STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

REQUEST FOR FURTHER ACTION BY LEGAL COUNSEL

This form is for use by claimant's attorney or licensed representative ONLY. Unrepresented claimants should use Form RFA-1W or ask for Board assistance.

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS		3. DATE OF INJURY
1. WCB CASE NO.	2. CARRIER CASE NO. (if known)	mm dd yy

	NAME	ADDRESS TO WHICH NOTICES SHOULD BE SENT	
4. CLAIMANT		Check if new address: ☐	APT. NO.
5. EMPLOYER (at time of injury)			
6. CARRIER			
7. ATTORNEY OR LICENSED REP.			

8. **INSTRUCTIONS:** The claimant seeks Board action regarding the claim identified above for the following reasons (**check all that apply**). Please note that the **required documentation** identified below **must be attached** to the form and submitted to the Board or **must be referenced** in the space provided below** (by date, name or title of document, and form ID) if it is already in the Board's electronic file. This form must be **mailed, faxed or e-mailed** to the Workers' Compensation Board. (See mailing and e-mail filing address on reverse side).

Compensation:

☐ a. Payments have been suspended or reduced on _____.

☐ b. Payments should be suspended as claimant returned to work at full wages on _____.

☐ c. Payments should be adjusted as claimant is working at reduced earnings as of _____. *(documentation of medical disability and current earnings required)*

☐ d. Payments should be adjusted as claimant has concurrent employment. *(documentation of weekly gross pay preceding injury and statement from second employer regarding lost time required)*

☐ e. Payments should begin as claimant is not working as of _____. *(medical documentation indicating disability required)*

☐ f. Payments should be resumed as claimant has been released from incarceration on _____ and now seeks benefits. *(medical documentation indicating disability and release from custody documentation required)*

☐ g. Payments have not been paid as directed by Decision filed on _____ .

☐ h. Payments have not included payment of the attorney/licensed representative's fee of $_____ directed by Decision filed on_____ .

Medical Issues:

☐ i. Claimant's medical condition has changed. *(medical documentation indicating change required)*

☐ j. Claimant's request for medical treatment has been denied or has not been addressed. *(documentation indicating denial of request for medical treatment required. Please use Form MG-2 for variance denials.)*

☐ k. Claimant's disability is now permanent. *(medical Form C-4.3, Doctor's Report of MMI/Permanent Impairment required)*

- ☐ Check this box if the claimant was under 25 years of age at time of accident.
- ☐ Check this box if the claimant accepts the carrier's opinion on the severity of disability/loss of use.

☐ l. Claimant's request for medical and transportation reimbursement has been denied or not addressed. *(receipts and Form C-257 required)*

Other:

☐ m. Parties have entered into a stipulation. *(Form C-300.5 or written stipulation required)*

☐ n. Parties have reached an agreement and seek a Proposed Conciliation Decision. *(Form C-312.5 or proposed findings required)*

☐ o. Claimant has discontinued or settled a lawsuit pertaining to the accident/injury of this claim. *(documents indicating discontinuance, settlement, or closing statement required)*

☐ p. Claimant has new or requested documentation regarding_____

_____ *(documents required)*

☐ q. Other (explain fully in the space provided below.)

**Document reference information (date, name/title,form ID):_____

I certify that this request for Board action is based upon reasonable grounds, has been submitted with my client's consent, and that this form with attachment(s) has been provided to the opposing party(ies). I also certify that (check one box below):

☐ **I have discussed the issue(s) above with the opposing party(ies) or its representative(s) (*give name of person contacted*)**

_____ **on (*date*)** _____ **and that: (check one)**

☐ no settlement of the issue(s) could be reached. ☐ settlement of the issue(s) was reached (*documentation required*).

☐ **I have attempted to contact (name)** _____ **on (*date*)** _____ **to discuss the issue(s) above, that I have waited a reasonable time for a response, but that no discussion was forthcoming.**

CERTIFIED BY (Please Print Name)	ATTY/REP ID NO.	DATE PREPARED mm dd yy	AREA CODE TELEPHONE NUMBER
	R		

☐ An attorney/licensed representative fee is requested and Form OC-400.1 has been submitted.

To the Claimant's Representative - General Information On Using This Form

You may file this form with the Workers' Compensation Board when you want the Board to take a specific action in your client's case, or if you need to alert the Board to any problem or situation that is affecting your client's case. Many of the most frequently requested actions/situations are contained in Section 8. These are categorized as compensation issues (items a. through h.), medical (items i. through l.), or other issues (items m. through p.). However, you are not limited to those listed. Check all that apply and/or add additional information or explanation in the space provided (q). If an attorney/licensed representative fee is requested, submit Form OC-400.1.

Complete the identifying information at the top of Form RFA-1LC and send the form, WITH ALL APPLICABLE EVIDENCE ATTACHED, to the Workers' Compensation Board (see address below). he Board will contact you and all parties when it takes action on your client's case.

YOU MUST CERTIFY THAT YOU HAVE DISCUSSED THE ISSUE(S) OR ATTEMPTED TO CONTACT THE CARRIER/EMPLOYER AND HAVE BEEN UNABLE TO SETTLE THE OUTSTANDING ISSUE(S).

YOU MUST SEND A COPY OF THIS FORM TO YOUR CLIENT, THE INSURANCE CARRIER(S), OR DIRECTLY TO THE EMPLOYER OR ITS THIRD PARTY ADMINISTRATOR IF THE EMPLOYER IS SELF-INSURED.

Additional information about the Board, including information about Board forms, is available at the Board's web site: www.wcb.ny.gov. If you would like on-line access to your client's case, you can register for eCase using the registration instructions available on the Board website under the eCase link.

ADDITIONAL INFORMATION

Upon the submission of this form with the applicable documentary evidence, the Board will take immediate action to advance your client's claim toward resolution. Some of these actions include, but are not limited to the following:

- Proposing an Administrative Determination An Administrative Determination (AD) is a decision concerning your client's claim rendered by the Board. All the evidence in your client's file is examined prior to an AD being issued. Once an AD is sent to the parties, any party may object to the determination within 30 days. If there is no objection, the determination becomes final. Appearance at the Board is not necessary because acceptance of an AD indicates that all parties are satisfied with the resolution of the issue(s).

- Placing the claim into Conciliation for resolution If your client's claim is not controverted, the Board works with the parties and their representatives to secure all necessary documentation and resolve all outstanding issues in the claim. Once the file has been thoroughly reviewed, the Board will issue a Proposed Decision (PD) and send it to the parties, or will schedule a meeting at the Board with the parties, if a meeting is necessary. Once a PD is sent to the parties, any party may object to the determination within 30 days. If there is no objection, the determination becomes final. Appearance at the Board is not necessary because acceptance of a PD indicates that all parties are satisfied with the resolution of the issue(s). Please Note: Use of this RFA-1LC form replaces Form CB-8 (Request for Conciliation).

- Notifying the parties of a Hearing before a WCL Judge If your client's claim involves an issue that requires a hearing or may require testimony, a hearing before a Workers' Compensation Law Judge may be necessary for resolution. A formal hearing requires a personal or telephonic appearance by all parties in the case at the Board hearing location most convenient to the claimant. The hearing will be recorded and an official record kept by the Board. While the WCL Judge will generally render a decision orally at the hearing, a written decision will be sent to all parties following the hearing. Parties may appeal the written decision to the Board's Administrative Review Division within 30 days of its filing.

- Referring the claim to the Administrative Review Division If your client's claim has been previously resolved by a lump sum settlement or a Section 32 Waiver Agreement, the Administrative Review Division will review your client's file to determine whether your client's claim should be reopened and further action taken.

Medical Treatment - In addition to medical services of less than $1000.00 in value, most medical services covered by the Medical Treatment Guidelines (regardless of the cost) do not require medical authorization. For these types of services, the Health Provider may provide treatment and bill the insurance carrier. If there is no response within 45 days of receipt of the bill, the Health Provider may file for an administrative award on Form HP-1. Certain treatments covered within the Medical Treatment Guidelines, such as complex surgical procedures, do require prior authorization. In addition to these treatment types, when medical services are $1000.00 or more in value and fall outside the Medical Treatment Guidelines, the Health Provider is to contact the carrier or self-insured employer for authorization. The Health Provider must also file Form C-4AUTH with the carrier or self-insured employer and the Board. If denying Medical Treatment Guideline services or medical services of $1000.00 or more in value, the carrier or self-insured employer is required to file Form C-8.1A and provide conflicting medical evidence.

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.

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. Sec. 552a).

The Workers' Compensation Board's ("Board") authority to request personal information from claimants is derived from Sections 20 and 142 of the Workers' Compensation Law. This information is collected to assist the Board in processing claims in an efficient manner and to help it maintain accurate claim records.

The Board is strongly committed to protecting the confidentiality of all personal information that it collects. Such information will be disclosed within the agency only to Board personnel and agents in furtherance of their official duties. Personal information will be disclosed outside the agency only in accordance with applicable state and federal law.

The Board's Director of Operations, located at 100 Broadway, Menands, New York 12241 (518-474-6674), is primarily responsible for the maintenance of agency records containing personal claimant information. Failure to provide the information requested on this form will not result in the denial of your claim, but may delay the processing of your claim.

Inquiries, medical and other reports should be sent directly to the Workers' Compensation Board at the address listed below:

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

Address for Email Filing: wcbclaimsfiling@wcb.ny.gov

Customer Service Toll-Free Line: 877-632-4996 **Statewide Fax Line: 877-533-0337**