NEW YORK STATE | Workers' Compensation Board

REQUEST FOR DECISION ON UNPAID MEDICAL BILL(S)

HP-1

Return this completed and signed form with the required attachments (listed under letter A) to the Workers' Compensation Board when the conditions listed below exist.

A. The medical bill(s) was submitted to the responsible insurance carrier or self-insured employer for payment on Form C-4, C-4.2, C-4.3, C-5, EC-4Narr, OT/PT-4, PS-4, CMS-1450 or CMS-1500 (with narrative) or UB-04; **AND**

B. The medical bill(s) was submitted to the responsible insurance carrier or self-insured employer for payment within 120 days from the day the service(s) was rendered. The medical bill(s) must contain all treatment rendered by a provider on a single day; **AND**

C. A minimum of 45 days has elapsed since the submission of the medical bill(s); **AND**

D. The provider has NOT received proper payment in accordance with the applicable Fee Schedule; **AND**

E. NO related Denial of Claim or Form C-8.1 [Notice of Treatment Issue(s)/Disputed Bill Issue(s)] has been received **OR**, if such form was received, a minimum of 30 days has elapsed since the date of a final decision by the WCB establishing the insurance carrier's or self-insured employer's liability for the bill and no RB-89 [Application for Board Review] is pending; **AND**

F. No more than 120 days has elapsed since the expiration of the time within which the insurance carrier or self-insured employer is required to notify the provider of partial or non-payment.

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

☐ **A. REQUEST FOR ADMINISTRATIVE AWARD**

The provider did NOT receive Form C-8.4 [Notice to Health Care Provider and Injured Worker of a Carrier's Refusal to Pay All (or a Portion of) a Medical Bill Due to Valuation Objection(s)] or an acceptable written explanation of the reasons for partial or non-payment (as defined by the WCB);

AND

The medical bill was NOT for one of the following types of care: Ambulance, Audiology, Dental, Durable Medical Equipment, Laboratory, Optometry, Other, Out of State or Pharmacy.

NOTE: HP-1s for these types of care **MUST** be submitted to Arbitration, even if the insurance carrier or self-insured employer did not notify of an objection to the bill.

Submit this completed and signed form to the address below. A copy of the medical bill must be attached.

DO NOT SUBMIT MORE THAN ONE BILL WITH THIS FORM.

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

DATE SPAN FOR ATTACHED BILL: _____/_____/_____ to _____/_____/_____

☐ **B. REQUEST FOR ARBITRATION**

The provider has received Form C-8.4 [Notice to Health Care Provider and Injured Worker of a Carrier's Refusal to Pay All (or a Portion of) a Medical Bill Due to Valuation Objection(s)] or an acceptable written explanation of partial or non-payment (as defined by the WCB); communication with the insurance carrier or self-insured employer has failed to resolve the issue(s);

The medical bill(s) was for one of the care types on the reverse side of this form.

OR

If the bill(s) was for one of the following types of care: Ambulance, Audiology, Dental, Durable Medical Equipment, Laboratory, Optometry, Other, Out of State or Pharmacy, the HP-1 **MUST** be submitted to Arbitration, even if the insurance carrier or self-insured employer did not notify of an objection to the bill.

Submit this completed and signed form to the address below. Copies of the medical bill(s) must be attached. If the medical bill(s) was not for one of the types of care listed above, then copies of the written explanation of partial or non-payment (including Form C-8.4) must be attached. Additional documents may also be attached for consideration by the Arbitrator.

RETURN THIS COMPLETED AND SIGNED FORM TO:
NYS Workers' Compensation Board Medical Director's Office
Riverview Center, Suite 195, 150 Broadway
Menands, NY 12204
NUMBER OF MEDICAL BILLS ATTACHED _____

NEW YORK STATE | Workers' Compensation Board

REQUEST FOR DECISION ON UNPAID MEDICAL BILL(S)

HP-1

WCB Case Number

Name of Injured Worker (First Name, Middle Initial, Last Name)

Injured Worker's Social Security Number

Date of Injury/Illness

Insurer or Self-Insured Employer ID

W

Claim Administrator Claim Number (Carrier Case)

Name of Employer

Name and Mailing Address of Insurer

Name

Address

City State Zip Code

CHECK APPLICABLE TYPE OF CARE:

- ☐ Acupuncturist
- ☐ Ambulance
- ☐ Audiology
- ☐ Chiropractor
- ☐ Dental
- ☐ Durable Medical Equipment
- ☐ Inpatient Hospital
- ☐ Laboratory
- ☐ Licensed Clinical Social Worker
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Optometry
- ☐ Osteopathic Physician
- ☐ Out of State
- ☐ Outpatient Hospital/ASC
- ☐ Pharmacy
- ☐ Physician
- ☐ Physician Assistant
- ☐ Physical Therapist
- ☐ Podiatrist
- ☐ Psychologist
- ☐ Other

National Provider Number (NPI)

WCB Authorization Number (if applicable)

Provider's WCB Rating Code (if applicable)

Federal Tax ID Number ☐ SSN ☐ EIN

Total Charge ($)

Amount Paid ($)

Amount in Dispute ($)

Name and Mailing Address of Health Provider/Supplier

Name

Address

City State Zip Code

Email Address: Phone Number:

Name and Billing Address of Health Provider/Supplier

Name

Address

City State Zip Code

Email Address: Phone Number:

I affirm, under penalty or perjury, that:

(1) The attached medical bill(s) was submitted to the responsible insurer/self-insured employer for payment, AND

(2) Proper payment in accordance with the applicable Fee Schedule has not been received, AND

(3) I will abide by the WCB's decision.

Date:

Health Provider/Supplier'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.

Any questions regarding the completion of this form, contact the NYS Workers' Compensation Board at 1-800-781-2362