NEW YORK STATE | Workers' Compensation Board

REQUEST FOR DECISION ON UNPAID MEDICAL BILL(S): Arbitration

For Office Use Only:

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
[redacted]	[redacted]	[redacted]

Patient Name [redacted]

Address [redacted]

SSN XXX-XX-[redacted] **DOB** [redacted] **Gender** F

Employer Name [redacted]

Address [redacted]

Insurer Name [redacted] **Insurer ID** [redacted]

Address [redacted]

Claim Admin Name [redacted] **Claim Admin ID** [redacted]

Address [redacted]

HEALTH CARE PROVIDER/ MEDICAL SUPPLIER INFORMATION

Name and Mailing Address of Health Care Provider/ Medical Supplier

Name [redacted]

Mailing Address [redacted]

Email Address [redacted] **Phone #** [redacted]

Type of Care Physician **FEIN/ SSN** [redacted]

WCB Auth # [redacted] **NPI** [redacted]

WCB Rating Code [redacted]

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HEALTH CARE PROVIDER/ MEDICAL SUPPLIER INFORMATION

Health Care Provider/ Medical Supplier Billing Information

Billing Address [redacted]

[redacted]

Email Address [redacted] **Phone #** [redacted]

MEDICAL BILL INFORMATION

Total Charge ($)	1000.00
Amount Paid ($)	10.00
Total # of Medical Bills Attached	1
Date Span for Attached Bill(s)	10/01/2021 to 10/01/2021

HEALTH CARE PROVIDER/ MEDICAL SUPPLIER'S ATTESTATION

I affirm, under penalty of perjury, that
1. The attached medical bill(s) was submitted to the responsible insurer/self-insured employer for payment, AND
2. Proper payment in accordance with the applicable Fee Schedule has not been received, AND
3. I will abide by the NYS Workers' Compensation Board's decision.

Name [redacted] **Date** 02/01/2022