Ancillary Medical Report

EC-4 AMR

State of New York - Workers' Compensation Board

THIS FORM MAY ONLY BE SUBMITTED ELECTRONICALLY. DO NOT MAIL TO THE BOARD.

Use this form to report ancillary medical services such as x-ray, anesthesia, pathology or diagnostic services by other than the attending provider. A medical provider who is only giving clearance for surgery may also use this form.
THIS FORM SHOULD NOT BE USED TO REPORT TREATMENT PROVIDED.

Please answer all questions completely, attach the report for the services provided, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary services, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization.

*Required Fields **Conditionally Required Fields** - Select ◯ for field requirements.

A. Patient's Information

1. *Last Name: _____ *First Name: _____ MI: ___
2. Social Security #: _____ 3. Home Phone #: _____
4.* Mailing Address: _____ Line 2: _____
*City: _____ ◯ State: _____ ◯ Zip Code: _____ *Country: _____
5. *Date of Birth: _____ 6. *Date of injury/onset of illness: _____ 7. WCB Case # (if known): _____
8. Carrier Case # (if known): _____ 9. Patient's Account #: _____

B. Doctor's Information

1. *Your Last Name: _____ *First Name: _____ MI: ___
2. *WCB Authorization #: _____ 3. *WCB Rating Code: _____
4. *Federal Tax ID #: _____ The Tax ID # is the (check one): ◯ SSN ◯ EIN
5. *Office Address: _____ Line 2: _____
*City: _____ ◯ State: _____ ◯ Zip Code: _____ *Country: _____
6. Billing Group or Practice Name: _____
7. *Billing Address: _____ Line 2: _____
*City: _____ ◯ State: _____ ◯ Zip Code: _____ *Country: _____
8. *Office phone #: _____ 9. Billing phone #: _____
10. Provider's NPI #: _____
11. Referring Doctor:
*Last Name: _____ *First Name: _____ MI: ___

C. Billing Information

◯ 1. Employer's insurance carrier: _____ ☐ Unknown
2. Carrier Code #: _____
◯ 3. Insurance carrier's address: _____ Line 2: _____
◯ City: _____ ◯ State: _____ ◯ Zip Code: _____ ◯ Country: _____

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

C. Billing Information Continued

4. *Diagnosis or nature of disease or injury:

Line *ICD9 Code *ICD9 Descriptor

Relate ICD9 codes above to Diagnosis Code column by line.

Dates of Service *From	*To	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies *CPT/HCPCS	Modifier 1	Modifier 2	*Diagnosis Code	*$ Charges	Days/ Units	COB	*Zip Code where service was rendered

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)

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

This form is signed under penalty of perjury.

***Board Authorized** Health Care Provider - Check one:

○ I provided the services listed above.

○ I actively supervised the health care provider named below who provided these services.

Provider's Last Name:_____ First Name:_____ MI:___

Provider's Specialty: _____

Board Authorized Health Care Provider:

*Last Name:_____ *First Name:_____ MI:____

*Specialty:_____ Date: _____

D. *Attach Report For Services

To attach a report for services, select **the paper clip icon** on the left side of the page and select the **Add** icon. **(**If you have Adobe Reader 7, select the **Attachments tab**.**)** **Do not submit the C-4 AUTH Form as an attachment to this form, the paper version must be sent to the carrier and the Board.**

IMPORTANT: If you would like to save this information to submit future EC-4 AMR forms for this patient, you **MUST** save the data BEFORE you submit the form. AFTER the form is successfully submitted, you will be able to save a copy of the submitted form, but it cannot be used for future submissions.