STATE OF NEW YORK - WORKERS’ COMPENSATION BOARD
REQUEST FOR ASSISTANCE BY INJURED WORKER
This form is not to be used to report an injury. To file a claim, use Form C-3.

WCB Case No.(if known)  MM  Date of Injury  DO  YY

Your Name  Employer’s Name

Your Address  Employer’s Address (if known)

Check if new address: ☐

REASON FOR THIS REQUEST
INSTRUCTIONS: Check all boxes that apply. Be sure to attach additional forms, medical reports, letters, etc. as required for each checkbox. If the additional information was already submitted do not attach it, but try to identify it in the space at the bottom of this form** by giving the form number or title and the date it was submitted to the Board. Sign and date the form below.

Compensation Payments:
☐ a. I am not working as of ________________ and not receiving payments. ATTACH MEDICAL REPORT THAT SHOWS A MEDICAL DISABILITY.
☐ b. My payments have been stopped or reduced.
☐ c. I have returned to work as of ________________ at full pay.
☐ d. I am making less money than I was before I got hurt. ATTACH CURRENT PAY STUB AND MEDICAL REPORTS FROM YOUR DOCTOR.
☐ e. I had two or more employers on the date of accident/injury (concurrent employment). ATTACH WEEKLY GROSS PAY BEFORE YOUR INJURY AND STATEMENT FROM SECOND EMPLOYER REGARDING TIME LOST.
☐ f. I was released from incarceration on ________________ and am not receiving payments. ATTACH MEDICAL REPORT THAT SHOWS A MEDICAL DISABILITY AND RELEASE FROM CUSTODY PAPERS.
☐ g. I have not been paid as directed in the decision filed on ________________.

Medical Issues:
☐ h. My request for medical treatment was denied or has not been addressed. ATTACH DENIAL LETTER.
☐ i. My disability is now permanent. ATTACH MEDICAL FORM C-4.3, DOCTOR’S REPORT OF MMI/PERMANENT IMPAIRMENT
☐ Check this box if you were under 25 years of age at time of accident.
☐ j. My medical condition has changed. ATTACH MEDICAL FORMS.
☐ k. My request for medical and transportation reimbursement was denied or has not been addressed. ATTACH RECEIPTS AND FORM C-257.

Other Issues:
☐ l. I have new information and/or information requested by the Board regarding ____________________________

ATTACH DOCUMENTS.
☐ m. Other (Explain fully in the space provided below.)

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

Injured Worker’s Signature: __________________________ Date: ______________ Telephone No.: __________________________

This form and any attachments must be mailed, faxed or e-mailed to the Workers’ Compensation Board. (See mailing and e-mail filing addresses on the reverse side.)

RFA-1W (1-11)
SEE IMPORTANT INFORMATION ON REVERSE - VEA INFORMACION IMPORTANTE AL DORSO
To the Claimant - General Information On Using This Form

You may file this form (RFA-1W) with the Workers' Compensation Board when you want the Board to take a specific action in your claim, or if you need to alert the Board to any problem or situation that is affecting your claim. Many of the most frequently requested actions/situations are listed as either compensation payment issues (items a through g), or medical issues (items h through k), but you are not limited to those listed. Check all that apply and/or add additional information or explanation in the space provided (l or m).

Complete the identifying information at the top of Form RFA-1W and send the form, WITH ALL APPLICABLE INFORMATION ATTACHED*, to: NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

The Board will contact you and all parties when it takes action on your claim.

*After each checkbox you will see the information needed in bold capital letters. For example, if you are letting the Board know that your disability is now permanent (box i), the information required is Form C-4.3, Doctor's Report of MMI/Permanent Impairment.

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

If you have any other concerns, you may contact the Board's ADVOCATE FOR INJURED WORKERS at 1-800-580-6665. Additional information about other Board services may be obtained at the Board's website: WWW.WCB.NY.GOV. If you would like to follow your claim on-line, you can register for eCase using the registration instructions available on the Board's website under the eCase link.

You have the right to legal representation. A lawyer cannot charge you directly for representation in a workers' compensation claim. If there is an award in your claim, any legal fee request must be approved by the Board and will be deducted from the award to you by the insurance carrier and paid directly to the lawyer.

Para el reclamante: información general sobre el uso del presente formulario

Puede presentar este formulario (RFA-1W) ante la Junta de Compensación Obrera en caso de que desee que la WCB tome una medida específica respecto de su reclamo, o si necesita alertar a la WCB sobre cualquier problema o situación que afecta su reclamo. Muchas de las acciones/situaciones requeridas con más frecuencia se enumeran como asuntos relacionados con pagos de indemnizaciones (puntos a al g) o asuntos médicos (puntos h al k); sin embargo usted no está limitado sólo a esos puntos. Marque todos aquellos que correspondan y/o agregue información adicional o explicaciones en el espacio previsto para tal fin (l o m).

Complete la información de identificación en la parte superior del formulario RFA-1W y envíelo, ADJUNTANDO TODA LA INFORMACIÓN QUE CORRESPONDA*, a la oficina distrital de su WCB (ver las direcciones a continuación) o a la casilla postal de Downstate Centralized Mailing si su oficinal distrital se encuentra en la ciudad de Nueva York, Hempstead, Hauppauge o Peekskill. La WCB se comunicará con usted y todas las partes cuando trate su reclamo.

*Una continuación de cada casilla de verificación verá la información necesaria en letras mayúsculas en negrita. Por ejemplo, si está informando a la WCB que su incapacidad ahora es permanente (recuadro i), la información requerida es el Formulario C-4.3, Informe del médico sobre Máxima mejoría médica/Incapacidad Permanente.

DEBE ENVIAR UNA COPIA DE ESTE FORMULARIO A LA(S) COMPAÑÍA(S) DE SEGUROS, O DIRECTAMENTE AL EMPLEADOR O ADMINISTRADOR DE TERCEROS SI EL EMPLEADOR ESTÁ AUTO ASEGURADO.

En caso de albergar otras inquietudes, puede comunicarse con el DEFENSOR(A) PARA LOS TRABAJADORES LESIONADOS al 1-800-580-6665. Puede obtener información adicional sobre otros servicios que ofrece la WCB en su sitio web: WWW.WCB.NY.GOV. Si desea realizar un seguimiento en línea de su reclamo, puede registrarse para ingresar a eCase utilizando las instrucciones para registro que están disponibles en el sitio web de la WCB en el enlace eCase.

Ud. tiene derecho a tener un representante legal. Ningún abogado puede cobrarle directamente por la representación en un reclamo de indemnización laboral. Si se indica un monto a pagar en la sentencia sobre su reclamo, todos los honorarios legales deberán ser aprobados por la WCB, serán deducidos de dicho monto por la compañía de seguros y se pagarán directamente al abogado.

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.


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.

www.wcb.ny.gov

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

RFA-1W (1-11) Reverse Statewide Fax Line: 877-533-0337 Address for Email Filing: wcblclaimsfiling@wcb.ny.gov