ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND CARRIER'S RESPONSE

State of New York - Workers' Compensation Board

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

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

A. Patient's Name: ..... (First / MI / Last) ..... Social Security No.: .....

Patient's Address: .....

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

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

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

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

C. **DATE VARIANCE REQUEST SUBMITTED AND METHOD OF TRANSMISSION: on ...../...../..... by.....**

The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:

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.)*

Approval Requested for: (one request type per form)	**CARRIER'S / EMPLOYER'S RESPONSE** **If service is denied, explain on reverse.**
.....	☐ Granted
.....	☐ Granted without Prejudice
.....	☐ Denied
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STATEMENT OF MEDICAL NECESSITY -- See item 4 on instruction page for requirements.

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Date of Service of Supporting Medical in WCB Case File: .....

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care. I ☐did / ☐did not contact the carrier by telephone to discuss this variance request before making the request. I contacted the carrier by telephone on (date)..... and spoke to (person spoke 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 (see addresses on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal counsel, if any, to the claimant if not represented, 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 NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW**

☐ The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the Variance Request.

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

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

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.

E. **CARRIER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST**

Carrier's response to the variance request is indicated in the checkboxes on the front side of this form. If request is denied, give reason(s) for denial. Carrier denial must be reviewed by a health professional. (Attach written report of medical professional as explained above.)

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Name of the Medical Professional who Reviewed the Denial:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board (see mail, fax and email addresses on instruction page), the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/self-insured employer/Special Fund attached, on the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally within 8 business days of receipt of the denial, I opt for the decision to be made by the ☐ Medical Arbitrator designated by the Chair or ☐ at a WCB Hearing. I understand that both parties, the carrier and the claimant, must opt in writing for resolution by the medical arbitrator; otherwise a decision will be made at a WCB Hearing. I understand that if both parties opt for resolution by the medical arbitrator, our right to an expedited hearing is waived, and that the resolution by the medical arbitrator is binding and not appealable under WCL § 23. I understand that if I choose to not complete this section, the variance issue will be decided at a Hearing.

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

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

F. **CLAIMANT'S REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S / CARRIER'S DENIAL**

☐ I request that the Workers' Compensation Board review the carrier's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made by the ☐ Medical Arbitrator designated by the Chair or ☐ at a WCB Hearing. I understand that both parties, the carrier and the claimant, must opt in writing for resolution by the medical arbitrator; otherwise a decision will be made at a WCB Hearing. I understand that if both parties opt for resolution by the medical arbitrator, our right to an expedited hearing is waived, and that the resolution by the medical arbitrator is binding and not appealable under WCL § 23. I understand that if I choose to not complete this section, the variance issue will be decided at a Hearing.

Claimant's Signature: ..... Date: .....

G. **CARRIER'S / EMPLOYER'S GRANTING OF ATTENDING DOCTOR'S VARIANCE REQUEST AFTER INITIAL DENIAL.**

I certify that the provider's variance request initially denied above is now granted.

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

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