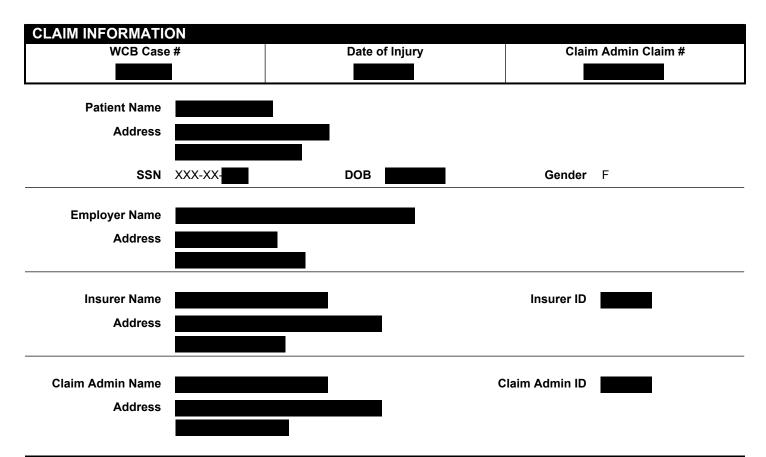
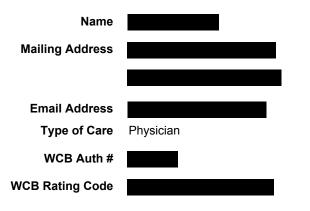


For Office Use Only:



## HEALTH CARE PROVIDER/ MEDICAL SUPPLIER INFORMATION

Name and Mailing Address of Health Care Provider/ Medical Supplier



Phone #	
FEIN/ SSN	
NPI	



HEALTH CARE PROVIDER/ MEDICAL SUPPLIER INFORMATION	
Health Care Provider/ Medical Sup	plier Billing Information
Billing Address	
Email Address	Phone #
MEDICAL BILL INFORMATION	
Total Charge (\$)	1000.00
Amount Paid (\$)	10.00
Total # of Medical Bills Attached	1
Date Span for Attached Bill(s)	10/01/2021 to 10/01/2021
HEALTH CARE PROVIDER/ MEDICAL SUPPLIER'S ATTESTATION	
I affirm, under penalty of perjury, that	
<ol> <li>The attached medical bill(s) was submitted to the responsible insurer/self-insured employer for payment, AND</li> <li>Proper payment in accordance with the applicable Fee Schedule has not been received, AND</li> </ol>	
<ol> <li>I will abide by the NYS Workers' Compensation Board's decision.</li> </ol>	
Name	Date 02/01/2022