permanent impairment, use Form C-4.3.) **Use this form only if attaching a detailed narrative report. See Section F for topics that must be addressed in the narrative attachment.** Please answer all questions completely 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.

A. Patient's Information

1. Name: _____ (Last / First / MI) 2. Social Security #: ___ - ___ - ____

3. Home phone #: (____)_____ 4. WCB Case # (if known): _____ 5. Carrier Case # (if known): _____

6. Mailing address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

7. Date of injury/onset of illness: ____/____/____ 8. Date of birth: ____/____/____ 9. Gender: ☐ Male ☐ Female

10. On the date of injury/illness what was the patient's job title or description: _____

11. On the date of injury/illness what were the patient's usual work activities: _____

_____

12. Is the patient working now? ☐ Yes ☐ No 13. Patient's Account #: _____

B. Employer Information

1. Employer when injury occurred: _____ (Company/Agency Name) 2. Phone #: (____)_____

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

C. Doctor's Information

1. Your name: _____ (Last / First / MI) 2. WCB Authorization #: _____

3. You are a (*check one*): ☐ Physician ☐ Podiatrist ☐ Chiropractor 4. WCB Rating Code: _____

5. Office address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

6. Billing address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

7. Office phone #: (____)_____ 8. Billing phone #: (____)_____ 9. NPI #: _____

10. Federal Tax ID #: _____ The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

D. Billing Information

1. Employer's insurance company: _____ 2. Carrier Code #: **W** _____

3. Insurance company's address: _____ (Number and Street) _____ (City) _____ (State) _____ (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD9 Code:	ICD9 Descriptor:
(1)		
(2)		
(3)		
(4)		

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

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered

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

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$	$	$

E. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☐ 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 percentage (0-100%) of temporary impairment? _____%

F. Narrative Requirements - for initial report, include all requirements listed below. For subsequent reports, include only facts and findings that are new or changed from your last report.

History of the Injury/Illness

- Who provided you with the information about the injury/illness?
- Describe where and how the injury/illness occurred
- Describe the patient's injury/illness and identify specifically any affected body parts
- Other treatment for the injury/illness including hospitalization or surgery
- Patient's subjective complaints
- Relevant medical history, incl. prior treatment for a similar work-related injury/illness

Objective Findings/Clinical Evaluation

- Physical examination (describe all relevant findings)
- Diagnostic procedure(s)/test(s) performed prior to the visit
- Diagnostic procedure(s)/test(s) performed during the visit
- Treatment rendered at time of exam, if any
- Diagnoses/clinical assessments

Plan of Care

- Proposed treatment and treatment goals (include type of treatment, frequency and anticipated duration of treatment)
- Medications (prescription and over-the-counter drugs) prescribed for the injury/illness
- Any work restrictions that may result from these medications
- Diagnostic test(s) ordered
- Referrals/Consultations requested
- Assistive devices prescribed
- Prognosis for recovery
- Follow-up appointment(s)

Work Status

- Can the patient return to usual work activities as indicated above (A.11)?
- Are there any work limitations? (If so, explain and quantify, including the anticipated duration of the limitations)
- Describe discussions with the patient and employer regarding return to work with any applicable limitations

Impairment (Comment only if patient has a temporary impairment as indicated above in E.4)

- Describe findings and explain how impairment percentage was determined

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 provided these services.

Provider's name_____ Specialty_____

Board Authorized Health Care Provider:

_____ _____ ____/____/____

Name Specialty Date

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.
   45 DAY PROGRESS REPORTS - File this form at intervals of 45 days during continuing treatment, unless change of condition necessitates additional 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 contain the attending doctor's authorization certificate number, code letters and NPI number. If the patient is hospitalized, it may be submitted 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** - You MUST follow the instructions contained on the form C-4 AUTH to request any special medical service over $1000.

   AUTHORIZATION FOR SPECIAL SERVICES IS NOT REQUIRED IN AN EMERGENCY
5. **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-l 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. 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 Albany address indicated 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.

IMPORTANTE PARA EL PACIENTE

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.

WORKERS' COMPENSATION BOARD DISTRICT OFFICES

Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

Albany DO - 100 Broadway-Menands, Albany NY 12241 866-750-5157 (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY13901 866-802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
Buffalo DO - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 866-211-0645 (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
Rochester DO - 130 Main Street West, Rochester NY 14614 866-211-0644 (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)
Syracuse DO - 935 James Street, Syracuse NY 13203 866-802-3730 (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego,St. Lawrence)
Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC 800-877-1373; in Hempstead 866-805-3630; in Hauppauge 866-681-5354; in Peekskill 866-746-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

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