# CMS-1500 Crosswalk - Ophthalmologist Report

**ATTENDING OPHTHALMOLOGIST'S REPORT**

**STATE OF NEW YORK WORKERS' COMPENSATION BOARD**

SERVICES PROVIDED UNDER WCB PREFERRED PROVIDER ORGRANIZATION (PPO) PROGRAM? ☐ YES ☐ NO

☐ 48 HR. INITIAL ☐ 15 DAY INITIAL ☐ 90 DAY PROGRESS *SEE ITEM 1 ON REVERSE FOR FILING INSTRUCTIONS*

***PLEASE TYPE ALL INFORMATION - COMPLETE ALL ITEMS***

| WCB CASE NO. | CARRIER CASE NO. (IF KNOWN) | DATE OF INJURY | & TIME | ADDRESS WHERE INJURY OCCURRED (CITY, TOWN OR VILLAGE) | INJURED PERSON'S SOCIAL SECURITY NUMBER |
|---|---|---|---|---|---|
| Field 9a | Field 11b | Field 14 | | | Field 1a |

| | | | |
|---|---|---|---|
| INJURED PERSON | (First Name) (Middle Initial) (Last Name) Field 2 | ADDRESS (Include Apt. No.) Field 5 | TELEPHONE NO. Field 5 |
| EMPLOYER* | Field 4 | Field 7 | PATIENT'S BIRTH DATE Field 3 |
| INSURANCE CARRIER | Field 0 | Field 0 | Indicate days of week & times (AM or PM) when you are available to testify. |

*If treatment was under the VFBL or VAWBL show as "Employer" the liable political subdivision and check one: ☐ VFBL ☐ VAWBL

If you have filed a previous report, setting forth a history of the injury, enter date and complete Items 3-23 below. If not, complete ALL items.

**HISTORY**

1. How did injury occur? Give source of information.

Ophthalmology Narrative Report

2. If there are any pre-existing ocular conditions, describe specifically.

Ophthalmology Narrative Report

**DIAGNOSIS**

3. Describe nature and extent of injury, including permanent ocular defects, and/or permanent facial, head or neck disfigurement, if any, due to present injury. Attach visual field test, diagram site of injury, if applicable.

Ophthalmology Narrative Report

4. Present condition: (Amount of corrected and uncorrected vision in injured eye and all other permanent defects must be known in order to determine compensation due, if any.)

Ophthalmology Narrative Report

(a) Acuity of central vision uncorrected: O.D.________ O.S.________ Is condition permanent? ☐ Yes ☐ No ☐ Is loss due to present injury? ☐ Yes ☐ No

(b) If less than 20/20, what is corrected: O.D.________ O.S.________ Is condition permanent? ☐ Yes ☐ No ☐ Is loss due to present injury? ☐ Yes ☐ No

(c) Lenses used for correction: O.D. ________ O.S. ________

(d) Loss of binocular vision________ Is condition permanent? ☐ Yes ☐ No Is loss due to present injury? ☐ Yes ☐ No

**TREATMENT**

5. Dates of examinations on which this report is based: Field 24A | Date of your first treatment Field 15 | Has patient reached maximum medical improvement? If no, when will patient be seen again?

6. Describe treatment you have rendered and planned future treatment. If X-rays were taken, so indicate. If patient was hospitalized give name/location of hospital and dates of hospitalization. If an authorization request is required (see items 4 & 5 on reverse), check box ☐ and explain below. If additional space is necessary, attach request.

Ophthalmology Narrative Report

**IMPAIRMENT**

7. First day of disability, if known: Ophthalmology Narrative Report | 8. Is patient working? ☐ YES ☐ NO | 9. Is patient disabled from regular duties or work? ☐ YES ☐ NO | If "yes" disability is: ☐ TOTAL ☐ PARTIAL Ophthalmology Narrative Report

10. Can patient do any type of work? ☐ YES ☐ NO If "yes" describe work capacity.

Ophthalmology Narrative Report

**BILLING FORM**

11. Diagnosis or nature of disease or injury (Relate Items 1,2,3 or 4 to Item 12E by line.) Enter ICD10 code and describe nature of injury.

1. Ophthalmology Narrative Report
2.
3.
4.

| 12. A Dates of Service From MM DD YY | To MM DD YY | B Place of Service | C Leave Blank | D (USE WCB CODES) Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E Diagnosis Code | F $ Charges | G Days or Units | H COB | I Zip Code Where Service was Rendered |
|---|---|---|---|---|---|---|---|---|---|---|
| Field 24A | | 24B | | 24D | 24D | 24E | 24F | 24G | | Field 32 |
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13. In your opinion, was the occurrence described above (or in your previous report which gave this information) the competent producing cause of the injury or disease? ☐ YES ☐ NO | 14. Total Charges Field 28 | 15. Amount Paid (carrier use only) Field 29 | 16. Balance Due (carrier use only)

**SIGNATURE**

| 17. Federal Tax I.D. Number ☐ SSN ☐ EIN | 18. Patient's Account No. | 19. WCB Authorization No. | 20. WCB Rating Code | **THE INJURED WORKER SHOULD NOT PAY THIS BILL.** |
|---|---|---|---|---|
| Field 25 | Field 26 | Field 19 | Field 19 | |

| Affirmed Under Penalty of Perjury | 22. Doctor's Name, Address & Phone Number | 23. Doctor's Billing Name, Address & Phone Number |
|---|---|---|
| Field 31 | Field 32 | Field 33 |
| 21. Signature of Doctor Date | | |

## IMPORTANT - TO THE ATTENDING OPHTHALMOLOGIST

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:
   **48 HOUR INITIAL REPORT** - File this form, complete in all details, within 48 hours after you first render treatment.
   **15 DAY INITIAL REPORT** - File this form within 15 days after you first render treatment.
   **90 DAY PROGRESS REPORT** - Following the filing of the 15 Day Initial Report, file this form and thereafter during continuing treatment without further request, when a follow-up visit is necessary, except the intervals betwen reports shall be no more than 90 days..
   All reports are to be filed with the Workers' Compensation Board, the workers' compensation insurance carrier (or self-insured employer), and if the patient is represented by an attorney or licensed representative, with such representative. If the claimant is not represented, a copy must be sent to the claimant.
2. Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number and code letters. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.
4. **AUTHORIZATION FOR SPECIAL SERVICES:** When it is necessary for the attending physician to engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures or to provide for special diagnostic laboratory tests costing more than $1,000, (s)he must request authorization from the self-insured employer or insurance carrier.
5. **AUTHORIZATION MUST BE REQUESTED AS FOLLOWS:**
   a. Telephone the self-insured employer or insurance carrier, explain the need for the special services, and request the necessary authorization.
   b. Confirm the request in writing, setting forth the medical necessity for the special services in item 6 of this form. Attach copy of request, if necessary.
   c. The self-insured employer or insurance carrier may have the patient examined within 4 working days of the request for authorization, if the patient is hospitalized, or within 30 calendar days if the patient is not hospitalized.
   d. If authorization or denial is not forthcoming within 30 calendar days, notify the Workers' Compensation Board at 877-632-4996.

**SUCH AUTHORIZATION IS NOT REQUIRED IN AN EMERGENCY UNDER THE PROVISIONS OF SECTION 13-a(5).**

6. **HIPAA NOTICE** - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

**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.**

## IMPORTANT TO THE PATIENT

**YOUR DOCTORS' BILLS (AND BILLS FOR HOSPITALS AND OTHER SERVICES OF A MEDICAL NATURE) WILL BE PAID BY YOUR EMPLOYER, THE LIABLE POLITICAL SUBDIVISION OR ITS INSURANCE COMPANY OR THE UNAFFILIATED VOLUNTEER AMBULANCE SERVICE IF YOUR CLAIM IS ALLOWED. DO NOT PAY THESE BILLS YOURSELF, UNLESS YOUR CASE IS DISALLOWED OR CLOSED FOR FAILURE TO PROSECUTE.**

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OF THIS NOTICE, OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO COMMUNICATE WITH THE BOARD OR THE CARRIER. ALSO, MENTION YOUR SOCIAL SECURITY NUMBER IF YOU WRITE OR CALL THE BOARD.

**IMPORTANTE PARA EL PACIENTE**

**LAS FACTURAS POR SERVICIOS MEDICOS INCLUYENDO HOSPITALES Y TODO SERVICIO DE NATURALEZA MEDICA SERA PAGADO POR EL PATRONO O POR LA ENTIDAD RESPONSABLE O SU COMPANIA DE SEGUROS SEGUN SEA EL CASO; SI SU RECLAMACION ES APROBADA. NO PAGUE ESTAS FACTURAS A MENOS QUE SU CASO SEA DESESTIMADO EN SU FONDO O ARCHIVADO POR NO REALIZAR LOS TRAMITES CORRESPONDIENTES.**

**SI USTED TIENE ALGUNA PREGUNTA, EN RELACION A ESTA NOTIFICACIONOASUCASO O EN RELACION A SUS DERECHOS BAJO LA LEY DE COMPENSACION OBRERA O LA LEY DE BOMBEROS VOLUNTARIOS O LA LEY DE SERVICIOS DE AMBULANCIAS VOLUNTARIOS DEBE COMUNICARSE CON LA OFICINA MAS CERCANA DE LA JUNTA PARA ORIENTACION. SIEMPRE USE EL NUMERO DEL CASO QUE APARECE EN LA PARTE DEL FRENTE DE ESTA NOTIFICACION, O EN OTROS DOCUMENTOS RECIBIDOS POR USTED.** SI LE ES NECESARIO COMUNICARSE CON LA JUNTA O CON EL "CARRIER." TAMBIEN MENCIONE EN SU COMUNICACION ORAL O ESCRITA SU NUMERO DE SEGURO SOCIAL.

INSTRUCTIONS: Reports should be sent directly to the Workers' Compensation Board at the address below:

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

***Statewide Fax Line: 877-533-0337***