NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Doctor's Narrative Report

State of New York - Workers' Compensation Board

THIS FORM MAY ONLY BE SUBMITTED ELECTRONICALLY. DO NOT MAIL

EC-4NARR

CMS-1500 Crosswalk EC-4NARR

This form may be used to report the *first* time you treated the patient or to report *continuing* services. (To report permanent impairment, use Form C-4.3.) **Use this form only if attaching a detailed narrative report.** Please answer all questions completely and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization.

A. Patient's Information

1. Last Name: Field 2 First Name: Field 2 MI: Field 2
2. Social Security #: Field 1a 3. Home Phone #: Field 5
4. WCB Case # (if known): Field 9a 5. Carrier Case # (if known): Field 11b
6. Mailing Address: Field 5 Line 2:
City: Field 5 State: Field 5 Zip Code: Field 5 Country: Field 5
7. Date of injury/onset of illness: Field 14 8. Date of birth: Field 3 9. Gender: Field 3
10. On the date of injury/illness what was the patient's job title or description: Medical Narrative / Attachment
11. On the date of injury/illness what were the patient's usual work activities:

Medical Narrative / Attachment

12. Is the patient working now? Medical Narrative / Attachment 13. Patient's Account #: Medical Narrative / Attachment

B. Employer Information

1. Employer when injury occurred:
Company/Agency Name: Field 4
2. Employer Phone #: Field 7
3. Employer Address: Field 7 Line 2:
City: Field 7 State: Field 7 Zip Code: Field 7 Country: Field 7

C. Doctor's Information

1. Your Last Name: Field 31 First Name: Field 31 MI: Field 31
2. WCB Authorization #: Field 19 3. WCB Rating Code: Field 19
4. Federal Tax ID #: Field 25 The Tax ID # is the: Field 25
5. Office Address: Field 32 Line 2:
City: Field 32 State: Field 32 Zip Code: Field 32 Country: Field 32
6. Billing Group / Practice Name Field 33
7. Billing Address: Field 33 Line 2:
City: Field 33 State: Field 33 Zip Code: Field 33 Country: Field 33
8. Office phone #: 9. Billing phone #: Field 33
10. Treating Provider's NPI #: Field 24J 11. You are a: Field 19

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

D. Billing Information

1. Employer's insurance carrier: Field 0

2. Carrier Code #: Field 0

3. Insurance carrier's address: Field 0 Line 2:

City: Field 0 State: Field 0 Zip Code: Field 0 Country: Field 0

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor
1	Field 21A	Medical Narrative / Attachment
2	Field 21B	Medical Narrative / Attachment
3	Field 21C	Medical Narrative / Attachment
4	Field 21D	Medical Narrative / Attachment

Relate ICD10 codes above to Diagnosis Code column by line.

Dates of Service From	To	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	Modifier 1	Modifier 2	Diagnosis Code	$ Charges	Days/ Units	COB	Zip Code where service was rendered
Field 24A		24B		24D	24D		24E	24F	24G		Field 32

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
Field 28	Field 29	

☐ Services were provided by a WCB preferred provider organization (PPO).

E. Doctor's Opinion

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? Field 10a
2. Are the patient's complaints consistent with his/her history of the injury/illness? Medical Narrative / Attachment
3. Is the patient's history of the injury/illness consistent with your objective findings? Medical Narrative / Attachment
4. What is the percentage (0-100%) of temporary impairment? Medical Narrative / Attachment

This form is signed under penalty of perjury.

Board Authorized Health Care Provider:

I provided the services listed above.

Provider's Last Name: First Name: MI:

Provider's Specialty:

Board Authorized Health Care Provider:

Last Name: Field 31 First Name: Field 31 MI: Field 31

Specialty: Field 19 Date: Field 31