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

C-4 AUTH

State of New York - Workers' Compensation Board

Answer all questions fully on this report

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

Patient's Name: ..... (First MI Last)

Social Security Number: .....

Employer's Name: .....

Insurance Carrier's Name: .....

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

Attending Doctor's Name: .....

Provider's Authorization Number: .....

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

Telephone Number: ..... Fax Number: .....

AUTHORIZATION REQUEST

The undersigned requests written authorization for the following special service(s) costing over $1,000, which are not on the pre-authorized list.

Authorization Requested:	**Carrier Response: If any service is denied, explain on reverse.**
Diagnostic Tests (indicate body part)	
❑ X-Rays	❑ Granted ❑ Denied
❑ CT Scan	❑ Granted ❑ Denied
❑ MRI	❑ Granted ❑ Denied
❑ EMG/NCV UE .....(L, R or B)	❑ Granted ❑ Denied
LE .....(L, R or B)	❑ Granted ❑ Denied
❑ Nerve Blocks	❑ Granted ❑ Denied
❑ Orthopedic Evaluation	❑ Granted ❑ Denied
❑ Neurological Evaluation	❑ Granted ❑ Denied
❑ Other	❑ Granted ❑ Denied
Treatment	
❑ Physical Therapy (____ times per week for _____ weeks)	❑ Granted ❑ Denied
❑ Occupational Therapy (____ times per week for _____ weeks)	❑ Granted ❑ Denied
❑ Other .....(____ times per week for _____ weeks)	❑ Granted ❑ Denied
Surgery	
❑ Type of Surgery	❑ Granted ❑ Denied
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❑ Surgical Implants	❑ Granted ❑ Denied
❑ Post-OP Physical Therapy (_____ times per week for _____ weeks)	❑ Granted ❑ Denied

STATEMENT OF MEDICAL NECESSITY

Pursuant to 12 NYCRR 325-1.4(a)(1), it is the attending physician's burden to set forth the medical necessity of the special services required. Failure to do so may delay the authorization process.

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I certify that I am making the above request for authorization. This request was made by telephone on (date) _____ to (person contacted) _____ This form was also mailed to the self-insured employer/carrier and a copy was provided to the Board on the date below.

Provider's Signature: ..... Date: .....

SELF-INSURED EMPLOYER / CARRIER RESPONSE TO AUTHORIZATION REQUEST

Response Time and Notification Required:

If claimant is hospitalized: The self-insured employer/carrier must grant or deny each request for authorization of special service to the doctor by telephone within 4 working days. This response must be confirmed in writing ***by completing this form and mailing it, within five days of the examination of the patient***, to the doctor, claimant's legal counsel if any, and the Workers' Compensation Board.

If claimant is not hospitalized: The self-insured employer/carrier must grant or deny each request for authorization of special service to the doctor by telephone and confirm its response in writing ***by completing this form and mailing it, within thirty days***, to the doctor, claimant's legal counsel if any, and the Workers' Compensation Board.

Denial of the Request for Authorization of a Special Service: A denial of authorization of a special service to an established body part **must** be based upon and accompanied by a **conflicting second opinion** rendered by a physician authorized to treat workers' compensation claimants. If the compensation case is controverted, the conflicting second opinion must address medical necessity only and such authorization shall not be construed as an admission that the condition for which these services are required is compensable. The employer/carrier shall not be responsible for the payment of such services until the question of compensability is resolved. When denying authorization for a special service, the employer/carrier must also file with the Board within 5 days of such denial **Board Form C-8.1 Part A** (Notice of Treatment Issue(s)/Disputed Bill Issue(s)). Failure to file timely the conflicting second opinion and Board Form C-8.1 Part A will render the denial defective.

Failure to Timely Respond to 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/carrier fails to respond within the time specified above. 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 CONFLICTING SECOND MEDICAL OPINION AS EXPLAINED ABOVE.)

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*I certify that the self-insured employer/carrier **telephoned** the office of the health care provider listed above within the response time-frame indicated above and advised that the self-insured employer/carrier 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 **mailed** to the health care provider listed above and to the Workers' Compensation Board on the date below:*

By: ..... Title: .....
(Please print name)

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 as follows:
   To confirm a telephone request for written authorization for special service(s) costing over $1,000 in a non-emergency situation.

2. 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 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.

2. When requesting authorization over the telephone, be sure to obtain the name of the person contacted since you must indicate this information along with the date of contact and certify its validity on the form.

3. It is the attending physician'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.

4. This form must be signed by the attending doctor (original signature only) and must contain her/his authorization certificate number and code letters. 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.

5. Please ask your patient for his/her WCB case number and the carrier's 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, the workers' compensation insurance carrier or self-insured employer, and, if the patient is represented by an attorney or licensed representative, such legal representative. If your patient is not represented, a copy must be sent to your patient.

6. If authorization or denial is not forthcoming within the 4 working days if the patient is hospitalized, or within the 30 calendar days if the patient is not hospitalized, notify the nearest office of the Workers' Compensation Board.

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.

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)