<table>
<thead>
<tr>
<th>Authorization Requested</th>
<th>Carrier Response: if any service is denied, explain on reverse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Tests:</td>
<td></td>
</tr>
<tr>
<td>☐ Radiology Services (X-Rays, CT Scans, MRI) indicate body part:</td>
<td>Granted Granted w/o Prejudice Denied</td>
</tr>
<tr>
<td>☐ Other</td>
<td>Granted Granted w/o Prejudice Denied</td>
</tr>
<tr>
<td>Therapy (including Post Operative):</td>
<td></td>
</tr>
<tr>
<td>☐ Physical Therapy:</td>
<td>Granted Granted w/o Prejudice Denied</td>
</tr>
<tr>
<td>☐ Occupational Therapy:</td>
<td>Granted Granted w/o Prejudice Denied</td>
</tr>
<tr>
<td>☐ Other</td>
<td>Granted Granted w/o Prejudice Denied</td>
</tr>
<tr>
<td>Surgery:</td>
<td></td>
</tr>
<tr>
<td>☐ Type of Surgery (Describe, include use of hardware/surgical implants)</td>
<td>Granted Granted w/o Prejudice Denied</td>
</tr>
<tr>
<td>Treatment:</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td>Granted Granted w/o Prejudice Denied</td>
</tr>
</tbody>
</table>

Medical Treatment Guidelines Procedures Requiring Pre-Authorization (Complete Guideline Reference for each item checked, if necessary. In first box, indicate body part: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)

1. Lumbar Fusions B E 4 a
2. Artificial Disk Replacement B E
3. Vertebroplasty B E 7 a i
4. Kyphoplasty B E 7 a i
5. Electrical Bone Growth Stimulators B E a
6. Spinal Cord Stimulators B E 10 a i
7. Osteochondral Autograft K D 1 f
8. Autologus Chondrocyte Implantation K D 1
9. Meniscal Allograft Transplantation K D
10. Knee Arthroplasty (total or partial knee joint replacement) K F 2
11. Second or Subsequent Procedure
Pursuant to 12 NYCRR 325-1.4(a)(1), it is the attending physician's burden to set forth the medical necessity of the special services required. Failure to do so may delay the authorization process.

I certify that I am making the above request for authorization. This request was made to the insurance carrier/self-insurer: (Complete A or B)

A copy of this form was sent to the Board on the date below.

Response Time and Notification Required

Failure to Timely Respond to C-4 AUTH: The special service(s) for which authorization has been requested will be deemed authorized by Order of the Chair if the self-insured employer/carrier fails to respond within the time specified above. An Order of the Chair is not subject to an appeal under Section 23 of the Workers' Compensation Law.

REASON FOR DENIAL(S), IF ANY. (ATTACH OR REFERENCE CONFLICTING SECOND MEDICAL OPINION AS EXPLAINED ABOVE.)

Date of service of supporting medical in WCB case file: ________________________ (If not already in file, supporting medical must be attached.)

I certify that I am making the above request for authorization. This request was made to the insurance carrier/self-insurer: (Complete A or B)

A. By fax on (date) ________________ to (person contacted) ____________________________________________

B. By telephone on (date) ________________ to (person contacted) ____________________________________________

and e-mailed/faxed/mailed on (date) ________________

A copy of this form was sent to the Board on the date below:

Provider's Signature: ________________________ Date: ________________________

D. SELF-INSURED EMPLOYER / CARRIER RESPONSE TO AUTHORIZATION REQUEST

Response Time and Notification Required:

The self-insured employer/carrier must respond to the authorization request orally and in writing via e-mail, fax or regular mail with confirmation of delivery within 30 days. The 30 day time period for response begins to run from the completion date of this form if e-mailed or faxed, or the completion date plus five days if sent via regular mail. The written response shall be on a copy of this form completed by the physician seeking authorization and shall clearly state whether the authorization has been granted, granted without prejudice, or denied. Authorization can only be granted without prejudice when the compensation case is controverted or the body part has not yet been established. Authorization without prejudice shall not be construed as an admission that the condition for which these services are required is compensable or the employer/carrier is liable. The employer/carrier shall not be responsible for the payment of such services until the question of compensability and liability is resolved. Written response must be sent to the health care provider, claimant, claimant's legal counsel, if any, the Workers' Compensation Board and any other parties of interest.

Denial of the Request for Authorization of a Special Service: A denial of authorization of a special service must be based upon and accompanied by a conflicting second opinion rendered by a physician authorized to conduct IMEs, or record review, or qualified medical professional, or a physician authorized to treat workers' compensation claimants. (If authorization is denied in a controverted case, the conflicting second opinion must address medical necessity only.) When denying authorization for a special service, the employer/carrier must also file with the Board within 5 days of such denial Board Form C-8.1 Part A (Notice of Treatment Issue(s)/Disputed Bill Issue(s)). Failure to file timely the conflicting second opinion and Board Form C-8.1 Part A will render the denial defective. If denial of an authorization is based upon claimant's failure to attend an IME examination scheduled within the 30 day authorization period, contemporaneous supporting evidence of claimant's failure must be attached.

Failure to Timely Respond to C-4 AUTH: The special service(s) for which authorization has been requested will be deemed authorized by Order of the Chair if the self-insured employer/carrier fails to respond within the time specified above. An Order of the Chair is not subject to an appeal under Section 23 of the Workers' Compensation Law.

REASON FOR DENIAL(S), IF ANY. (ATTACH OR REFERENCE CONFLICTING SECOND MEDICAL OPINION AS EXPLAINED ABOVE.)

By: (print name) ________________________ Title: ________________________ Date: ________________________

Signature: ________________________ Date: ________________________
1. This form is used for a workers’ compensation, volunteer firefighters’ or volunteer ambulance workers’ benefit case as follows: To confirm a telephone request for written authorization for special service(s) costing over $1,000 in a non-emergency situation or requiring pre-authorization pursuant to the Medical Treatment Guidelines.

2. SPECIAL SERVICES - Services for which authorization must be requested are as follows:

   **Physicians** - To engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than $1,000.
   **Podiatrists** - In treating the foot, to provide physiotherapeutic procedures, X-ray examinations, or special diagnostic laboratory tests costing more than $1,000.
   **Chiropractors** - In treating a condition as provided in Section 6551 of the Education Law, to engage the services of a specialist, consultant, or a surgeon, or to provide for X-ray examinations or physiotherapeutic or other procedures, or to provide for special diagnostic laboratory tests costing more than $1,000.
   **Occupational/Physical Therapists** - In treating a condition as provided in Article 136 or 156 of the Education Law, and the Rules of the Chair relative to Occupational/Physical Therapy Practice to provide occupational/physical therapy procedures costing more than $1,000.
   **Psychologists** - Prior authorization for procedures enumerated in section 13-a(5) of the Workers’ Compensation Law costing more than $1,000 must be requested from the self-insured employer or insurance carrier. In addition, authorization must be requested for any biofeedback treatments, regardless of the cost, or and special diagnostic laboratory tests which may be performed by psychologists. Where a claimant has been referred by an authorized physician to a psychologist for evaluation purposes only and not for treatment, prior authorization must be requested if the cost of consultation exceeds $1,000.

3. When requesting authorization over the telephone, be sure to obtain the name of the person contacted since you must indicate this information along with the date of contact and certify its validity on the form.

4. It is the attending physician’s burden to set forth the medical necessity of the special services required. Be sure to provide this information in the Statement of Medical Necessity section of this form.

5. This form must be signed by the attending doctor and must contain her/his authorization certificate number and code letters. If the patient is hospitalized, it may be signed by a licensed doctor to whom the treatment of the case has been assigned as a member of the attending staff of the hospital.

6. Please ask your patient for his/her WCB case number and the carrier’s case number and show these numbers on this form. In addition, ask your patient if he/she has retained a representative. If represented, ask for the name and address of the representative.

   This request must be sent to the Workers’ Compensation Board, the workers’ compensation insurance carrier or self-insured employer, and, if the patient is represented by an attorney or licensed representative, such legal representative. If your patient is not represented, a copy must be sent to your patient.

7. If authorization or denial is not forthcoming within 30 calendar days, notify the nearest office of the Workers’ Compensation Board.

8. HIPAA NOTICE - In order to adjudicate a workers’ compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA’s restrictions on disclosure of health information.

   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.

   Reports should be filed by sending directly to the Workers’ Compensation Board at the address below with a copy sent to the insurance carrier:

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

   Customer Service Toll-Free Number: 877-632-4996
   Statewide Fax Line: 877-533-0337

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