

Doctor's Narrative Report (EC-4NARR) Web Submission Process Tutorial

Submitting an EC-4NARR Form For a Patient

Instead of filing the Doctor's Initial Report (C-4) and Doctor's Progress Report (C-4.2) forms, health care providers may file the Doctor's Narrative Report (EC-4NARR) to report both the initial and continued treatment, however, a narrative attachment must be included with the form which provides all the additional information which otherwise would be provided on the other forms.

Please read "[Attachment Requirements](#)".

To report permanent impairment, submit form Doctor's Report of MMI/Permanent Impairment (C-4.3).

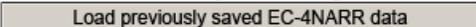
You may choose to [create templates](#) which are .xml data files containing specific information that you may use for subsequent form submissions.

You will need to decide where to save these files. If all EC-4NARR forms for the doctor will be submitted from the same computer, you may choose to save them to the computer's hard drive; however, if the forms will be generated from multiple computers that are on a network, you may want to save them to a shared network drive.

Certain fields on the form are required and they are noted with a red asterisk *. Other fields may be required based on information provided. These fields are noted with a . To determine if these fields are required, either hover your mouse pointer over the  or click on the .

Filling out the Form

Select the "Load previously saved EC-4NARR data" button near the top of the form,



and then select the data file that you [previously created for the doctor](#) (doctorName.xml), or for [the doctor and carrier](#) (carrierName.xml), or complete section C. Doctor's Information and the insurance carrier's information in section D. Billing Information.

On the form, complete section A. Patient's Information.

A. Patient's Information			
1. *Last Name: Doe	*First Name: John	MI: J	
2. Social Security #: 123-45-6789	3. Home Phone #: (518) 555-4567		
4. WCB Case # (if known): 40800323	5. Carrier Case # (if known): 1234567890		
6. * Mailing Address: 18 West Glenwood Dr.		Line 2:	
*City: Latham	 State: New York	 Zip Code: 12110	*Country: USA
7. *Date of injury/onset of illness: 11/14/2008	8. *Date of birth: 6/25/1958	9. *Gender: <input checked="" type="radio"/> Male <input type="radio"/> Female	
10. *On the date of injury/illness what was the patient's job title or description: Chef			
11. *On the date of injury/illness what were the patient's usual work activities: Cooking			
12. *Is the patient working now? <input checked="" type="radio"/> Yes <input type="radio"/> No		13. Patient's Account #: 987654	

Complete section B. Employer Information.

B. Employer Information

1. Employer when injury occurred:
 *Company/Agency Name: Acme Restaurant

2. Employer Phone #: (518) 555-1234

3. *Employer Address: 10 Elmore Dr. Line 2:

*City: Latham State: New York Zip Code: 12110 *Country: USA

Review all sections to be sure the information is accurate.

Adding Billing Information

Complete section D. Billing information. You may add additional ICD9 codes by selecting the "Add Another ICD9 Code" button and as many billing rows as needed by selecting "Add Another Billing Row".

4. *Diagnosis or nature of disease or injury:

Line	*ICD9 Code	*ICD9 Descriptor
1	836.0	Tear of Medial Cartilage

Add Another ICD9 Code **Remove Last ICD9 Code**

Relate ICD9 codes above to Diagnosis Code column by line.

Dates of Service		Place of Service	Leave Blank	Use WCB Codes			*Diagnosis Code	* \$ Charges	Days/ Units	COB	* Zip Code where service was rendered
*From	*To			Procedures, Services or Supplies	Modifier 1	Modifier 2					
12/4/2008	12/4/2008	22		29875			1	\$816.00	1		12110
12/4/2008	12/4/2008	22		22612			1	\$1,810.56	1		12110

Add Another Billing Row **Remove Last Billing Row**

<input checked="" type="checkbox"/> Services were provided by a WCB preferred provider organization (PPO).	Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
	\$2,626.56		

You may remove the last ICD9 code in the list by selecting the "Remove Last ICD9 Code" button and the last billing row by selecting "Remove Last Billing Row".

A minimum of one ICD9 code and one billing row is required information to be provided on the form.

Complete section E. Doctor's Opinion

E. Doctor's Opinion

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

Indicate Who Provided the Services

If the services were provided by someone other than the Board Authorized Health Care Provider select " I actively supervised the health care provider named below who provided these services." and complete the information for the doctor who provided the services.

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.

<input checked="" type="radio"/> Provider's Last Name:	<input type="text"/>	First Name:	<input type="text"/>	MI:	<input type="text"/>
<input checked="" type="radio"/> Provider's Specialty:	<input type="text"/>				

Board Authorized Health Care Provider:
*Last Name: *First Name: MI:
*Specialty: Date: 1/5/2009

Otherwise select "I provided the services listed above." and make sure the Board Authorized Health Care Provider section is complete.

Board Authorized Health Care Provider:
*Last Name: *First Name: MI:
*Specialty: Date: 1/5/2009

Saving Data for Subsequent EC-4NARR Submissions

Scroll to the bottom of the form and select the Save Data button.

Create a folder for the patient.

Export Form Data As

Save in:

- Desktop
- My Network Places

- Doctors
- DoeJohn

File name:

Save as type:

Save the file in the patient's folder, include in the name the date the form is being submitted (i.e. patientName12-31-08.xml). This file will have an .xml file extension.

Export Form Data As

Save in:

- Desktop

File name:

Save as type:

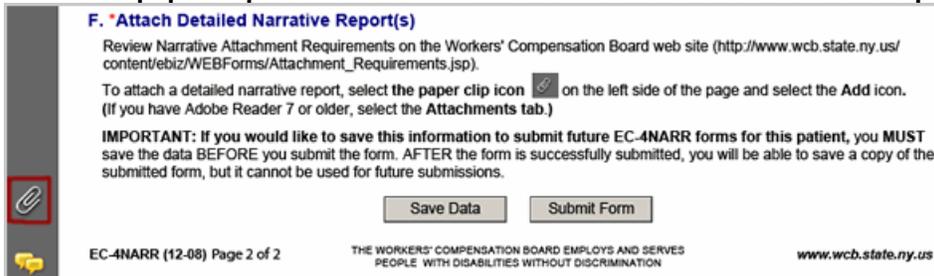
You now have a completed form containing the patient, the employer, the doctor, and the insurance carrier's information that you can use when you need to submit subsequent EC-4NARR forms for that patient.

Adding Narrative Attachments

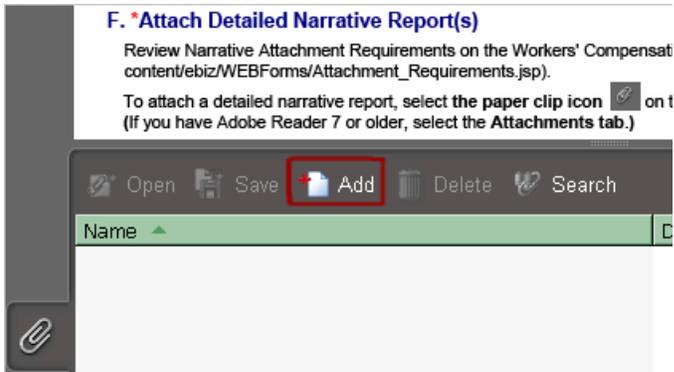
Attachment File Types Accepted:

- Text files (.txt file extension)
- MS Word files (.doc file extension)
- Rich Text files (.rtf file extension)
- Tiff files preferably with a resolution of 200 dpi (.tif or .tiff file extension)
- JPEG files (.jpg file extension)
- GIF files (.gif file extension)
- BMP files (.bmp file extension)
- PDF files (.pdf file extension)

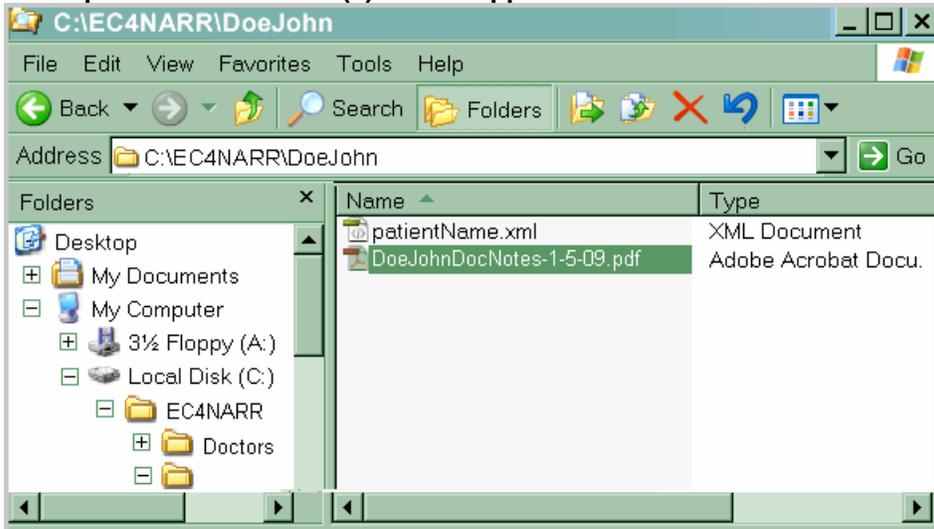
Select the paper clip icon or the attachment tab on the left of side of the page.



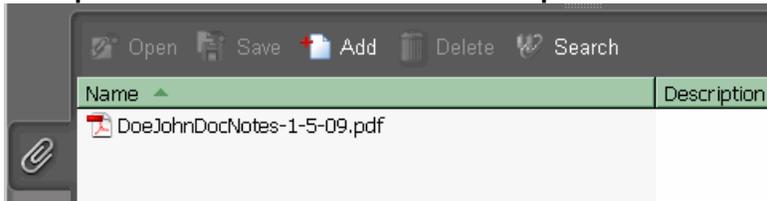
Select the Add icon.



Select the Detailed Narrative Report file that should accompany this form and then select the "Open" button. The file(s) should appear in the attachment box below the form.



Example of Attached Detailed Narrative Report

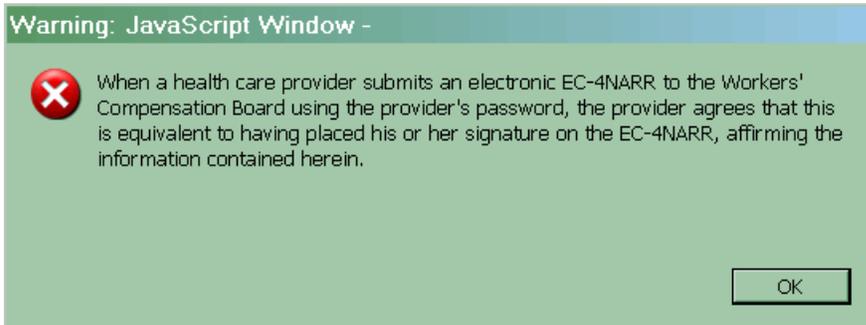


Submitting the Form

Select Submit Form



There are two separate validations done on your form. The first is done before the form is sent to the Board's web server. This checks for required information and that data entered is formatted correctly. If an error is found, you will need to fix it before your form will be accepted by the Workers' Compensation Board. Once all required fields have been completed, the health care provider will be required to attest to the information on the form.



Please wait while your form and attachment is submitted to the Board. Depending upon the size of the attachment and the type of internet connection you have, this may take a minute.

After the form is received by the Board's web server, your form will be checked a second time to confirm a detailed narrative report was attached and the doctor's WCB Authorization Number and CPT codes are valid.

If there is an error, the Board will reject your form and will return the form to your web browser so you can correct the errors and resubmit it. The error(s) will be identified at the top of the form.

Example of error messages at top of form.

The form you submitted was rejected by the NYS Workers' Compensation Board due to the following errors.
Please correct these errors and resubmit your form.

The WCB Authorization Number you entered is NOT Valid.
Procedure Code (00011) is NOT Valid.
Procedure Code (00012) is NOT Valid.
This form must include 1 or more attachments.

After correcting any error's you should re-save the patient's data file so that it is accurate and then select the Submit Form button.

Successful Submissions

When your form passes all validations, a non-editable PDF of the form will be returned to your web browser. **Do not close your web browser until you receive this PDF, otherwise you will not know if your form was successfully submitted to the Board.**

This is the only official copy of your EC-4NARR form.

The first page of the form will be a confirmation by the Board that your form was successfully submitted and information about sending required copies to the insurance carrier, attorney, licensed representative and the patient.



Doctor's Narrative Report **EC-4NARR**
State of New York - Workers' Compensation Board

Your EC-4NARR form was successfully submitted
to the NYS Workers' Compensation Board on: 1/5/09

**THIS FORM MAY ONLY BE SUBMITTED ELECTRONICALLY.
DO NOT MAIL A COPY TO THE NYS WORKERS' COMPENSATION BOARD.**

PLEASE PRINT AND SAVE A COPY FOR YOUR RECORDS.

You should print the form and attachments and save a copy for your records.

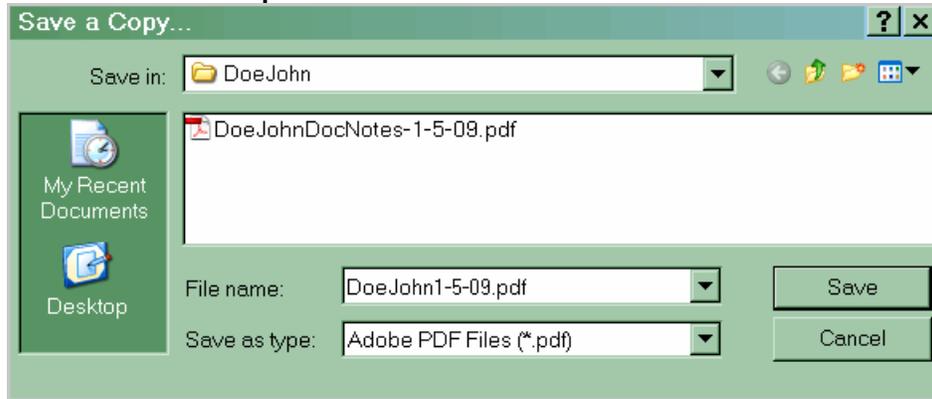
Saving the Form

In the previous steps, you saved data from the form to be used for the next EC-4NARR submitted for the patient.

Now you will save the actual form in PDF format.

At the bottom of the last page select the Save Copy button

Save the PDF in the patient's folder.

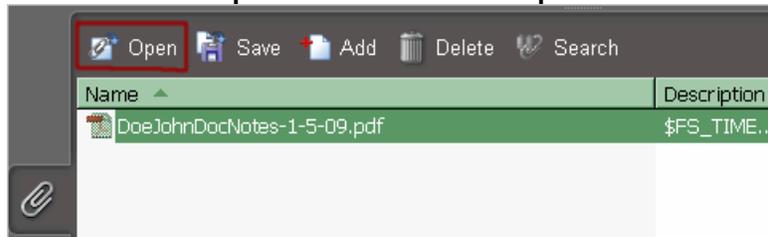


Printing the Form

Select the Print button to print the form



You will need to open the attachment and print it.



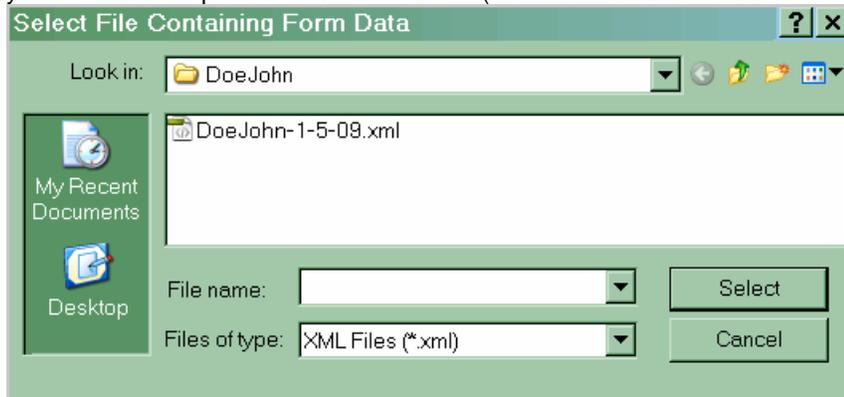
Mail required copies to the insurance carrier, attorney, licensed representative and the patient.

Submitting Additional EC-4NARR Forms

If you would like to submit another EC-4NARR form for a different patient and you haven't closed your web browser, select the back button and it will take you back to a new EC-4NARR form.

Submitting Subsequent EC-4NARR Forms for the same patient

1. Access the EC-4NARR form on the Board's web site.-
2. Select the "Load previously saved EC-4NARR data" button and select the data file you saved when you submitted the previous EC-4NARR form (the one with the .xml file extension)



3. Review **all sections** to be sure the information is accurate.
 4. Update section D. Billing information.
 5. Update section E. Doctor's Opinion
 6. Provide the information about who provided the services and the name and specialty of the Board Authorized Health Care Provider.
 7. Scroll to the bottom of the form and select the Save Data button.
 8. Save the file in the patient's folder include in the name the date the form is being submitted. (i.e. patientName12-31-08.xml). This file will have an .xml file extension.
 9. Select the paper clip icon or the attachment tab on the left of side of the page.
 10. Select the Add icon.
 11. Select the Detailed Narrative Report file that should accompany this form and then select the "Open" button. The file(s) should appear in the attachment box below the form.
 12. Select Submit Form
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