STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

Disputed Medical Bills Unit

1-800-781-2362

PROVIDER'S REQUEST FOR JUDGMENT OF AWARD

SECTION 54-b, Enforcement on Failure to Pay Award or Judgment

Upon issuance of an administrative award and/or arbitration decision you must wait at least 30 days before requesting consent for judgment. To avoid the complications of filing unnecessary requests, waiting 60 days is recommended. The 60 day time period will allow for carriers' billing/payment cycles.

This form may be used by an authorized workers' compensation provider whenever a carrier or self-insured employer has not paid for an award or decision (for awards/decisions made on or after March 13, 2007). Section 54-b of Workers' Compensation Law provides that in the event an insurance carrier or self-insured employer defaults in the payment of an award made by the Board, any party to an award may, with the Chair's consent (or the consent of the Chair's designee), file with the County Clerk for the county in which the injury occurred or the county in which the carrier or self-insured employer has its principal place of business, a certified copy of the decision that awarded compensation.

Request for Consent and Certified Copy of Unpaid Award or Decision for Medical Care

I request consent for judgment and a certified copy of the unpaid award or decision for WCB dispute number(s):

ATTACH A COPY OF THE ORIGINAL AWARD(S)

Name and Address of Health Care Provider

Name 1					
2					
Address					
City		State		Zip Code	-

Name and Address of Carrier/Self-Insured Employer

Name 1					
2					
Address					
City		State		Zip Code	-

WCB Case Number

WCB Authorization Number

Date of Accident or Injury

Carrier Case Number

Carrier/Self-Insured Employer I.D. Number

County in Which Injury Occurred

Employer

Affirmation of Non-Payment

PHYSICIANS COMPLETE THE FOLLOWING:

I state that I am a physician, authorized by law to practice in the State of New York, am not a party to this proceeding, am the physician not remunerated for the above award(s) or decision(s), have read and know the contents thereof; that the same is true to my knowledge, except as to the matters stated to be on information and belief, and as to those matters I believe it to be true. Affirmed as true under the penalty of perjury.

Written Signature (Facsimile not Accepted) _____ Date _____

ALL OTHERS COMPLETE THE FOLLOWING:

IMPORTANT: BY LAW THOSE COMPLETING THIS SECTION MUST BE SWORN TO BEFORE A NOTARY PUBLIC.

I state that I am a chiropractor, authorized hospital representative, physical or occupational therapist, podiatrist or psychologist, authorized by law to practice in the State of New York and/or authorized to represent a hospital, am not a party to this proceeding, am the provider or representative of a hospital not remunerated for the above award(s) or decision(s), have read and know the contents thereof; that the same is true to my knowledge, except as to the matters stated to be on information and belief, and as to those matters I believe it to be true. Affirmed as true under the penalty of perjury.

Written Signature (Facsimile not Accepted) _____ Date _____

State of New York) ss:
County of _____) _____, being duly sworn, deposes and says:
That (s)he is the _____, duly licensed in the State of New York and/or authorized to represent a hospital, who has not been remunerated for the above award(s) or decision(s), and that (s)he has read the same and knows the contents thereof; that the same is true to the knowledge of the deponent, except as to the matters stated to be on information and belief, and as to those matters (s)he believes it to be true.

Subscribed and sworn before me this
_____ day of _____, _____

_____
(Signature of Notary Public)

Mail completed form to: Workers' Compensation Board
Disputed Medical Bills Unit
328 State Street
Schenectady, NY 12305