



**To the claimant:** Additional information regarding the electronic *Request for Further Action by Insurer/Employer (Form RFA-2)* can be found on the Board's website [www.wcb.ny.gov](http://www.wcb.ny.gov) under the eForms page.

**CASE INFORMATION**

<b>WCB Case ID</b> 55555555	<b>Date of Injury</b> 01/01/2020	<b>Claim Admin Claim #</b> 555
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**Claimant Name** Fake, Case

**Employer Name** NYS WCB Fake Case Primary Employer

**Insurer Name** WCB Test Insurer Attn: Michael [REDACTED]

**Insurer ID** [REDACTED]

**Claim Admin Name** WCB Test Insurer Attn: Michael [REDACTED]

**Claim Admin ID** [REDACTED]

**RFA-2 SUBMITTED ON BEHALF OF**

**Insurer Name:** WCB Test Insurer Attn: Michael [REDACTED]

**Insurer ID:** [REDACTED]

**Employer Name:** NYS WCB Fake Case Primary Employer

**Claim Admin Name:** WCB Test Insurer Attn: Michael [REDACTED]

**Claim Admin ID:** [REDACTED]

**Submitter Firm Name:** [REDACTED]

**Representative ID:** [REDACTED]

**RFA-2 SUMMARY**

**Summary of selected request reason(s):**

1. Claimant is at maximum medical improvement and a medical report on permanency has been filed
2. Insurer requests apportionment finding for medical treatment

**Additional proposed findings:**

1. Establish case (ANCR/ODNCR)

**RFA-2 REQUEST DETAILS**

1. Claimant is at maximum medical improvement and a medical report on permanency has been filed

Medical report on permanency is required.

**Description:** Medical report(s) on permanency has been filed

2. Insurer requests apportionment finding for medical treatment

Medical documentation indicating apportionment (see table below)

Form ID	Medical Provider Name	Medical Service Date	Document ID	Received Date
ECF-16.1M			[REDACTED]	[REDACTED]

**ADDITIONAL PROPOSED FINDINGS**

1. Establish case (ANCR/ODNCR)

Injury Location	Toe(s)/Finger(s)	Body Part(s)/Condition(s)
Left		Hand
Left	Index	Fingers other than thumb
Left	Middle	Fingers other than thumb
Left	Ring	Fingers other than thumb
Left	Little	Fingers other than thumb

**SUPPORTING DOCUMENTATION**

**Referenced Document(s):**

Form ID	Medical Service Date	Document ID	Received Date
O1K-L1			

## CERTIFICATION

The following request(s) require certification:

1. Insurer requests apportionment finding for medical treatment
2. Additional Proposed Findings: Establish case (ANCR/ODNCR)

I certify that I have attempted to contact the opposing party(ies) or its representative(s) to discuss the reason(s) selected, and have waited at least 24 hours for a response, but that no discussion was forthcoming.

First Name	Last Name	Name Unknown	Organization/Individual Name	Date	Phone Number	Email
Jane	Tester		Claimant/Beneficiary	01/29/2026	5555555555	test@test.com

## ATTESTATION

I affirm that:

- (1) my statements are true and correct, and
- (2) I am authorized to submit this request, and
- (3) this request for Board action is based upon reasonable grounds and that this form with attachment(s) has been provided to the opposing party(ies), and
- (4) I accept that the electronic submission of this form to the Workers' Compensation Board is equivalent to placing my signature on the request.

**Submitter Name:** Joe Tester

**Email:** test@test.com

**Date:** 01/30/2026

**Phone Number:** 5555555555 **Ext.:**