Carrier's Request for Reimbursement of Medical Payments Under WCL Section 15(8)

NEW YORK STATE Workers' Compensation Board

Submit Completed Form via Email or Mail:
Attention Special Funds Group
328 State Street, Room 331
Schenectady, NY 12305
SpecialFunds@wcb.ny.gov

Submission of this form is a certification to the Chair of the Workers' Compensation Board that the amount of reimbursement requested is the same as that which was expended, that all payments were made in accordance with the applicable Medical Fee Schedule and Medical Treatment Guidelines, that no part thereof has been previously reimbursed, that the amount stated herein is due and owing, and that the information contained herein is true and correct. Invalid or inaccurate requests may be subject to penalty.

Carrier Code / Carrier Name: SELECT CARRIER CODE / CARRIER NAME FROM LIST

Claim Administrator: _____ Contact Name: _____

Phone Number: _____ Email: _____

Submit Date: _____

Claim Information	
WCB Case Number	
Carrier Case Number	
Claimant Name	
State of Residence	

Request Summary			
Service Date Range		-	
Payment Date Range		-	
Total Amount			

Request Details

The following information should be entered for each bill/charge with the actual bill and appropriate supporting documentation attached to the form in the order listed. A separate detail sheet may be attached to the form in lieu of completing this section, provided all of the required information is included.

ID	Provider Name	Service Date	Paid Date	App %	Paid Amount	SDF %	Requested Amount
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

SUBMISSION INFORMATION

Submission by Email - Email submissions must be sent to **SpecialFunds@wcb.ny.gov** with "15(8) Medical Reimbursement" noted in the subject line. Emails received in any other inbox or using any other subject heading may not be considered. All supporting documentation must be included as attachment(s) and may not be submitted separately. Supporting documentation must be in PDF format so that it may be reviewed by Specials Funds Group, and by the Office of the State Comptroller if selected for audit. Failure to follow any of these instructions will result in a rejection of the submission.

Carrier Code - Enter the WCB-assigned Carrier 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].

Carrier Name - The form will populate the name of the carrier 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].

Carrier Case Number - Enter the claim number assigned by the carrier [OPTIONAL].

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

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

REQUEST SUMMARY

Service Date Range - Enter the first and last date service was rendered for the bills/charges where reimbursement is being requested [REQUIRED].

Payment Date Range - Enter the first and last date payment was made for the bills/charges where reimbursement is being requested [REQUIRED].

Total Amount - Enter the total amount of reimbursement being requested [REQUIRED].

REQUEST DETAILS

The following information should be entered for each bill/charge with the actual bill and appropriate supporting documentation attached to the form in the order listed. A separate detail sheet may be attached to the form in lieu of completing this section, provided all of the required information is included.

Provider Name - Enter the name of the provider who was paid for the bill/charge [REQUIRED].

Service Date - Enter the date service was rendered for the bill/charge [REQUIRED].

Paid Date - Enter the date payment was made for the bill/charge [REQUIRED].

Appt % - Enter the percentage of medical treatment on this bill/charge that is paid by this insurer on this claim; this percentage should be reflected in the Paid Amount [REQUIRED - CANNOT BE ZERO].

Paid Amount - Enter the amount of the bill/charge that was paid by this insurer on this claim; this amount should reflect the Apportionment % [REQUIRED].

SDF % - Enter the percentage of the amount paid by the insurer for this bill/charge that is eligible for reimbursement from the SDF; this percentage should be reflected in the Requested Amount [REQUIRED - CANNOT BE ZERO].

Requested Amount - Enter the amount of reimbursement being requested for the bill/charge; this amount should reflect the SDF Liability % [REQUIRED].

Additional information can be found on the Workers' Compensation Board website: www.wcb.ny.gov.