STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

REQUEST FOR FURTHER ACTION BY LEGAL COUNSEL

This form is for use by claimant's attorney or licensed representative ONLY. Unrepresented claimants should use Form RFA-1W or ask for Board assistance.

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS		3. DATE OF INJURY (MM/DD/YY)
1. WCB CASE NO.	2. CLAIM ADMINISTRATOR CLAIM (Carrier Case) NO.	

	NAME	ADDRESS TO WHICH NOTICES SHOULD BE SENT	
4. CLAIMANT		Check if new address: ☐	APT. NO.
5. EMPLOYER (at time of injury)			
6. INSURER			
7. ATTORNEY / LICENSED REP.			

8. **INSTRUCTIONS:** The claimant seeks Board action regarding the claim identified above for the following reasons (**check all that apply**). Please note that the **required documentation** identified below **must be attached** to the form and submitted to the Board or **must be referenced** in the space provided below** (by date, name or title of document, and form ID) if it is already in the Board's electronic file. This form must be **mailed, faxed or emailed** to the Workers' Compensation Board. (See mailing and email filing address on reverse side).

Compensation:

☐ a. Payments should begin as claimant is not working as of _____ *(medical documentation indicating disability required)*

☐ An expedited (45-day) hearing is requested under WCL 25(2)(a). **By checking this box I affirm that**: A claim has been filed for a work related injury; the employer is not paying wages; the claim has not been denied; there has not been a decision barring the claimant from compensation. I have reached out to the insurer to try to resolve the issue and was unable to resolve it. **I understand that I may be liable for a penalty if I check this box and any of the above conditions do not apply**.

☐ b. Payments have been suspended or reduced on _____

☐ c. Payments should be suspended as claimant returned to work at full wages on _____

☐ d. Payments should be adjusted as claimant is working at reduced earnings as of _____
(documentation of medical disability and current earnings required)

☐ e. Payments should be adjusted as claimant has concurrent employment.
(documentation of weekly gross pay preceding injury and statement from second employer regarding lost time required)

☐ f. Payments should be resumed as claimant has been released from incarceration on _____ and now seeks benefits.
(medical documentation indicating disability and release from custody documentation required)

☐ g. Payments have not been paid as directed by Decision filed on _____

Medical Issues:

☐ h. Claimant's medical condition has changed. *(medical documentation indicating change required)*

☐ i. Claimant's request for medical treatment has been denied or has not been addressed.
(documentation indicating denial of request for medical treatment required. Please use Form MG-2 for variance denials.)

☐ j. Claimant's disability is now permanent. *(medical Form C-4.3, Doctor's Report of MMI/Permanent Impairment required)*

☐ Check this box if the claimant was under 25 years of age at time of accident.

☐ Check this box if the claimant accepts the insurer's opinion on the severity of disability/loss of use.

☐ k. Claimant's request for medical and transportation reimbursement has been denied or not addressed. *(receipts and Form C-257 required)*

Other:

☐ l. Parties have reached an agreement *(Form C-300.5 or written stipulation, Form C-312.5 or proposed findings or Form C-32 required)*

☐ m. Claimant has discontinued or settled a lawsuit pertaining to the accident/injury of this claim.
(documents indicating discontinuance, settlement, or closing statement required)

☐ n. Claimant has new or requested documentation regarding _____
_____ *(documents required)*

☐ o. Other (explain fully in the space provided below.)

**Document reference information (date, name/title,form ID): _____

I certify that this request for Board action is based upon reasonable grounds, has been submitted with my client's consent, and that this form with attachment(s) has been provided to the opposing party(ies). I also certify that (check one box below):

☐ **I have discussed the issue(s) above with the opposing party(ies) or its representative(s) (*give name of person contacted*)**
_____ **on (date)** _____ **and that:**

☐ no settlement of the issue(s) could be reached. ☐ settlement of the issue(s) was reached (*documentation required*).

☐ **I have attempted to contact (name)** _____ **on (date)** _____ **to discuss the issue(s) above, that I have waited a reasonable time for a response, but that no discussion was forthcoming.**

CERTIFIED BY (Please Print Name)	ATTY/REP ID NO.	DATE PREPARED (MM/DD/YY)	AREA CODE TELEPHONE NUMBER
	R		

☐ An attorney/licensed representative fee is requested and Form OC-400.1 has been submitted.

To the Claimant's Representative - General Information On Using This Form

You may file this form with the Workers' Compensation Board when you want the Board to take a specific action in your client's case, or if you need to alert the Board to any problem or situation that is affecting your client's case. Many of the most frequently requested actions/situations are contained in Section 8.However, you are not limited to those listed. Check all that apply and/or add additional information or explanation in the space provided (o). If an attorney/licensed representative fee is requested, submit Form OC-400.1. **Please note**: in order to receive an expedited (45-day hearing) you must check box 'a' and enter the date the claimant stopped working, AND you must check the box below for "An expedited (45-day) hearing is requested under WCL 25(2)(a)".

Complete the identifying information at the top of Form RFA-1LC and send the form, WITH ALL APPLICABLE EVIDENCE ATTACHED, to the Workers' Compensation Board (see address below). The Board will contact you and all parties when it takes action on your client's case.

YOU MUST CERTIFY THAT YOU HAVE DISCUSSED THE ISSUE(S) OR ATTEMPTED TO CONTACT THE INSURER/EMPLOYER AND HAVE BEEN UNABLE TO SETTLE THE OUTSTANDING ISSUE(S).

YOU MUST SEND A COPY OF THIS FORM TO YOUR CLIENT, THE INSURER(S), OR DIRECTLY TO THE EMPLOYER OR ITS THIRD PARTY ADMINISTRATOR IF THE EMPLOYER IS SELF-INSURED.

Additional information about the Board, including information about Board forms, is available at the Board's web site: www.wcb.ny.gov. If you would like on-line access to your client's case, you can register for eCase using the registration instructions available on the Board website under the eCase link.

ADDITIONAL INFORMATION

Upon the submission of this form with the applicable documentary evidence, the Board will take immediate action to advance your client's claim toward resolution. Some of these actions include, but are not limited to the following:

- Proposing an Administrative Determination An Administrative Determination (AD) is a decision concerning your client's claim rendered by the Board. All the evidence in your client's file is examined prior to an AD being issued. Once an AD is sent to the parties, any party may object to the determination within 30 days. If there is no objection, the determination becomes final. Appearance at the Board is not necessary because acceptance of an AD indicates that all parties are satisfied with the resolution of the issue (s).

- Placing the claim into Conciliation for resolution If your client's claim is not controverted, the Board works with the parties and their representatives to secure all necessary documentation and resolve all outstanding issues in the claim. Once the file has been thoroughly reviewed, the Board will issue a Proposed Decision (PD) and send it to the parties, or will schedule a meeting at the Board with the parties, if a meeting is necessary. Once a PD is sent to the parties, any party may object to the determination within 30 days. If there is no objection, the determination becomes final. Appearance at the Board is not necessary because acceptance of a PD indicates that all parties are satisfied with the resolution of the issue(s). Please Note: Use of this RFA-1LC form replaces Form CB-8 (Request for Conciliation).

- Notifying the parties of a Hearing before a WCL Judge If your client's claim involves an issue that requires a hearing or may require testimony, a hearing before a Workers' Compensation Law Judge may be necessary for resolution. A formal hearing requires a personal or telephonic appearance by all parties in the case at the Board hearing location most convenient to the claimant. The hearing will be recorded and an official record kept by the Board. While the WCL Judge will generally render a decision orally at the hearing, a written decision will be sent to all parties following the hearing. Parties may appeal the written decision to the Board's Administrative Review Division within 30 days of its filing.

- Referring the claim to the Administrative Review Division If your client's claim has been previously resolved by a lump sum settlement or a Section 32 Waiver Agreement, the Administrative Review Division will review your client's file to determine whether your client's claim should be reopened and further action taken.

Medical Treatment - In addition to medical services of less than $1000.00 in value, most medical services covered by the Medical Treatment Guidelines (regardless of the cost) do not require medical authorization. For these types of services, the Health Provider may provide treatment and bill the insurer. If there is no response within 45 days of receipt of the bill, the Health Provider may file for an administrative award on Form HP-1. Certain treatments covered within the Medical Treatment Guidelines, such as complex surgical procedures, do require prior authorization. In addition to these treatment types, when medical services are $1000.00 or more in value and fall outside the Medical Treatment Guidelines, the Health Provider is to contact the insurer or self- insured employer for authorization. The Health Provider must also file Form C-4AUTH with the insurer or self-insured employer and the Board. If denying Medical Treatment Guideline services or medical services of $1000.00 or more in value, the insurer or self-insured employer is required to file Form C-8.1A and provide conflicting medical evidence.

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.

Notification Pursuant to the New York Personal Privacy Protection Law
(Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

NYS Workers' Compensation Board, PO Box 5205, Binghamton, NY 13902-5205
Address for Email Filing: wcbclaimsfiling@wcb.ny.gov

Customer Service Toll-Free Line: (877) 632-4996 **Statewide Fax Line: (877) 533-0337**