CONTINUATION TO CARRIER/EMPLOYER BILLING PORTION OF FORMS C-4, C-4.2, C-4.3, C-5, PS-4 or OT/PT-4

Doctor's Name	WCB Case Number	Carrier Case Number	Date of Accident or Injury

Patient	Patient's Social Security Number:

	A						B	C	D (USE WCB CODE)		E	F	G	H	I
	Dates of Service														
	From			To			Place of Service	Leave Blank	Procedures, Services or Supplies		Diagnosis Code	$ Charges	Days or Units	COB	Zip Code Where Service was Rendered
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER					
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C-4.1 (9-08) **THE INJURED WORKER SHOULD NOT PAY THIS BILL.** NY-WCB