Highview
A Muller Company

WORKERS COMPENSATION

WELCOME PACKAGE AND CLAIM KIT

NEW YORK

NEW YORK

NEW YORK

Dear Policyholder:

Thank you for placing your workers' compensation coverage with Highview National Insurance Company (HNIC). We look forward to providing you with superior customer service and compassionate care for your injured workers.

Enclosed you will find important information and instructions regarding workers' compensation requirements and the claims process. **Please read and follow all instructions contained herein to ensure compliance, avoid penalties, and mitigate the cost of any claims.**

This packet includes documentation necessary for the processing and administration of a claim in the event of a workplace injury. Please use these documents to collect all information regarding the claim, and send them when reporting a claim and/or upon request. The assigned claims professional will forward necessary documentation to the appropriate state entity.

To mitigate the cost of claims, it is critical that you thoroughly and *immediately* investigate, document, and report all workplace injuries *within 24 hours of the incident*.

For fastest claims processing, please use our online reporting tool:

- Login to your account at www.highviewins.com
- Click Incidents, then New Incident to enter the claim
- After entering all requested information, upload all forms and claim-related documents including HNIC Root Cause Mitigation Form Employee Incident Report, Supervisor's Report, any witness statements, and Form C2-F
- Make sure to hit submit when you have completed incident entry

Claims can also be reported via fax at 845-751-7253 or via email at claims@highviewins.com.
The NYS Workers' Compensation Board is strictly enforcing the timely reporting of claims and may issue penalties directly to the policyholder for any claims that are not reported in a timely manner.

In addition, you must notify your Highview adjuster immediately, if the employee loses time from work at any point during the claim, either initially following the injury or at any point thereafter.

If an employee has a severe injury and needs immediate medical assistance, please call 911.

1 Alpine Ct. Suite 102, Spring Valley, NY, 10977
info@highviewins.com / 845.363.0500 / highviewins.com

If an employee needs treatment for any work-related injury, please have them call 833-281-0215 to speak with a nurse. The nurse will assist by arranging a telehealth or onsite physician appointment, as appropriate. Please note this is NOT a substitute for reporting the claim.

If employee needs treatment, please also provide them with:

- First Aid Treatment Authorization
- Work Assessment Form

Please provide all injured workers with the following documents upon notice of injury:

- Form C3 and C3.3 (To be completed and returned to Highview)
- WCB C3.3 HIPAA Release (To be completed and returned to Highview)
- Notice to Injured Employee Regarding Medical Benefits
- First Fill Letter
- NYS WCB Claimant Information Packet

If employee is losing time from work, please complete upon request:

- WCB C-11 Form (to be completed and returned to Highview)
- WCB C240 Form, statement of wages (to be completed and returned to Highview)

If an injured worker is placed out of work or has their work duties restricted by the treating physician, they should be required to provide a completed work assessment form following each doctor's visit. These forms should be sent to claims@highviewins.com or the adjuster upon receipt. Restricted duty should be transitional and provide a path for the injured employee's return to a full duty capacity.

All efforts should be made to have an injured worker return to work as soon as possible following an injury. When an employee loses time from work due to a workers' compensation injury, the cost of the claim increases exponentially. Furthermore, with every day they remain out of work, their chances of ever returning drop dramatically. If you need assistance making suitable accommodations to accommodate the return of an employee with physical restrictions, please reach out to the claims adjuster or HNIC.

Should you have any questions regarding the contents of this kit, a claim, or claim reporting, please contact us via phone at **(845) 363-0500** or via email at claims@highviewins.com. Questions regarding your insurance policy or coverage should be directed to your broker or representative.

Please remember: to mitigate the cost of your claims, complete and return all forms to the best of your knowledge, provide as much information and documentation as you can regarding the claim or any related event, and cooperate fully with HNIC staff and your claims adjuster in a timely manner for the duration of the claim.

THE LEAST EXPENSIVE CLAIM IS ALWAYS THE PREVENTED CLAIM

For assistance on enhancing your safety and loss control processes, please contact Highview National Insurance Company today at 845-363-0500 or via email at info@highviewins.com.

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Accident Investvation

Accident Investigation → Root Cause Determination → Correction Actions

The goal of accident investigation is to determine the root cause of an event in order to implement corrective measures to prevent recurrence of similar accidents.

The **ROOT CAUSE** is the initiating event in the sequence of events leading to the accident that if removed, would have prevented it from happening. The root cause is **NOT** the direct cause of the accident. Root causes are often confused with surface causes, which are symptoms of the root cause and are discovered along the way to determining the root cause.

HOW DO YOU KNOW IF YOU HAVE REACHED THE ROOT CAUSE?

It is helpful to establish an event chain, beginning with the direct cause and working your way through the symptoms until the root cause is determined. If you can still ask 'why', you have likely not yet reached the root cause. The reporting form provides a listing of root causes to select from.

ACCIDENT INVESTIGATION EXAMPLE (WITH EVENT CHAINS):

An employee slips and falls due to water collecting on the floor from a leaking pipe, which could have been discovered and fixed had someone inspected the facility for hazards. If there are no procedures in place to ensure regular inspections, "no inspection procedures" is the root cause of this accident and the accident investigation chain is as follows:

Slip/Trip/Fall	Wet Floor	Leaking Pipe	Failure to Inspect	NO INSPECTION PROCEDURES
(Direct Cause)	*(Symptom)*	*(Symptom)*	*(Symptom)*	*(Root Cause)*

If instead, someone was supposed to conduct an inspection, but did not, "procedures not followed" is the root cause and the accident investigation chain is as follows:

Slip/Trip/Fall	Wet Floor	Leaking Pipe	Failure to Inspect	PRODCEDURES NOT FOLLOWED
(Direct Cause)	*(Symptom)*	*(Symptom)*	*(Symptom)*	*(Root Cause)*

Finally, if CORRECTIVE ACTION(S) have not been executed, the accident investigation process is not complete. Incidents should be reviewed with all department employees to assist in avoiding the same accident re-occurring with a different employee, as should any resulting corrective action policies/procedures. While re-trainings on existing procedures may sometimes be a necessary and important loss control response, on their own they are the least effective corrective action method. Physical and procedural controls, such as footwear requirements, machine guards, re-assigning a caregiver to no longer work with a specific combative resident, observing the employee to confirm correct practices are being followed, and establishing accountability and disciplinary procedures (discipline not necessarily for the injured employee, but for the employee who failed to adhere to the policy in question) are far more effective and should be implemented whenever possible.

APPLYING TRAINING AND PHYSICAL /PROCEDURAL CONTROLS FOR EACH ROOT CAUSE IDENTIFIED IS BEST PRACTICE.

HNIC will provide guidance, as needed, on each claim submission to ensure the root cause is discovered and appropriate corrective action(s) implemented in response to both the symptoms and the root cause. The form itself is designed to guide you to provide this necessary information.

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Root Cause Analysis & Corrective Action Response

Are there specific procedures in place relating to this incident? ☐ Yes ☐ No

- **If YES, procedures are in place:**
- Who is responsible/accountable for compliance with the procedures? _____
  - ☐ Were the procedures followed? ☐ Yes ☐ No
    - **If NO, procedures were not followed:**
    - Was there training provided on the procedures? ☐ Yes ☐ No
      - ☐ **If YES, training was provided:**
      - ☐ How often? _____
      - ☐ When was it last administered to the employee(s) involved?
    - Is there a discipline/corrective action policy for failure to follow the procedures? _____ ☐ Yes ☐ No
      - ☐ **If YES, there is a discipline policy:**
      - ☐ Please describe:_____
      - ☐ Was it applied to the employee(s) identified above as responsible/accountable for compliance? ☐ Yes ☐ No

Root Cause Determination

- ☐ **NO INSPECTION PROCEDURES**
- ☐ **GAP IN INSPECTION PROCEDURES**
- ☐ **INSPECTION PROCEDURES NOT FOLLOWED**
- ☐ **NO SAFE PATIENT HANDLING PROCEDURES**
- ☐ **GAP IN SAFE PATIENT HANDLING PROCEDURES SAFE PATIENT**
- ☐ **HANDLING PROCEDURES NOT FOLLOWED**
- ☐ **COMBATIVE RESIDENT BEHAVIOR - NO IDENTIFIED TRIGGER**
- ☐ **COMBATIVE RESIDENT BEHAVIOR - IDENTIFIED TRIGGER**
  PLEASE DESCRIBE IDENTIFIED TRIGGER HERE
- ☐ **NO DE-ESCALATION PROCEDURES DE-ESCALATION**
- ☐ **PROCEDURES NOT FOLLOWED**
- ☐ **NO APPLICABLE PPE/FOOTWEAR REQUIREMENTS**
- ☐ **REQUIRED PPE/FOOTWEAR NOT WORN**
- ☐ **NO RESIDENT SPECIFIC CARE PLAN IN PLACE**
- ☐ **GAP IN RESIDENT SPECIFIC CARE PLAN**
- ☐ **RESIDENT SPECIFIC CARE PLAN NOT FOLLOWED**
- ☐ **NO APPLICABLE POLICIES/PROCEDURES**
  PLEASE DESCRIBE APPLICABLE PROCEDURES
- ☐ **GAP IN APPLICABLE POLICIES/PROCEDURES**
  PLEASE DESCRIBE APPLICABLE PROCEDURES
- ☐ **APPLICABLE POLICIES/PROCEDURES NOT FOLLOWED**
  PLEASE DESCRIBE APPLICABLE PROCEDURES

Root Cause Corrective Actions

- ☐ **REVIEWED PROPER PROCEDURES WITH EMPLOYEE ENSURED EMPLOYEE'S UNDERSTANDING**
- ☐ **OBSERVED EMPLOYEE PERFORMING PROCEDURE(S) PROPERLY**
- ☐ **REVIEWED INCIDENT WITH ALL DEPARTMENT EMPLOYEES EMPLOYEE**
- ☐ **DISCIPLINED FOR DISREGARDING PROCEDURES**
- ☐ **ACCOUNTABILITY/RESPONSIBILITY/RISK OWNER ASSIGNED**
  PLEASE PROVIDE NAME AND JOB TITLE OF ACCOUNTABLE PARTY HERE:
- ☐ **ESTABLISHED INCENTIVE PROGRAM TO ENCOURAGE COMPLIANCE WITH PROCEDURES**
- ☐ **ESTABLISHED TRAINING(S)**
- ☐ **INCREASED TRAINING FREQUENCY**
- ☐ **NOTED RESIDENT'S CARE PLAN**
- ☐ **ADJUSTED OR EXPANDED EXISTING PROCEDURES**
  PLEASE DESCRIBE 'ADJUSTED OR EXPANDED EXISTING PROCEDURES' HERE:
- ☐ **ESTABLISHED NEW PROCEDURES**
  PLEASE DESCRIBE 'NEW PROCEDURES' HERE
- ☐ **OTHER**
  PLEASE DESCRIBE 'OTHER' HERE

THE ABOVE REPORT IS TRUE AND CORRECT

PREPARED BY:	TITLE:	DATE PREPARED:

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Supervisor's Report of Employee Accident

Employee Name	
Employer Name	

Date of Accident	
Time of Accident	
Date Accident Reported	

Did the employee report the accident immediately?	YES	NO
Location of Accident *(specify if off-site address)*		

How did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were reported as injured?

Has the employee sought any medical treatment for these injuries? If so, specify where and when.

What witnesses were present when the accident occurred (including self)?

Do you have any reason to question the legitimacy of the accident? If so, please explain:

Any other info to share?

The above report is true and correct:

Prepared by:	Title:	Date prepared:

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Witness' Report/Statement of Employee Accident

Employee Name	
Witness Name, Title, & Phone	
Witness Address	

Date of Accident	
Time of Accident	
Location of Accident (specify if off-site address)	

Did you witness the above-reported accident? If so, how did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were injured? Describe the type of injury (strain, bruise, etc.)

What did the injured employee say at the time of injury? Did the injured employee complain of pain at the time of injury? If they complained of pain, please specify the body part(s).

What did the employee do after the accident occurred?

Were any other witnesses present at the time of the accident? If so, please list them below.

I certify that the above statement is accurate and complete to the best of my knowledge

Witness Signature: _____ Date: _____

If not completed by person given statement, Interviewer Name: _____

Interviewer Signature: _____

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.

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NEW YORK STATE | Workers' Compensation Board

State of New York - Workers' Compensation Board

Employer's First Report of Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ Date of Injury _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name _____ Insurer ID _____

Name _____

Info/Attn _____

Address _____

City _____ State _____

Postal Code _____ Country _____

Claim Admin ID _____

EMPLOYEE INFORMATION

First Name _____ Middle Name/Initial _____

Last Name _____ Suffix _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Phone Number _____ Date of Hire _____

Date of Birth _____ Gender ☐ Male ☐ Female ☐ Unknown

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

Time of Injury _____ Date Employer Had Knowledge of the Injury _____

Employment Status _____ Date Employer Had Knowledge of Date of Disability _____

Estimated Weekly Wage _____ Number of Days Worked Per Week _____

Work Week Type ☐ Standard Work Week ☐ Fixed Work Week ☐ Varied Work Week

Work Days Scheduled ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury ☐ Yes ☐ No Employer Paid Salary in Lieu of Compensation ☐ Yes ☐ No

Initial Treatment ☐ No Medical Treatment ☐ Minor On-Site Treatment By Employer ☐ Minor Clinic/Hospital Treatment Future Major ☐ Emergency Evaluation ☐ Hospitalization Greater Than 24 Hours ☐ Medical/Lost Time Anticipated

Death Result of Injury ☐ Yes ☐ No ☐ Unknown Date of Death _____ Number of Dependents _____

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____

Part of Body (i.e. left arm, right foot, head, multiple, etc) _____

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____

Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ Return To Work Type ☐ Actual ☐ Released

Initial Date Disability Began _____ Physical Restrictions ☐ Yes ☐ No No

Initial Return to Work Date _____ Return To Work Same Employer ☐ Yes ☐

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) ☐ Employer ☐ Lessee ☐ Other

Organization Name _____

Street _____ State NY

City _____ Postal Code _____

County _____ Country USA

Location Narrative _____

Witnesses	Business Phone Number

EMPLOYER INFORMATION

Name _____ Employer FEIN _____

UI Number _____ Manual Classification Code _____

Industry Code _____

Info/Attn _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Physical Addr _____

City _____ State _____

Postal Code _____ Country _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ Insured FEIN _____

Insured Type ☒ Insured ☐ Self-Insured ☐ Uninsured Insured Location ID _____

Policy Number ID _____

Policy Effective Date _____ Policy Expiration Date _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form _____ Date _____

Print Name _____

Title _____ Phone Number _____

State of New York – Workers' Compensation Board

Instructions for Completing Form C-2F "Employer's First Report of Work-Related Injury/Illness"

Enter the name of the injured employee at the top of the report. Fill out the Date of Injury/Illness, to the best of your knowledge. If you do not have or know the Workers' Compensation Board Case Number or Claim Administrator Claim Number, please leave the corresponding field blank. It is not required to process the form.

Insurer / Claim Administrator Information:

- **Insurer Name** – the name of your Workers' Compensation Insurer or Self-Insured Group name.
- **Insurer ID** – Carrier Code Number (**W** Number) issued by the Workers' Compensation Board. If you do not know the **W** number, contact your insurer.
- **Name** – the name of the Claim Administrator (claim adjusting office handling the claim).
- **Info/Attn** –any additional pertinent contact information for the Claim Administrator.
- **Address, City, State, Postal Code, & Country** – address of claims administrator, if known.
- **Claim Admin ID** – Carrier Code Number (W Number) or Third Party Administrator Number (T Number) issued by the Workers' Compensation Board. If you do not know the Third Party Administrator Number (T Number), contact your Claim Administrator.

Employee Information:

- **First Name, Middle Initial, Last Name, Suffix** – the injured employee's full legal name.
- **Mailing Address, City, State, Postal Code, & Country** – the full address of the injured employee.
- **Phone Number** – the employee's phone number including area code.
- **Date of Hire** – the date the employee was hired.
- **Date of Birth** – the employee's date of birth.
- **Gender** – check the appropriate gender.
- **Employee SSN** – the employee's Social Security Number (SSN).
- **Occupation Description** – identify employee's primary occupation at the time of accident

Claim Information:

- **Time of Injury** – the time when the injury/illness occurred.
- **Date Employer Had Knowledge of the Injury** – the date the employer had knowledge of the injury/illness.
- **Employment Status** – the applicable employment status for the employee (i.e. full time, part time, seasonal, volunteer, etc.).
- **Date Employer Had Knowledge of Date of Disability** – the date the employer was notified or became aware of employee's work related disability/incapacity.
- **Estimated Weekly Wage** – enter the employee's average weekly gross pay before the injury/illness.
- **Number of Days Worked Per Week** – enter the number of regularly scheduled workdays per week (1-7).
- **Work Week Type** – Check which type of work week the claimant was working at the time of injury. Standard (5 Days, scheduled Monday through Friday), Fixed (Set days of the week worked but not scheduled 5 Days, Monday through Friday), or Varied (Employee had no specific set work week schedule).
- **Work Days Scheduled** – Check which days of the week correspond with the claimant's work schedule at the time of the injury. If Work Week Type of "Varied Work Week" is selected, this field may be left blank.

Employee Injury:

- **Full Wages Paid for Date of Injury** – check Yes or No.
- **Employer Paid Salary in Lieu of Compensation** – check Yes or No to indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.
- **Initial Treatment** – check the initial treatment type.
- **Death Result of Injury** – check Yes, No or Unknown to indicate if the injury/illness resulted in death.
- **Date of Death** – indicate the date of death, if applicable.
- **Number of Dependents** – the number of dependents, if known (for death cases only).
- **Natures of Injury** – indicate the type of injury (i.e. Laceration, Burns, Fracture, Strain, etc.).
- **Part of Body** – indicate the part of body that was injured (i.e. left arm, right foot, head, multiple, etc.).
- **Causes of Injury** – indicate what caused the injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.).
- **Accident/Injury Description** – describe how the accident occurred and the resulting injuries.

Work Status:

- **Initial Date Last Day Worked** – the last day worked prior to lost time.
- **Return to Work Type** – check Actual for employee actually returned to work, or check Released for employee was released to work but did not do so.
- **Initial Date Disability Began** – first day of disability (lost time) after the 7 day waiting period requirement has been met. If the employee was a Volunteer Ambulance Worker or Volunteer Firefighter there is no 7 day waiting period.
- **Physical Restrictions** – check Yes if the employee has returned to work with restrictions; check No if the employee has returned to work without restrictions.
- **Initial Return to Work Date** – if the employee has returned to work, indicate the initial return to work date.
- **Return to Work Same Employer** – check Yes or No.

Accident Location and Witnesses:

- **Premises** – check appropriate location where injury occurred. Employer-accident occurred on employer's premises; Lessee-accident occurred on the premises of the lessee for which the employee was hired to work; or Other-accident occurred at a location other than the employer for which the employee was hired to work. Check Employer, if employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department and was injured while working for his/her own service/department. Check Other, if the employee was injured working in an official capacity for a Volunteer Ambulance Service or Volunteer Fire Department other than the one he/she was a member of.
- **Organization Name** – the name of the organization where the injury/illness occurred.
- **Street, City, State, Postal Code, County, & Country** – the address where the injury/illness occurred.
- **Location Narrative** – provide any additional description of the location (i.e. Building C, 4th Floor in Room 101).
- **Witnesses & Business Phone Number** – indicate the names and business phone numbers of any witnesses to the injury/illness.

Employer Information:

- **Name** – the name of the company or the owner's name and DBA name. If the employee was member of a Volunteer Ambulance Service or Volunteer Fire Department, the name of the Political subdivision should be entered.
- **Employer FEIN** – your Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the employer was a Volunteer Ambulance Service or Volunteer Fire Department, the FEIN of the Political subdivision should be entered.
- **UI Number** – enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.
- **Manual Classification Code** – the New York Compensation Insurance Rating Board (NYCIRB) manual classification code, if known. This can be found on your workers' compensation insurance policy.
- **Industry Code** – the North American Industry Classification System (NAICS). If you do not know your NAICS, please describe the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
- **Info/Attn** – indicate any additional pertinent contact information for the employer.
- **Mailing Address, City, State, Postal Code, & Country** – the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
- **Physical Address, City, State, Postal Code, & Country** – the physical address of the employer (if different).
- **Supervisor Name & Supervisor Business Phone Number** – indicate the name and phone number for the employee's direct supervisor, including area code.

Insured Information:

- **Insured Name** – the name of the insured entity. If the employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department, the name of the ambulance service or fire department should be entered.
- **Insured FEIN** – the Insured's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the insured is a Volunteer Ambulance Service or Volunteer Fire Department the FEIN of the ambulance service or fire department should be entered.
- **Insured Location ID** – indicate the Insured Location ID, if any (i.e. Store 202, Jobsite 51, etc.).
- **Insured Type** – check the insurance arrangement: Insured, Self-Insured, or Uninsured.
- **Policy Number ID** – your Workers' Compensation Insurance Policy Number.
- **Policy Effective & Expiration Date** – the policy effective and expiration dates.

NEW YORK STATE Workers' Compensation Board

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness.Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A.YOUR INFORMATION (Employee)

1.Name: _____ (First / MI / Last) 2.Date of Birth: _____/_____/_____

3.Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4.Social Security Number: ___-___-_____ 5.Phone Number: (_____)_____ 6.Gender: ☐ Male ☐ Female

7.Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B.YOUR EMPLOYER(S)

1.Employer when injured: _____ 2.Phone Number: (_____)_____

3.Your work address: _____ (Number and Street / City / State / Zip Code)

4.Date you were hired: _____/_____/_____ 5.Your supervisor's name: _____

6.List names/addresses of any other employer(s) at the time of your injury/illness: _____

7.Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C.YOUR JOB on the date of the injury or illness

1.What was your job title or description? _____

2.What types of activities did you normally perform at work?_____

3.Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other:_____

4.What was your gross pay (before taxes) per pay period? _____ 5.How often were you paid? _____

6.Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D.YOUR INJURY OR ILLNESS

1.Date of injury or date of onset of illness: _____/_____/_____ 2.Time of injury: _____ ☐ AM ☐ PM

3.Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4.Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5.What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6.How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7.Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead):_____

YOUR NAME: _____ _____ _____ **DATE OF INJURY/ILLNESS:** _____/_____/_____
First MI Last

D.YOUR INJURY OR ILLNESS *continued*

8.Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9.Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No

If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____

If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

_____

10.Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No

If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/_____/_____

11.Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

_____

E.RETURN TO WORK

1.Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ N o , skip to Section F.

2.Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty

3.If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed

4.What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F.MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1.What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)

2.Were you treated on site? ☐ Yes ☐ No

3.Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room

☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours

Name and address where you were first treated: _____

_____ Phone Number: (_____)_____

4.Are you still being treated for this injury/illness? ☐ Yes ☐ No

Give the name and address of the doctor(s) treating you for this injury/illness: _____

_____ Phone Number: (_____)_____

5.Have you had another injury to the same body part, or a similar illness? ☐ Yes ☐ No

If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**

_____

_____

_____

6.Was the previous injury/illness work related? ☐ Yes ☐ No

If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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.

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____

NEW YORK STATE | Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it):*_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____

3. Mailing Address: _____

4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____

6. Current injury/illness, including all body parts injured:_____

_____

7. Your legal representative's name and address (if any):_____

_____

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____

3. Mailing Address: _____

4. Other provider (if any):_____ 5. Phone Number: (_____)_____

6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____

Your name Relationship to Claimant Signature (ink only -- use blue ballpoint pen, if possible.) Date

Versión en español al reverso de la forma.

Divulgación limitada de información sobre la salud (HIPAA)

NEW YORK STATE | Workers' Compensation Board

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe]*)

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **ITratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A.YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1.Name (Nombre)

2.Social Security Number (Número de seguro social)

3.Mailing Address (Dirección postal)

5.Date of the current injury/illness (Fecha de la lesión/enfermedad actual)

4.Date of Birth (Fecha de nacimiento)

6.Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)

7.Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

Check here if you allow your health provider(s) to release ***mental health care*** *information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre* ***tratamientos de salud mental****.)*

B.YOUR HEALTH CARE PROVIDERS (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1.Provider (Proveedor de salud)

2.Phone Number (No de teléfono)

3.Mailing Address (Dirección postal)

4.Other provider (if any) (Otro proveedor [si corresponde])

5.Phone Number (No de teléfono)

6.Mailing Adress (Dirección postal)

C.READ AND SIGN BELOW

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) use solo tinta - preferiblemente azul   Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre)   Relationship to Claimant (Relación con el reclamante)   Signature(Firma)   Date(Fecha)

Instructions for Completing Employee Claim (Form C-3)

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the end of these instructions. If you need additional help completing this form, contact the Workers' Compensation Board at 1-877-632-4996. You may also fill this form out online at **wcb.ny.gov**. If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):
In Section A, enter your name, address and other requested information.
Note on Item 7: Board hearings are conducted in English. If you need a translator, select Yes and indicate the language needed.

Notification Pursuant to the New York Personal Privacy Protection Law
(Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).

The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Section B - Your Employer(s):
In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.
Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

Section C - Your Job on the Date of the Injury or Illness:
In Section C, enter your job title, work activities and pay information.

Section D - Your Injury or Illness:
In Section D, enter your injury or illness information.
Item 1: Enter the date you were injured or the first date you noticed you became ill.
If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now).
Item 8: Indicate if some object was involved in the accident other than a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:
Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate the date you stopped working. If you have not stopped working, check No and skip to the next section.
Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)
Item 3: If you have returned to work, indicate who you are working for now.
Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.
Item 2: Check if you were first treated on the job for this injury or illness.
Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).
Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise, check No.
Item 5: If you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**
Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative must complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:
New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996

Highview
A Muller Company

CLINICALCARE24

Injured at Work?
Report your injury to your supervisor
Then call the Nurse Triage line at

833-281-0215

Nurse Triage Service Available 24/7/365

IF IT'S AN EMERGENCY, CALL 911

Highview
A Muller Company

First Aid Treatment Authorization

(Employee Copy)

Date:

Employee:

Job Title:

Claim Number:

Injury Date:

Employer:

The above, noted employee, _____

requests medical treatment at your clinic/hospital for injury to the following body part[s]

_____.

THIS WILL SERVE AS AUTHORIZATION FOR INITIAL EVALUATION AND TREATMENT AND WILL BE PAID IN ACCORDANCE WITH NEW YORK WORKERS' COMPENSATION FEE SCHEDULE.

If the employee can return to work without restrictions, please give the employee a full duty release note.

The employer may offer temporary transitional duty and may be able to accommodate medical work restrictions. If it's your medical opinion that the employee is unable to return to work to full duty, please complete the attached *Work Assessment Form.*

Bill Submission:

Paper Bill Submissions - PO Box: Highview National Insurance Company, PO Box 2936, Clinton IA 52733 Fax Line: +1(845) 422-9994

Electronic Bill Submissions:

Payer ID: J4588
Clearinghouse: Jopari Solutions

Provider Inquiries / Provider Contact Center (Client Dedicated Line): (877) 547-9955

WORKERS' COMPENSATION FRAUD STATEMENT: 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.

1 Alpine Ct. Suite 102, Spring Valley, NY, 10977
info@highviewins.com / 845.363.0500 / highviewins.com

Work Assessment Form

To Be Completed by the Treating Physician

Claimant: _____ SSN/ID: _____

Date of Injury: _____ Date of evaluation: _____

Diagnosis/ condition (brief explanation): _____

Is the injury or illness causally related to the worker's employment? ☐ Yes ☐ No

What is the *current* percentage (0-100%) of temporary disability? _____

Evidence of preexisting condition? ☐ Yes ☐ No If yes, please explain: _____

_____

Anticipated date of discharge from your care OR anticipated date of MMI: _____

Please outline your current treatment plan:

_____

_____

Anticipated RTW Light Duty: _____ Anticipated RTW Full Duty: _____

Based on my assessment and treatment of this injury, I recommend:

- Can the employee work an 8-hour day? ☐ Yes ☐ No If no, how many hours / day? _____
- In an 8-hour day, employee can: (circle full capacity for each)

Sit	1	2	3	4	5	6	7	8	Hours/ day
Stand	1	2	3	4	5	6	7	8	Hours/ day
Walk	1	2	3	4	5	6	7	8	Hours/ day

- Employee can lift / carry: (Please check as appropriate)

	Not at this time		Occasionally		Frequently		No Restriction	
	Lift	Carry	Lift	Carry	Lift	Carry	Lift	Carry
0-10 lb.	☐	☐	☐	☐	☐	☐	☐	☐
11-25 lb.	☐	☐	☐	☐	☐	☐	☐	☐
26-50 lb.	☐	☐	☐	☐	☐	☐	☐	☐
51-100 lb.	☐	☐	☐	☐	☐	☐	☐	☐
100+	☐	☐	☐	☐	☐	☐	☐	☐

- Employee is able to: (please check all that apply)

	Not at this time	Occasionally	Frequently	No Restriction
	0%	1-33%	34-66%	67-100%
Balance	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Use Foot	☐	☐	☐	☐

- Employee can use upper extremities for repetitive: (check as appropriate)

Simple Grasp	Firm Grasp	Fine Manipulation	Pushing / Pulling	(Circle Appropriate)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Right ☐ Left

- Employee can use lower extremities for repetitive movement such as foot controls:
  Right ☐ Yes ☐ No Left ☐ Yes ☐ No

Can the employee drive or independently use public transportation? ☐ Yes ☐ No

Employee is released to work as of: ___/___/_____ ☐ With ☐ Without restrictions noted above.

Date of next evaluation: ___/___/_____

Medical Provider's Signature: _____ Date: ___/___/_____

Print Provider's Name: _____ Provider's Phone Number: (_____) _____- _____

Mitchell ScriptAdvisor

FAST & SIMPLE: GETTING YOUR FIRST PRESCRIPTION FILLED

Mitchell ScriptAdvisor has been selected by **Highview National Insurance Company** to assist you in obtaining prescription drugs related to your claim. This form enables you to fill prescriptions written by your authorized physician for medications related to your injury. Simply present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses.

Please Note: This is a temporary prescription card; you may receive a permanent drug card in the future.

For your convenience, **Mitchell ScriptAdvisor** has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at https://portal.mitchellscriptadvisor.com/main/pharmacylocator.aspx to access the pharmacy locator.

Employee

- **You may contact Mitchell Customer Service at 866.846.9279 or you may present this sheet to the pharmacist along with your prescription.**

Pharmacy

- This sheet is a Temporary Prescription ID Card for a **10** Days' Supply Fill until this individual's permanent card can be provided.
- **Create the ID number** based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Attention Pharmacists: Process through Script Care and Enter RxBIN, RxPCN and GROUP.

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	023377
PCN:	MPS
Group:	001806TC

Questions? Need Help?

Call (866) 846-9279

Our representatives are available 24/7 to answer any questions you may have regarding your pharmacy benefits.

This card is to be used for prescriptions related to your injury covered under your insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

mitchell

Mitchell International

866.846.9279

Mitchell ScriptAdvisor

RÁPIDO Y SIMPLE: OBTENER SU PRIMERA RECETA SURTIDA

Mitchell ScriptAdvisor ha sido seleccionado por **Highview National Insurance Company** para ayudarlo a obtener medicamentos recetados relacionados con su reclamo. Este formulario le permite surtir recetas escritas por su médico autorizado medicamentos relacionados con su lesión. Simplemente preséntelo en la farmacia en el momento en que se surta su receta. Este formulario debe garantizar que NO tendrá gastos de bolsillo.

Tenga en cuenta: Esta es una tarjeta de prescripción temporal; es posible que reciba una tarjeta de medicamentos permanente en el futuro.

Para su comodidad, **Mitchell ScriptAdvisor** tiene una extensa red de farmacias minoristas, incluidas las principales cadenas de farmacias. Para ubicaciones de farmacias, puede llamar a nuestro número gratuito al 866.846.9279 o visitar nuestro sitio web en https://portal.mitchellscriptadvisor.com/main/pharmacylocator.aspx para acceder al localizador de farmacias.

Empleado

- **Puede comunicarse con el Servicio al Cliente de Mitchell al 866.846.9279 o puede presentar esta hoja al farmacéutico junto con su receta.**

Farmacia

- Esta hoja es una tarjeta de identificación de prescripción temporal para un suministro de **10** días hasta que se pueda proporcionar la tarjeta permanente de esta persona.
- **Cree el número de identificación** basado en los criterios proporcionados y escríbalo, junto con el nombre del individuo, en la tarjeta de identificación a continuación.
- Todos los datos necesarios para procesar este script a través del Sistema de Adjudicación de Script Care se incluyen en la tarjeta de medicamentos que se representa a continuación.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Attention Pharmacists: Process through Script Care and Enter RxBIN, RxPCN and GROUP.

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	023377
PCN:	MPS
Group:	001806TC

Preguntas? Necesita Ayuda?

Call (866) 846-9279

Our representatives are available 24/7 to answer any questions you may have regarding your pharmacy benefits.

Esta tarjeta debe usarse para medicamentos recetados relacionados con su lesión cubierta por la póliza de seguro. El uso de esta tarjeta no renuncia a ninguna limitación o exclusión de la póliza. Esta tarjeta no confirma la cobertura. Para confirmar la elegibilidad u obtener información específica, comuníquese con la mesa de ayuda con la información que se encuentra en el anverso de esta tarjeta.

mitchell
AN ENLYTE COMPANY

Mitchell International
866.846.9279

You were injured at work. What now?

If you have suffered a workplace injury or illness, you may be eligible for workers' compensation benefits. You may have already received medical treatment. If you haven't, you should seek medical care as soon as possible.

For assistance with your claim, call the **Workers' Compensation Board (Board)** at **(877) 632-4996**.

YOUR RESPONSIBILITIES

- Notify your employer, in writing, detailing when, where and how you were injured or became ill. Do this as soon as possible within 30 days of injury or illness. Do not text it; instead send a letter, email or other document that can be saved or printed.
- Advise your health care providers that you have a work-related injury or illness and give the name of your employer's workers' compensation insurer. If you do not know the name of your employer's insurer, either ask your employer or contact the Board immediately. Your health care provider will file medical reports with the Board and with your employer or its insurer. A medical report needs to be filed with the Board for you to access your benefits.
- File an ***Employee Claim (Form C-3)*** reporting your injury or illness to the Board as soon as possible. You must notify the Board of your injury or illness within two years. If you injured the same body part before, or had a similar illness, you must also file a ***Limited Release of Health Information (Form C-3.3)***.
  Citizenship and immigration status are not factors in workers' compensation.

How to file a claim
Quickest method: Visit wcb.ny.gov and select "File a Claim."
For questions about filing a *Form C-3*, or to receive a copy of the form, please call (877) 632-4996. A Board representative will help you.

MEDICAL AND TRAVEL EXPENSES

Medical care to treat your work-related injury or illness is a workers' compensation benefit that is provided at no cost to you. Medical bills for your injury or illness are paid directly by your employer's workers' compensation insurer to your health care provider. If your case is disputed by the insurer, the health care providers will be paid if the Board decides your case in your favor. However, if the Board decides against you, or if you don't pursue a case, you will have to pay the health care provider or hospital (or submit the bill(s) to your own health insurer).

Your employer's workers' compensation insurance covers medically necessary drugs and equipment your health care provider prescribes. You may also be reimbursed for mileage, public transportation or other necessary expenses incurred when traveling for treatment. Submit those expenses (including receipts if you have any) to your employer's workers' compensation insurer and to the Board on a ***Claimant's Record of Medical and Travel Expenses and Request for Reimbursement (Form C-257)***.

Generally, you can choose any health care provider authorized by the Board. You can search for an authorized health care provider in your area using the "Health Care Provider Search" feature at **wcb.ny.gov**. You can also use occupational health clinics. However, if your employer's workers' compensation insurer has a Preferred Provider Organization (PPO) to provide care for workers' compensation injuries, you must get your first treatment from the PPO network. If that insurer also has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them. However, in an emergency, you can see any provider.

BENEFITS FOR LOST WAGES

You are entitled to a portion of your lost wages, which must be paid promptly, if your injury or illness affects you in one or more of the following ways:

1. It keeps you from work for more than seven calendar days;
2. Part of your body is determined to be permanently disabled; and/or
3. Your pay is reduced because you now work fewer hours or do other work.

After you have healed from your injury or illness and when no further medical improvement is expected (typically one year after the date of accident/illness or surgery, if surgery was performed), you can ask your doctor to evaluate whether your accident/illness has resulted in a permanent injury/condition. To learn more about this benefit, please visit **wcb.ny.gov**, click on the "Workers" section, then select "Disability Classifications."

You may hire an attorney or licensed representative for help with your claim, but it isn't required. You or your family should not directly pay your attorney or licensed representative. Their fees are approved by the Board and deducted from your lost wage award.

If your case is disputed, you may receive disability benefits while the case is pending review by the Board. To get a ***Notice and Proof of Claim for Disability Benefits (Form DB-450)***, visit **wcb.ny.gov**; call the Board for assistance; or visit a Board office. If the case is resolved in your favor, the disability benefits will be deducted from your lost wages award.

WHAT'S NEXT?

The workers' compensation insurer will contact you. If your claim is accepted, your health care providers will be paid, and lost wage benefits begin. If your case needs a hearing, the Board will contact you. There are online resources available to make the hearing process easier:

- **eCase:** You can upload and view case-related documents online with the Board's eCase system, which is used to process claims for injured workers. You must register for eCase at **wcb.ny.gov**.
- **Virtual Hearings:** You have the option of attending hearings without having to travel to a Board office by using virtual hearings. Learn more about virtual hearings, and the Board's free app, at **wcb.ny.gov/virtual-hearings**.

HELP IS AVAILABLE

Sometimes you need help getting back to work. Your employer may have alternative or light duty assignments that enable you to work while you heal. An injury or illness can also cause family or financial problems. The Board has vocational rehabilitation counselors and social workers to help. Call the Board for more information on available services and for assistance.

If you are concerned about dependency on opioid pain medications, please call the NYS OASAS HOPELine at **877-8-HOPENY (877-846-7369).**

Important Contact Information		
Workers' Compensation Board	(877) 632-4996	claims@wcb.ny.gov
		wcb.ny.gov

New York State Workers' Compensation Board
PO BOX 5205
Binghamton, NY 13902-5205

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

WCB-Claimant-QuickGuide-v1 (1-21)

NEW YORK STATE Workers' Compensation Board

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

C-11

PO Box 5205, Binghamton, NY 13902-5205

- Web Upload Link: https://wcbdoc.xrxfs.com/login.aspx
- Email Filing: wcbclaimsfiling@wcb.ny.gov

This report is to be filed directly with the Chair, Workers' Compensation Board as soon as the employment status of an injured employee, as reported on First Report of Injury, or on a previous Form C-11 or EC-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages. **A copy should also be sent to your insurer.**

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: _____ WCB Case #: _____

Claim Administrator Claim (Carrier Case) #: _____

Employee Information

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Daytime phone #: _____ Email Address: _____

Social Security #: _____ Date of Birth: _____ Gender: ◯ M ◯ F ◯ X

Employer Information

Employer Name: _____

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Employer Phone #: _____ Federal Tax ID #: _____ The Tax ID # is the (check one): ◯ SSN ◯ EIN

Insurer Information

Insurer Name: _____ Insurer ID (W#): W _____

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Insurer Phone #: _____

Date of first full day employee lost from work: _____ Date employee first returned to work: _____

Loss of time resulting from the above injury since initial date of lost time or last C-11 filed with the Board:

Loss of Time Start Date	Return To Work Date	Reason

As a result of the above injury, was there an increase or decrease in hours worked or wages paid? ◯ Yes ◯ No

If yes, enter status of change below:

Employment Status	Effective Date	Hours per Day	Days per Week	Earnings	Remarks
Prior to Injury					
Changed To					

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Prepared By:

Last Name: _____ First Name: _____ MI: ___

Employer Name: _____

Official Title: _____ Phone #: _____

Email Address: _____ Date of this report: _____

NEW YORK STATE | Workers' Compensation Board

EMPLOYER'S STATEMENT OF WAGE EARNINGS (Preceding the Date of Injury/Illness)

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: _____ WCB Case #: _____ Claim Administrator Claim (Carrier Case) #: _____

Injured Worker Information

Last Name: _____ First Name: _____ MI: __

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

Job Title: _____ Social Security #: _____

Insurer Information

Insurer Name: _____ Insurer ID (W#): _____

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

Insurer Phone #: _____ Insurer Fax #: _____ Email Address: _____

Employer Information

Employer Name: _____

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

Employer Phone #: _____ Federal Tax ID #: _____ The Tax ID # is the (check one): ☐SSN ☐EIN

To determine Average Weekly Wage, the Board needs the gross weekly earnings for the 52 weekly periods immediately preceding the date of the injury/illness. This information can be provided by 1) attaching detailed payroll information that indicates days paid and gross weekly earnings; 2) if injured worker is paid by salary and their weekly pay does not change from week-to-week, attach document(s) providing their salary information for the previous 52 weeks; or 3) by completing and submitting the **Injured Worker Payroll** section on page 2 of this form.

If the injured worker has not worked at the same employment for one year or a substantial part of the year, also attach detailed payroll information for an employee of the same class, or complete and submit the **Employee of the Same Class Payroll** section on page 2 of this form. "Substantial part of the year" does not require any particular number of days worked but as a guideline 234 days at 5 days per week and 270 days at 6 days per week .

1. Payroll information is: ☐ attached ☐ completed on page 2

2. Did the injured worker's compensation include board, rent, housing, tips and/or gratuities, in addition to gross weekly earnings? ☐Yes ☐No

   If Yes, what was the weekly value: _____

   Nature of the compensation:

3. Basis for the injured worker pay rate is: ☐hourly ☐daily ☐weekly ☐monthly ☐annually

4. The injured worker works a: ☐5 ☐6 ☐7 ☐ Other day week. If Other, Explain: _____

5. Total days paid in the preceding 52 weeks: ____ 6. Total gross amount paid including overtime in the preceding 52 weeks: _____

7. Was there any wage adjustment made that affected the 52-week period? (If injured worker was in military service, please indicate and provide date of discharge.) ☐ Yes ☐ No

   If "Yes", explain:

8. Was the injured worker laid off during the preceding 52 weeks? ☐Yes ☐No

   If Yes, provide dates of layoff : _____

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Prepared By - The above information is true and to the best of my knowledge and belief.

Last Name: _____ First Name: _____ MI: ___

Employer Name: _____

Official Title: _____ Daytime Phone #: _____

Email Address: _____ Date of this Report: _____

Injured Worker's Name: _____ Date of Injury/Illness: _____ WCB Case #: _____

INJURED WORKER PAYROLL Enter the injured worker's gross weekly earnings for the 52 weekly periods immediately preceding the date of injury/illness. In the "**Days Paid**" column enter the number of days compensated, including paid time off.

Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

EMPLOYEE OF THE SAME CLASS PAYROLL. If the injured worker has not worked at the same employment for one year or a substantial part of the year, enter the gross weekly earnings for an employee of the same class. "Substantial part of the year" does not require any particular number of days worked, but as a guideline 234 days at 5 days per week and 270 days at 6 days per week.

Employee of the Same Class

First Name: _____ Last Name: _____ MI: ___

Job Title: _____

Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

Instructions for Completing Employer's Statement of Wage Earnings (Form C-240)

CLAIM INFORMATION

Date of Injury/Illness: Enter the date the injured worker was injured or noticed they were ill. Enter the date in month/day/year format. Include the four digit year.
WCB Case #: The Workers' Compensation Board Case number.
Insurer Case #: The Claim Administrator Claim (Carrier Case) number.

INJURED WORKER INFORMATION

Last Name, First Name, MI: Enter the injured worker's full legal name.
Mailing Address: Enter the injured worker's full address, including PO Box, if applicable, city or town, state, zip code.
Social Security #: Enter the injured worker's Social Security Number.

INSURER INFORMATION

Insurer Name: Enter the name of the Workers' Compensation Insurer or Self-Insured Group name.
Mailing Address: Enter the insurer or claims administrator address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the insurer phone number, including area code and extension, if applicable.
Fax #: Enter the insurer fax number, including area code, if applicable.
Email Address: Enter the insurer or claims administrator email address.

EMPLOYER INFORMATION

Employer Name: Enter the name of the injured worker's employer.
Mailing Address: Enter the employer's full address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the employer phone number, including area code and extension, if applicable.
Federal Tax ID #: Enter the employer Federal Tax ID number.

1. **Payroll Information** - Indicate if payroll information is attached to this form or if the information is entered on page 2.
2. **Other Earnings**: If the injured worker received board, rent, housing, tips and/or other gratuities, provide the weekly value and describe the additional earnings. Note: Other earnings does not include accrued time such as vacation.
3. **Wage Information**: Enter the basis for injured worker's pay rate (hourly, daily, weekly, monthly or annually).
4. **Days Worked Per Week:** Check the number of days per week the injured worker's work schedule is based on. If it is other than a 5, 6 or 7 day week, explain.
5. **Total Days Paid**: Enter the total number of days for which the injured worker was paid in the 52 weeks immediately prior to the date of injury/ illness, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7. Do not include accrued time such as vacation time.
6. **Total Gross Amount Paid Including Overtime:** Enter the injured worker's total gross pay (prior to taxes) for the 52 weeks immediately prior to the date of injury/illness, including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.
7. **Wage Adjustments**: If any wage adjustments (e.g., if the injured worker was demoted) were made during the 52 weeks prior to the injury/ illness, explain. Advise if the injured worker was in military service during the 52 week period, and give date of discharge.
8. **Laid Off**: Indicate if the injured worker was laid off during the 52 week period immediately prior to the date of injury/illness, and provide the dates of layoff.

PREPARED BY

Last Name, First Name, MI: Enter the preparer's full legal name.
Employer Name: Enter the name of the preparer's employer.
Official Title: Enter the preparer's official title.
Phone #: Enter the preparer's phone number, including area code and extension, if applicable.
Email Address: Enter the preparer's email address.
Date of this Report: Enter the date this report was prepared.

INSTRUCTIONS FOR COMPLETING INJURED WORKER PAYROLL AND EMPLOYEE OF SAME CLASS PAYROLL

Injured Worker Payroll

Week Ending Date: Enter the week ending dates for each of the 52 weeks immediately prior to the date of injury/illness.
Days Compensated (including paid time off): In the "**Days Paid**" column, give the number of days worked in the employment for which the worker was paid, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7 on page 1. Do not include accrued time such as vacation time.
Gross Amount Paid including Overtime: Enter the injured worker's average weekly gross pay (prior to taxes), including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.

Employee of the Same Class Payroll: Give the gross weekly wages for an employee of the same class if the injured worker worked less than a substantial part of the year (234 days for a 5-day worker, or 270 days for a 6-day worker). In addition, provide name of employee in the same class and their job title. NOTE: "Number of days worked" is a guideline, and the Board may find that an injured worker has worked a substantial part of the year even if the injured worker did not work 234 days (5-day worker) or 270 days (6-day worker).

If attaching payroll information, do not submit page 2. All attachments should include the Injured Worker's full name, WCB Case # and Date of Injury/Illness.

Submit by mail or electronically directly to:

New York State Workers' Compensation Board
PO Box 5205

Fax #: (877) 533-0337
WCB Address for Email Filing: wcbclaimsfiling@wcb.ny.gov

Highview
A Muller Company

ADDITIONAL REFERENCES

FOR MORE INFORMATION, VISIT: WWW.WCB.NY.GOV

NEW YORK

NEW YORK