NEW YORK STATE | Workers' Compensation Board

# Insurer's Request for Reconsideration of Reduction Under WCL Section 14(6) or Section 15(8)

Email completed form to: 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.

Insurer ID (W Number) / Insurer Name: SELECT INSURER ID / INSURER NAME FROM LIST

Claim Administrator: _____ Contact Name: _____

Phone Number: _____ Email: _____

Submit Date: _____

| Claim Information | |
|---|---|
| WCB Case Number | |
| Claim Admin Claim Number | |
| Claimant Name | |

| Request Summary | |
|---|---|
| Reference Number | |
| Begin Date | |
| End Date | |
| Original Amount | |
| Requested Amount | |

**Explanation**

Enter information in support of the request for reconsideration in the space provided. A single page document may be attached as an addendum and, if not previously submitted, relevant supporting evidence may be attached to the form (see instructions for further details). Failure to follow these instructions may result in rejection of the request for reconsideration.

**SUBMISSION INFORMATION**

**Insurer ID (W Number)** - Enter the WCB-assigned Insurer 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].

**Insurer Name** - The form will populate the name of the insurer 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].

**Claim Admin Claim Number** - Enter the claim number assigned by the entity that is administering the claim [OPTIONAL].

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

**REQUEST SUMMARY**

**Reference Number** - Enter the reference number assigned to the original request by Special Funds Group. This number appears on Form C-251R and Form C-251.1R [REQUIRED].

**Begin Date** - Enter the begin date of the original request [REQUIRED].

**End Date** - Enter the end date of the original request [REQUIRED].

**Original Amount** - Enter the amount of the original request [REQUIRED].

**Requested Amount** - Enter the amount that reconsideration is being requested for; this amount cannot be greater than the difference between the amount of the original request and the amount that was approved by Special Funds Group for that request [REQUIRED].

**EXPLANATION**

Provide a brief statement of the particular grounds upon which the request for reconsideration is based. A one-page document may be attached as an addendum, using 12-point font, with one inch margins, on 8.5-inch by 11-inch paper. An addendum longer than one page will not be considered, unless the insurer specifies in writing, why the basis of the request could not have been made within the space provided and the one-page addendum. Additional supporting evidence may be submitted if such evidence has not been submitted previously and is not already available for consideration in the Board's electronic case folder. The number of additional documents submitted shall not exceed the number of medical bills at issue and/or, more than ten pages where the request involves indemnity reimbursement.

Additional information can be found on the WCB website: www.wcb.ny.gov.