COMMUNITY CARE PHYSICIANS

Worker's Comp Information

General Information

Name: _____ Marital Status: _____ Sex: _____

Address: _____ City: ___ _ State: _____ Zip: ___ _

Home Ph: _____ Work Ph: _____ DOB: _____ Age: _____

Insurance Information

Have you reported your injury to your employer? Yes or No (Circle One)

Worker's Comp Carrier.:.: _____ Phone: _____

Address: _____

WCB#: _____ Carrier Case #: _____

Employer: _____ Phone#: _____

Address: _____

Occupation or Job Title:

Contact Person:

Injury Information

Date of injury: _____ Time: _____

Were X-Rays Taken: Yes or No (Circle One) Where: _____ Date: _____

Have you been treated by anyone else, including an ER? _____

Where? _____

Briefly describe the accident and injury: _____

_____

Briefly describe your work activities: _____

Address where accident occurred: _____

Arc you out of work? Yes or No (Circle One) Date last worked: _____

Authorization

I authorize Community Care Physicians, P.C, to release all records pertaining to medical history, services rendered or treatment to me or my depends for insurance claims. I authorize payment of medical benefits to Community Care Physicians, P.C. I promise as guarantor for the above patient or as the patient to pay for all medical services disputed or denied by my insurance.

Patient Signature: _____ Date: _____

☐ **OCCUPATIONAL THERAPIST'S REPORT**
☐ **PHYSICAL THERAPIST'S REPORT**

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

SERVICES PROVIDED UNDER WCB PREFERRED PROVIDER ORGANIZATION (PPO) PROGRAM? YES ☐ NO ☐

☐ **48 HR. INITIAL** ☐ **15 DAY INITIAL** ☐ **90 DAY PROGRESS** *SEE ITEM 1 ON REVERSE FOR FILING INSTRUCTIONS*

PLEASE TYPE ALL INFORMATION - COMPLETE ALL ITEMS

WCB CASE NO.	CARRIER CASE NO. (IF KNOWN)	DATE OF INJURY	& TIME	ADDRESS WHERE INJURY OCCURRED (CITY, TOWN OR VILLAGE)	INJURED PERSON'S SOCIAL SECURITY NUMBER

INJURED PERSON	(First Name) (Middle Initial) (Last Name)	ADDRESS (Include Apt. No.)	TELEPHONE NO.
EMPLOYER*			PATIENT'S DATE OF BIRTH
INSURANCE CARRIER			
REFERRING PHYSICIAN/ PODIATRIST			TELEPHONE NO.

*If treatment was under the VFBL or VAWBL show as "Employer" the liable political subdivision and check one: ☐ VFBL ☐ VAWBL

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

HISTORY

1. Diagnosis of referring physician/podiatrist.

2. If patient has given any history of pre-existing injury, disease or physical impairment, describe specifically.

EVALUATION/TREATMENT

3. Referral was for: ☐ 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:

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 ☐ No If yes, frequency of treatment 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 ☐ No If yes, when: If no, was patient referred back to attending doctor: ☐ Yes ☐ No

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

BILLING FORM

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. |_____ . __ 3. |_____ . __
2. |_____ . __ 4. |_____ . __

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

8. 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)

SIGNATURE

Affirmed Under Penalty of Perjury

14. Signature of Treating Therapist Date

15. Therapist's Name, Address & Phone No.

16. Therapist's Billing Name, Address & Phone No.

THE INJURED WORKER SHOULD NOT PAY THIS BILL

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature _____ Date _____

Provider's Name and Address _____

_____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.