ATTENDING DOCTOR'S REQUEST FOR OPTIONAL PRIOR APPROVAL AND CARRIER'S/EMPLOYER'S RESPONSE

MG-1

State of New York - Workers' Compensation Board

FOR ADDITIONAL APPROVAL REQUESTS IN THIS CASE, ATTACH FORM MG-1.1

Answer all questions where information is known.

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

A. Patient's Name: ..... Social Security Number: .....
First MI Last

Patient's Address: .....

Employer's Name & Address: .....

Insurance Carrier's Name & Address: .....

Note: This form is used only if the employer/carrier participates in the Optional Prior Approval program. You can obtain participation status from the WCB website.

B. Attending Doctor's Name & Address: .....

Individual Provider's WCB Authorization No.: ☐☐☐☐☐☐-☐☐ Telephone No.: ..... Fax No.: .....

C. **DATE REQUEST SUBMITTED:** .....

The undersigned requests optional prior approval under the WCB Medical Treatment Guidelines as indicated below:

Treatment/Procedure Requested: .....

Guideline Reference: ☐ - ☐☐☐☐ *(In first box, indicate body part: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)*

Date of Service of Supporting Medical in WCB Case File: ..... **(if not already in file, please attach.)**

Other Comments:

I certify that I am making the above request for optional prior approval and my affirmative statements are true and correct. I ☐ did / ☐ did not contact the carrier by telephone to discuss this request before making it. I contacted the carrier by telephone on (date) _____ and spoke to (person spoken to or was not able to speak to anyone) _____.

☐ A copy of this form was sent to the carrier/employer/self-insured employer/Special Fund by (fax, email) _____, a copy was sent to the Workers' Compensation Board (see the Board's email address and fax number on the reverse), and copies were provided to the claimant's legal counsel, if any, and to any other parties of interest on the date below.

☐ I am not equipped to send or receive forms by fax or email. This form was mailed to the parties indicated above on .....

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

D. **CARRIER'S / EMPLOYER'S RESPONSE** (Response is due 8 business days from receipt of this request or medical care is deemed approved (12 NYCRR 324.4(c)). The provider's request is:

☐ **Granted**

☐ **Granted without Prejudice** **(see item 7 on reverse)**

☐ **Denied** IF DENIED, STATE THE BASIS FOR THE DENIAL IN THE SPACE PROVIDED BELOW. SEE IMPORTANT INFORMATION TO CARRIER ON REVERSE.

Name of the Medical Professional who Reviewed the Denial: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting optional prior approval, the Workers' Compensation Board (see email address and fax number on the reverse), the claimant's legal counsel, if any, and any other parties of interest, on the date below.

By: ..... Title: .....

Signature: ..... Date: .....

E. **MEDICAL PROVIDER'S REQUEST FOR REVIEW BY MEDICAL ARBITRATOR OF DENIAL**

☐ I hereby request review by a medical arbitrator designated by the Chair of the carrier's decision to deny optional prior approval of the above request. I understand that resolution by the medical arbitrator is binding and is not appealable under Workers' Compensation Law §23. (Request is due within 14 calendar days of the date of denial.) Supporting medical report(s) dated _____ is/are attached or is/are available in the WCB case file.

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

F. **CARRIER / EMPLOYER IS APPROVING THIS REQUEST FOR OPTIONAL PRIOR APPROVAL AFTER AN INITIAL DENIAL**

☐ I certify that the provider's request for optional prior approval given above, **which was initially denied on** ....., is now granted.

By: ..... Title: .....

Signature: ..... Date: .....