Ancillary Medical Report

C-4 AMR

State of New York - Workers' Compensation Board

Use this form to report ancillary medical services such as x-ray, anesthesia, pathology or diagnostic services by other than the attending provider. A medical provider who is only giving clearance for surgery may also use this form. THIS FORM SHOULD NOT BE USED TO REPORT TREATMENT PROVIDED.

Please answer all questions completely, attaching the report for the services provided, 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 services, 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.ny.gov.

A. Patient's Information

1. Name: _____ (Last / First / MI) 2. Soc. Sec. #: ___ - ___ - _____

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

4. Home phone #: (___)_____ 5. Date of Birth: ___/___/___ 6. Date of injury/onset of illness: ___/___/___

7. WCB Case # (if known): _____ 8. Carrier Case #: _____ 9. Patient's Account #: _____

B. Doctor's Information

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

3. WCB Rating Code: _____ 4. Federal Tax ID #: _____ The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

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

6. Billing group or practice name: _____

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

8. Office phone #: (___)_____ 9. Billing phone #: (___)_____ 10. Provider's NPI #: _____

11. Referring Doctor: _____ (Last / First / MI)

C. Billing Information

1. Employer's insurance carrier: _____ 2. Carrier Code #: W_____

3. Insurance carrier'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) _____ _____

Relate ICD9 codes in (1), (2) or (3) to Diagnosis Code column 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)
$	$	$

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 signature:

_____ / /

Name Signature Specialty Date