NEW YORK STATE | Workers' Compensation Board

HEALTH PROVIDER'S REQUEST FOR DECISION ON UNPAID MEDICAL BILL(S)

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Return this original and completed form with the required attachments to the Workers' Compensation Board when the conditions listed below exist. If you have any questions regarding the completion of this form, you may contact us at **1-800-781-2362**.

A. The medical bill(s) originally submitted on Form C-4, UB-04, CMS-1450 or CMS-1500 (with detailed narrative to the responsible carrier/ self-insured employer); AND

B. The medical bill(s) was timely submitted to the responsible insurance carrier or self-insured employer for payment. Timely submission of a bill is within 120 days for a hospital and 90 days for all other health providers from the last day of the month in which the service(s) was rendered or 90 days from the last day of the month in which the claimant receives the final treatment in a continuous course of treatment, whichever is later (and the bill was not returned by the post office); AND

C. The fee(s) billed is in accordance with the fees indicated in the appropriate Fee Schedule; AND

D. NO related Denial of Claim or C-8.1 has been received or if such form was received, the issue(s) raised thereon by the workers' compensation carrier has been ruled on by the Workers' Compensation Board, in the health provider's favor and no RB-89 is pending; AND

E. FOR ADMINISTRATIVE AWARD: Treatment was rendered to an injured worker and a minimum of 45 days has elapsed since the submission of the bill, or 30 days since the date of a final decision by the WCB establishing the carrier's or self-insurer's liability for the bill; and, no more than 120 days has elapsed since the expiration of the time within which the carrier or self-insurer is required to notify the health provider of non-payment or since the date of expiration of any continuous course of treatment of the claimant. The provider has NOT received payment, Form C-8.4, or an acceptable written explanation of non-payment (as defined by the WCB) from the responsible carrier. Communication with the insurer has been unsuccessful; OR

F. FOR ARBITRATION: Treatment was rendered to an injured worker and proper payment, in accordance with the appropriate Fee Schedule has NOT been received. The provider has received a written explanation from the carrier or self-insured employer explaining the reason(s) for partial or non-payment and Form C-8.4 has been filed. Communication with the insurer has failed to resolve the issue(s). A minimum of 45 days has elapsed since the submission of the medical bill(s) to the responsible insurance carrier, or 30 days from the date of a final decision establishing the carrier's or self-insurer's liability for the bill(s); and, no more than 120 days have elapsed since the date of receipt of notification of non-payment, or the date of expiration of any continuous course of treatment of the claimant.

PROVIDER: CHECK ONLY ONE REQUEST BOX: (PLEASE TYPE OR PRINT THIS FORM IN BLACK OR BLUE INK ONLY)

☐ **A. REQUEST FOR ADMINISTRATIVE AWARD**

Carrier did not reply with Form C-8.4, nonpayment explanation, or pay for medical services submitted on the attached bill. More than 45 days have passed since the date of the medical bill submission or more than 30 days from the receipt of a related notice establishing carrier/employer liability. Complete the front and Section A on the reverse of this form. DO NOT SUBMIT MORE THAN ONE BILL WITH THIS FORM.

RETURN THIS ORIGINAL AND COMPLETED FORM TO:
NYS Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

DATE SPAN FOR ATTACHED BILL:
_____/_____/_____ **to** _____/_____/_____

☐ **B. REQUEST FOR ARBITRATION**

Carrier has not satisfactorily paid for services rendered as shown on the attached medical bill(s). A copy of the carrier's payment explanation, including a copy of Form C-8.4, must be attached. If you wish to submit other documents to be considered by the Arbitrator/Panel, attach them to this form. Complete the front and Section B reverse of this form.

RETURN THIS ORIGINAL AND COMPLETED FORM TO:
NYS Workers' Compensation Board
Medical Director's Office
Riverview Center, Suite 195
150 Broadway
Menands, NY 12204

NUMBER OF MEDICAL BILLS ATTACHED _____

TYPE OF CARE: ☐ Medical ☐ Outpatient Hospital ☐ Inpatient Hospital ☐ Chiropractic ☐ Physical Therapy ☐ Occupational Therapy ☐ Psychology ☐ Podiatry ☐ Osteopathic

Name and Mailing Address of Health Provider (MAXIMUM OF 30 CHARACTERS)
Name _____
Address _____
City _____ State _____ Zip Code _____

Name and Billing Address of Health Provider (MAXIMUM OF 30 CHARACTERS)
Name _____
Address _____
City _____ State _____ Zip Code _____

Name and Mailing Address of Carrier (MAXIMUM OF 30 CHARACTERS)
Name _____
Address _____
City _____ State _____ Zip Code _____

Name and Mailing Address of Employer (MAXIMUM OF 30 CHARACTERS)
Name _____
Address _____
City _____ State _____ Zip Code _____

WCB Case Number

WCB Authorization Number

Provider's WCB Rating Code

Date You First Treated Claimant (mm/dd/yy)
_____/_____/_____

Provider's Telephone Number (include area code)

Date of Accident (mm/dd/yy)
_____/_____/_____

Carrier Case Number

Carrier or Self-Insured Employer ID #
W

County where Service was Rendered

Claimant's Social Security Number
_____-_____-_____

Name of Claimant (First, Middle Initial, Last Name)

I affirm, under penalty of perjury, that the conditions indicated above are true.

_____
Health Provider's Signature

Date: _____

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SECTION A: REQUEST FOR ADMINISTRATIVE AWARD - PLEASE COMPLETE THE FOLLOWING

Federal Tax ID Number		Total Charge ($)	Amount Paid ($)	Amount in Dispute ($)
	☐ SSN ☐ EIN			

SECTION B: REQUEST FOR ARBITRATION - PLEASE COMPLETE THE FOLLOWING

Amounts in Dispute of $1,000 or less: The Board automatically assigns any claim of $1,000 or less to Desk Arbitration. A single arbitrator makes a determination based on the parties' paper submissions.

Amounts in Dispute Greater than $1,000: Providers with claims greater than $1,000 may elect resolution by Desk Arbitration or Panel Arbitration.

Desk Arbitration allows for faster resolution. Disputes involving similar services are grouped for review by an appropriate arbitrator. The arbitrator makes a determination based on the parties' paper submissions. Parties do not have to appear at a hearing.

Panel Arbitration is conducted at a hearing before a panel of two or more arbitrators. Parties appear at the hearing and present arguments to the arbitration panel.

Please check one:

☐ I hereby elect resolution of my claim greater than $1,000 by **Desk Arbitration.** A single arbitrator will conduct a review based on the parties' paper submissions.

☐ I hereby elect resolution of my claim greater than $1,000 by **Panel Arbitration.** A hearing will be scheduled at which parties may present arguments to an arbitration panel of two or more members.

Federal Tax ID Number		Total Charge ($)	Amount Paid ($)	Amount in Dispute ($)
	☐ SSN ☐ EIN			

I certify that the foregoing bill(s) was originally submitted on Form C-4, UB-04, CMS-1450 or CMS-1500 (with detailed narrative) to the responsible carrier/self-insured employer for payment. Acceptable payment has not been received and arbitration is required. In the event the dispute is resolved by a single arbitrator or I fail to appear at a scheduled hearing, I will abide by the arbitration decision.

_____ Date: _____

Health Provider's Signature

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.