Insurer's Notification of Initial Request for Reimbursement Under WCL Section 14(6) or Section 15(8)

NEW YORK STATE Workers' Compensation Board

Email completed form to: SpecialFunds@wcb.ny.gov

A form must be fully completed and submitted for each claim where reimbursement is being requested for the first time. The actual reimbursement request should be included on Form C-251 or Form C-251.1, as applicable.

Insurer ID (W Number) / Insurer Name: _____

Claim Administrator: _____ Contact Name: _____

Phone Number: _____ Email: _____

Submit Date: _____

Claim Information	
Type	
WCB Case Number	
Claim Admin Claim Number	
Claimant Name	
Beneficiary Name	
Gender	
Date of Birth	
ANCR/ODNCR	
Date of Injury	
Date of Classification	
Date of SDF Liability	
Benefit Cap	
Average Weekly Wage	
Overall CCP Rate	
CCP Type	
Apportionment %	
SDF Liability %	
SDF Reimbursable Rate	
State of Residence	
Medicare Status	

Established Sites / Conditions (WCL Section 15(8) Only)		
Established Site / Condition	Appt %	SDF %

Retention Period (WCL Section 15(8) Only)		
Begin Date	End Date	Weeks
	Total:	

SUBMISSION INFORMATION

Insurer ID (W Number) - Enter the WCB-assigned Insurer Code ("W Number") for the insurer that is responsible for the claim and seeking reimbursement; this entity must be identified as a Party of Interest (POI) on the claim in the WCB case folder in order for reimbursement to be processed [REQUIRED].

Insurer Name - The form will populate the name of the insurer that is responsible for the claim and seeking reimbursement from the name in Groups tab.

Claim Administrator - Enter the name of the entity that is administering the claim and will receive the reimbursement or indicate if claim is self-administered; this entity must be identified as a POI on the claim in the WCB case folder in order for reimbursement to be processed. Payment will be directed to the address the WCB Special Funds Group has on file for the administrator [REQUIRED].

Contact Name - Enter the name of the person that the WCB Special Funds Group can contact with questions about the submission [REQUIRED].

Phone Number - Enter the phone number for the contact [REQUIRED].

E-Mail Address - Enter the e-mail address for the contact [REQUIRED].

Submit Date - Enter the date the form was submitted to the WCB Special Funds Group [REQUIRED].

CLAIM INFORMATION

WCB Case Number - Enter the claim number assigned by WCB; this number should be entered as it appears in eCase with no spaces or extra characters [REQUIRED].

Claim Admin Claim Number - Enter the claim number assigned by the entity that is administering the claim [OPTIONAL].

Claimant Name - Enter the name of the claimant [REQUIRED].

Beneficiary Name - Enter the name of the person receiving the indemnity benefits (if someone other than the claimant). If claim has more than one beneficiary indicate "Multiple" [OPTIONAL].

Gender - Enter the gender of the person receiving the indemnity benefits [REQUIRED].

Date of Birth - Enter the date of birth of the person receiving the indemnity benefits [REQUIRED].

ANCR/ODNCR - Enter whether the claim has a finding of Accident Notice Causal Relationship (ANCR) or Occupational Disease Causal Relationship (ODNCR) [REQUIRED].

Date of Injury - Enter the date of accident/date of disablement for the claim [REQUIRED].

Date of Classification - Enter the effective date of the finding that the claimant has a Permanent Partial Disability (PPD) [REQUIRED].

Date of SDF Liability - Enter the effective date of the finding that the Special Disability Fund is liable for some portion of the claim [REQUIRED].

Benefit Cap - If claim is capped, enter the number of weeks of indemnity benefits allowed under the cap [REQUIRED].

Average Weekly Wage - Enter the average weekly wage found for the claimant [REQUIRED].

Overall CCP Rate - Enter the weekly CCP rate that is currently being paid [REQUIRED].

CCP Type - Enter the type of CCP from the options listed below [REQUIRED]:
- DBF   Death Benefits
- PPD   Permanent Partial Disability
- TRE   Tentative Reduced Earnings

Apportionment % - Enter the percentage of the weekly CCP rate that is currently being paid by the insurer on this claim [REQUIRED - CANNOT BE ZERO].

SDF Liability % - Enter the percentage of the weekly CCP rate that is being paid by the insurer on this claim that is reimbursable from the SDF. For 14(6) Concurrent Employment claims this is equal to the percentage of Average Weekly Wage that is attributable to the concurrent employer [REQUIRED - CANNOT BE ZERO].

SDF Reimbursable Rate - The form will calculate the weekly rate for which reimbursement from the SDF is being requested; based on the Overall CCP Rate, Apportionment % and SDF Liability %.

State of Residence - Enter the state or states where the claimant currently resides [REQUIRED].

Medicare Status - Enter the Medicare eligibility status of the claimant from the options listed below [REQUIRED]:
- ENR   Currently Enrolled And Receiving Benefits
- ELG   Eligible Within The Next 30 Months
- NOT   Not Eligible Within The Next 30 Months

ESTABLISHED SITE / CONDITIONS

The following section is required for 15(8) claims only.

Established Site / Condition - Enter each site (body part) or condition that has been established as related to the claim [AT LEAST ONE REQUIRED].

Appt % - Enter the percentage of the cost of medical treatment related to the established site / condition that is currently being paid by the insurer on this claim [REQUIRED FOR EACH SITE/CONDITION].

SDF % - Enter the percentage of cost of medical treatment related to the established site / condition that is being paid by the insurer on this claim that is reimbursable from the SDF [REQUIRED FOR EACH SITE/CONDITION].

RETENTION PERIOD

The following section is required for 15(8) claims only.

Begin Date - Enter the first day of the period for which benefits were paid as part of the retention period ("From Date") [AT LEAST ONE REQUIRED]

End Date - Enter the last day of the period for which benefits were paid as part of the retention period ("To Date") [REQUIRED FOR EACH BEGIN DATE].

Weeks - The form will calculate the number of weeks within the period based on the Begin Date and End Date.

Additional information can be found on the WCB website: www.wcb.ny.gov.