New York State - Workers' Compensation Board
Health Insurers' Match Program

Part I - Health Insurer's/Health Benefit Plan's Request for Reimbursement

WCB Case Number	Claimant's Social Security No.	Date of Accident/Injury	Claimant's Name	
WC Carrier Case Number	WC Carrier Code	Reimbursement Amt. Requested	Employer's Name	
Date Payment Made (Earliest date if multiple claim)	Date Request for Reimb. Filed (If previously filed for this case)	Health Insurer's Claim ID No.	Date of Partial Match (If Applicable)	Date of Full Match (If Applicable)
Name and Address of Workers' Compensation Insurance Carrier/Employer/Special Fund			Was ANCR Established? ❑ Yes ❑ No	Status of Case ❑ Open ❑ Closed
			WCB District Office (Where claim was determined or is pending)	Health Insurer's Fed. Tax ID No.
Name and Address of Health Insurer/Health Benefit Plan			Health Insurer's Telephone No.	Health Insurer's Fax No.
			Attach copies of all documentation pertaining to this reimbursement request. SEE INSTRUCTIONS ON REVERSE.	

The undersigned Health Insurer/Health Benefits Plan hereby requests reimbursement from the carrier for health benefits paid in the workers' compensation case indicated above. A copy of this notice was mailed to the carrier on the date indicated below. (Proof of service attached.)

Printed Name _____ Signature _____ Title _____ Date Form Mailed _____

Part II - W.C. Insurance Carrier's/Employer's/Special Fund's Objection to Reimbursement Request
(See 12 NYCRR Section 325-6.4 for full explanation of objections)

The carrier named above objects to this reimbursement request ❑ in whole ❑ in part (explain below) for the following reason(s): **Documentation and detailed explanation supporting your objection(s) must be attached. Undisputed amount must be paid.**

1. ❑ The compensability of the claim is not finally established or case was closed without finding of Accident, Notice & Causal Relationship.
2. ❑ The claim has a payment date prior to January 1, 1988.
3. ❑ Judicial proceedings have commenced prior to July 17, 1992.
4. ❑ The claim has not been timely filed as defined in 12NYCRR, Subpart 325-6.
5. ❑ Treatment was for a condition unrelated to the workers' compensation claim, or was on behalf of a person other than the claimant.
6. ❑ Treatment was obtained after authorization was sought and denied by the Board in a compensation proceeding.
7. ❑ Fee exceeds Workers' Compensation fee schedule, or payment rate for inpatient hospital services pursuant to Public Health Law.
8. ❑ Bill(s) should have been pro-rated with another health provider.
9. ❑ The documentation submitted is insufficient.
10. ❑ The health insurer, health benefits plan or health provider has previously been reimbursed. (Proof of date and amount of payment attached.)
11. ❑ Other _____

A copy of this notice was mailed to the health insurer/health benefit plan on the date indicated. (Proof of service attached.) All further correspondence must be delivered, faxed or mailed to the individual named below:

Printed Name _____ Signature _____ Title _____ Date Form Mailed _____

Address (if different from Part I) _____ Telephone Number _____ Fax Number _____

Part III - Request for Arbitration

AAA Case No._____

❑ No objection has been mailed or payment made within 50 business days after the date of mailing of Request for Reimbursement Form.
❑ The undersigned requests impartial examination of the bill(s) to which the workers' compensation carrier objected in Part II above.
Arbitration is requested on ❑ All bills/issues ❑ The following bills/issues only: _____

The undersigned requests (check one): ❑ desk arbitration ❑ oral hearing.

Enclosed is arbitration fee of $_____ (See reverse for filing fee information.) Designated locale of oral hearing _____.
A copy of this notice and attached documents was mailed to the above-named carrier or (if objection has been timely received) to the individual named in Part II. (Proof of service attached.)

Printed Name _____ Signature _____ Title _____

Date Form Mailed _____ Telephone Number _____ FAX Number _____

Name of Representative _____ Address of Representative _____

Representative's Telephone Number _____ Representative's FAX Number _____

Prescribed by Chair,
Workers' Compensation Board
State of New York

INSTRUCTIONS

Requests for reimbursement by a health insurer or health benefits plan ["Plan"] for payments made to health providers on behalf of injured employees entitled to workers' compensation benefits, and requests for arbitration of disputed requests for reimbursement, shall be submitted and processed in accordance with the provisions of Subpart 325-6 of Title 12 NYCRR. ALL PARTIES TO WHOM THESE RULES ARE APPLICABLE SHOULD THOROUGHLY FAMILIARIZE THEMSELVES WITH THE RULES, AS THE INSTRUCTIONS HEREIN ARE INTENDED AS A PROCEDURAL GUIDE AND ARE NOT TO BE CONSTRUED AS A COMPREHENSIVE INTERPRETATION OF THE RULES REQUIREMENTS.

To All Plans:

Requests for reimbursement must be submitted to an employer, workers' compensation carrier or special fund ["carrier"] on this form, completed with such information as required on Part I of this form, together with the documentation specified in Section 325-6.3(b).

A Plan must send requests for arbitration within 90 calendar days after the earlier of the date on which a carrier has mailed a notice of objection to a request for reimbursement or has failed to make payment or failed to mail a notice of objection within 50 business days after mailing of the request for reimbursement (but no earlier than 55 business days after the date of mailing of the request for reimbursement form if no objection has been received), unless the parties mutually agree to extend the period in which the carrier must reply. If the Plan fails to submit its request for arbitration within the prescribed period, it shall be deemed to have waived its right to arbitration, except as otherwise provided in Subpart 325-6.

The Plan shall initiate the request for arbitration by completing Part III of this form and forwarding the completed request for arbitration to the carrier and 2 copies of the completed form, together with 2 copies of all documents previously submitted to the carrier, proof of service of all documents upon the carrier and the prescribed filing fee to:

American Arbitration Association
Attention: HIMP Unit
120 Broadway, 11th Floor
New York, NY 10271

If the carrier has failed to file a timely objection to a request for reimbursement, the Plan shall indicate on the form that no objections have been received. All hearings shall be desk arbitrations based on documents alone, unless an oral hearing is requested. If the Plan requests an oral hearing, it shall indicate its request on the form and designate the locale of the oral hearing, which shall be the city of the Board district office where the underlying compensability of the compensation claim giving rise to the request for reimbursement was established. The filing fee for all desk arbitrations shall be $150 per request, and $475 for an oral hearing. Requests for arbitration which are not accompanied by the completed form, proof of service and/or the required fee shall not be processed and shall be returned to the Plan.

To All Carriers:

A carrier objecting to a request for reimbursement, in whole or in part, must state its objections by completing Part II of the form submitted to it by the Plan and mailing such notice of objection together with supporting documentation and explanation to the Plan within 50 business days after the dating of mailing of this form to the carrier. If a carrier does not object or objects only in part, the undisputed amount must be paid to the Plan within such 50 business days.

The carrier may interpose objections to the request for reimbursement which are specifically set forth in Section 325-6.4(b) and Part II of this form, and any objection which is not specifically prohibited by Section 325-6.4(c). If the carrier fails to make payment or send timely notice of objections, it will be deemed to have waived all objections, except as provided in Section 325-6.13(c).

Within 10 business days after receipt of acknowledgment of the completed request for arbitration from the American Arbitration Association ("AAA"), the carrier shall submit to the AAA 2 copies of such documents together with proof of timely filing of such documents with the Plan. Such documents will not be considered unless the carrier has previously filed a timely notice of objection and the supporting documents with the Plan, except as provided in Section 325-6.13.

If the carrier is the party requesting an oral hearing, it may make such request within 10 business days after receipt of its copy of the request for arbitration by designating the locale of the hearing and sending the filing fee of $475 to the AAA.

Arbitrations:

The conduct of all desk arbitrations and oral hearings shall be under the auspices of the AAA, and shall be governed by Subpart 325-6 and the AAA's internal rules of procedure, to the extent that such rules are not inconsistent with Subpart 325-6. Enforcement and collection of awards, and allocation of fees, shall be made as set forth in Sections 325-6.14 and 325-6.16.