Doctor's Narrative Report

EC-4NARR

State of New York - Workers' Compensation Board

THIS FORM MAY ONLY BE SUBMITTED ELECTRONICALLY. DO NOT MAIL.

This form may be used to report the *first* time you treated the patient or to report *continuing* services. (To report permanent impairment, use Form C-4.3.) **Use this form only if attaching a detailed narrative report.** Please answer all questions completely 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 treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization.

Load previously saved EC-4NARR data

***Required Fields** **Conditionally Required Fields -** Select (CR) for field requirements.

A. Patient's Information

1. *Last Name: _____ *First Name: _____ MI: ____
2. Social Security #: _____ 3. Home Phone #: _____
4. WCB Case # (if unknown leave blank): _____ 5. Carrier Case # (if unknown leave blank): _____
6.* Mailing Address: _____ Line 2: _____
   *City: _____ (CR) State: _____ (CR) Zip Code: _____ *Country: USA
7. *Date of injury/onset of illness: _____ 8. *Date of birth: _____ 9. *Gender: ◯ Male ◯ Female
10. *On the date of injury/illness what was the patient's job title or description:
_____
11. *On the date of injury/illness what were the patient's usual work activities:
_____
12. *Is the patient working now? ◯ Yes ◯ No 13. Patient's Account #: _____

Sample Document

B. Employer Information

1. Employer when injury occurred:
   *Company/Agency Name: _____
2. Employer Phone #: _____
3. *Employer Address: _____ Line 2: _____
   *City: _____ (CR) State: _____ (CR) Zip Code: _____ *Country: USA

C. Doctor's Information

1. *Your Last Name: _____ *First Name: _____ MI: ____
2. *WCB Authorization #: _____ 3. *WCB Rating Code: _____
4. *Federal Tax ID #: _____ The Tax ID # is the (check one): ◯ SSN ◯ EIN
5. *Office Address: _____ Line 2: _____
   *City: _____ (CR) State: _____ (CR) Zip Code: _____ *Country: USA
6. Billing Group / Practice Name _____

Fill Billing Address with Office Address

7. *Billing Address: _____ Line 2: _____
   *City: _____ (CR) State: _____ (CR) Zip Code: _____ *Country: USA
8. *Office phone #: _____ 9. Billing phone #: _____
10. Treating Provider's NPI #: _____ 11. *You are a (select one): ◯ Physician ◯ Podiatrist ◯ Chiropractor

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

D. Billing Information

CR 1. Employer's insurance carrier: _____ ☐ Unknown

2. Carrier Code #: _____

CR 3. Insurance carrier's address: _____ Line 2: _____

CR City: _____ CR State: _____ CR Zip Code: _____ CR Country: USA

4. *Diagnosis or nature of disease or injury:

Line *ICD9 Code *ICD9 Descriptor

_____ _____

Add Another ICD9 Code | Remove Last ICD9 Code

Relate ICD9 codes above to Diagnosis Code column by line.

Dates of Service *From	*To	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies *CPT/HCPCS	Modifier 1	Modifier 2	*Diagnosis Code	*$ Charges	Days/ Units	COB	*Zip Code where service was rendered

Add Another Billing Row | Remove Last Billing Row

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)

☐ Services were provided by a WCB preferred provider organization (PPO).

Sample Document

E. Doctor's Opinion

1. *In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ◯ Yes ◯ No
2. *Are the patient's complaints consistent with his/her history of the injury/illness? ◯ Yes ◯ No
3. *Is the patient's history of the injury/illness consistent with your objective findings? ◯ Yes ◯ No ◯ N/A (No findings at this time)
4. *What is the percentage (0-100%) of temporary impairment? _____ %

This form is signed under penalty of perjury.

***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.

CR Provider's Last Name: _____ First Name: _____ MI: ___

CR Provider's Specialty: _____

Board Authorized Health Care Provider:

*Last Name: _____ *First Name: _____ MI: ____

*Specialty: _____ Date: _____

F. *Attach Detailed Narrative Report(s)

Review Narrative Attachment Requirements on the Workers' Compensation Board web site (http://www.wcb.ny.gov/content/ebiz/WEBForms/Attachment_Requirements.jsp). Do not submit the C-4 AUTH Form as an attachment to this form, the paper version must be sent to the carrier and the Board.

To attach a detailed narrative report, select **the paper clip icon** on the left side of the page and select the **Add** icon. (If you have Adobe Reader 7, select the **Attachments tab**. The Board recommends upgrading to the latest version of Adobe Reader.)

IMPORTANT: If you would like to save this information to submit future EC-4NARR forms for this patient, you **MUST** save the data BEFORE you submit the form. AFTER the form is successfully submitted, you will be able to save a copy of the submitted form, but it cannot be used for future submissions.

Save Data | Submit Form