WORKERS' COMPENSATION BOARD
New York State

HEALTH PROVIDER'S REQUEST FOR DECISION ON UNPAID MEDICAL BILL(S)

HP-1

Return this original and completed form with the required attachments to the Workers' Compensation Board when the conditions listed below exist. If you have any questions regarding the completion of this form, you may contact us at **1-800-781-2362**.

A. The fee(s) billed is in accordance with the fees indicated in the appropriate Fee Schedule; AND

B. NO related Denial of Claim or C-8.1 has been received or if such form was received, the issue(s) raised thereon by the workers' compensation carrier has been ruled on by the Workers' Compensation Board, in the health provider's favor and no RB-89 is pending; AND

C. FOR ADMINISTRATIVE AWARD: Treatment was rendered to an injured worker and a medical bill was timely** submitted to the responsible insurance carrier or self-insured employer for payment. A minimum of 45 days has elapsed since the submission of the bill, or 30 days since the date of a final decision by the WCB establishing the carrier's or self-insurer's liability for the bill; and, no more than 120 days have elapsed since the expiration of the time within which the carrier or self-insurer is required to notify the health provider of non-payment or since the date of expiration of any continuous course of treatment of the claimant. The provider has not received payment or an acceptable written explanation of non-payment (as defined by the WCB) from the responsible carrier. Communication with the insurer has been unsuccessful; OR

D. FOR ARBITRATION: Treatment was rendered to an injured worker and a medical bill(s) was timely** submitted to the responsible insurance carrier or self-insured employer for payment. Proper payment, in accordance with the appropriate Fee Schedule has NOT been received. The provider has received a written explanation from the carrier or self-insured employer explaining reason(s) for partial or non-payment and Form C-8.4 has been filed. Communication with the insurer has failed to resolve the issue(s). A minimum of 45 days has elapsed since the submission of the medical bill(s) to the responsible insurance carrier, or 30 days from the date of a final decision establishing the carrier's or self-insurer's liability for the bill(s); and, no more than 120 days have elapsed since the date of receipt of notification of non-payment, or the date of expiration of any continuous course of treatment of the claimant.

** Timely submission of a bill is within 120 days for a hospital and 90 days for all other health providers from the last day of the month in which the service(s) was rendered or 90 days from the last day of the month in which the claimant receives the final treatment in a continuous course of treatment, whichever is later (and the bill was not returned by the post office).

PROVIDER: CHECK ONLY ONE REQUEST BOX: (PLEASE TYPE OR PRINT THIS FORM IN BLACK OR BLUE INK ONLY)

☐ **A. REQUEST FOR ADMINISTRATIVE AWARD**

Carrier did not reply with nonpayment explanation or pay for medical services submitted on the attached bill. More than 45 days have passed since the date of the medical bill submission or more than 30 days from the receipt of a related notice establishing carrier/employer liability. Complete the front of this form and Section A on the reverse. FEE IS NOT REQUIRED**. DO NOT SUBMIT MORE THAN ONE BILL WITH THIS FORM.**

RETURN THIS ORIGINAL AND COMPLETED FORM TO:
NYS Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

☐ **B. REQUEST FOR ARBITRATION**

Carrier has not satisfactorily paid for services rendered as shown on the attached medical bill(s). A copy of the carrier's payment explanation must be attached. If you wish to submit other documents to be considered by the Arbitrator/Panel, attach them to this form. Complete the front and reverse of this form. SEE TABLE OF ARBITRATION FEES ON REVERSE. CHECK FOR APPROPRIATE FEE, PAYABLE TO CHAIR, WCB, MUST ACCOMPANY EACH REQUEST.

RETURN THIS ORIGINAL AND COMPLETED FORM TO:
NYS Workers' Compensation Board
Medical Director's Office/Finance
328 State Street
Schenectady, NY 12305-2318

NUMBER OF MEDICAL BILLS ATTACHED _____
FEE SUBMITTED $ _____ **CHECK/M.O. NO.** _____

TYPE OF CARE: ☐ Medical ☐ Outpatient Hospital ☐ Inpatient Hospital ☐ Chiropractic ☐ Physical Therapy ☐ Occupational Therapy ☐ Psychology ☐ Podiatry ☐ Osteopathic

Name and Mailing Address of Health Provider (MAXIMUM OF 30 CHARACTERS)
Name _____
Address _____
City _____ State _____ Zip Code _____

Name and Billing Address of Health Provider (MAXIMUM OF 30 CHARACTERS)
Name _____
Address _____
City _____ State _____ Zip Code _____

Name and Mailing Address of Carrier (MAXIMUM OF 30 CHARACTERS)
Name _____
Address _____
City _____ State _____ Zip Code _____

Name and Mailing Address of Employer (MAXIMUM OF 30 CHARACTERS)
Name _____
Address _____
City _____ State _____ Zip Code _____

WCB Case Number

WCB Authorization Number

Provider's WCB Rating Code

Date You First Treated Claimant (mm/dd/yy)
_____/_____/_____

Provider's Telephone Number (include area code)

Date of Accident (mm/dd/yy)
_____/_____/_____

Carrier Case Number

Carrier or Self-Insured Employer ID #
W

County where Service was Rendered

Claimant's Social Security Number
_____-_____-_____

Name of Claimant (First, Middle Initial, Last Name)

I affirm, under penalty of perjury, that the conditions indicated above are true.

_____
Health Provider's Signature

Date: _____

SECTION A: REQUEST FOR ADMINISTRATIVE AWARD - PLEASE COMPLETE THE FOLLOWING

Federal Tax ID Number		Total Charge ($)	Amount Paid ($)	Amount in Dispute ($)
	☐ SSN ☐ EIN			

SECTION B: REQUEST FOR ARBITRATION - PLEASE COMPLETE THE FOLLOWING

Any arbitration involving $1,000 or less is handled by desk arbitration using a single arbitrator (Desk). For disputes involving more than $1,000, the provider may opt for a single arbitrator by checking the box below. Otherwise, it will be handled by an arbitration hearing conducted by a panel of two or more arbitrators (Panel).

Federal Tax ID Number		Total Charge ($)	Amount Paid ($)	Amount in Dispute ($)	Amount of Fee Submitted ($)
	☐ SSN ☐ EIN				

☐ **Check box ONLY if the total amount of this Request for Arbitration is over $1,000 and the provider opts for desk arbitration.**

ARBITRATION FEES

AMOUNT IN DISPUTE	DESK FEE	PANEL FEE
0 - $999.99	$50.00	n/a
$1,000.00 - $4,999.99	$150.00	$250.00
$5,000.00 +	$300.00	$500.00

I certify that the foregoing bill(s) was originally submitted on Form C-4, UB-92 or HCFA-1500 to the responsible carrier/self-insured employer for payment. Acceptable payment has not been received, arbitration is required. In the event the dispute is resolved by a single arbitrator or I fail to appear at a scheduled hearing, I will abide by the arbitration decision.

_____ Date: _____

Health Provider's 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.