



## Filing a Report of Injury

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It is the employer's responsibility to file Form C-2, "Employer's Report of Work-Related Injury/Illness," with NYSIF and the Workers' Compensation Board (WCB) immediately upon becoming aware of a work-related injury, unless it is being treated as a First Aid case, and no later than 10 days after the employer's knowledge of a work-related injury.

-  **Effective April 1, 2009**, the Workers' Compensation Board is imposing strict new standards concerning the filing of the recently updated Form C-2 (dated 10/08). There are serious consequences for failure to use the new C-2, including penalties of \$50 to \$2,500 payable by the employer. Do not use old versions of the C-2 on and after April 1, 2009.
-  On and after April 1, 2009, you must also provide your injured employee with a "Claimant Information Packet" (Claimant Information Packet - Spanish). This information must be provided by the employer to the injured employee before filing the Employer's Report of Work-Related Injury/Illness (Form C-2).

Claimant Information Packet (English)  
Claimant Information Packet (Spanish)

### **NYSIF eFROI®**

Once you have determined when to file a report of injury or illness, don't delay. Early filing helps the employer lower overall claim costs by allowing NYSIF to actively manage the claim as soon as possible. NYSIF eFROI® is the fastest way to report workplace injuries to NYSIF. The online system allows employers to fill out, print and electronically file a "First Report of Injury" with NYSIF at anytime. Upon review of the report, NYSIF files the completed C-2 with the WCB if appropriate. You do not need to file a duplicate paper Form C-2 with NYSIF and the WCB if you have filed an electronic C-2 using NYSIF eFROI®.

Policyholders may submit a First Report of Injury electronically. NYSIF eFROI® retains a permanent prior report of your injury, retrievable on the web with your transaction number, policy number and the last four digits of the claimant's social security number. For those employers who do not want to report electronically, a blank Form C-2 for paper filing can be obtained from the WCB.

Notify NYSIF immediately if you are suspicious about a claim. Statements made in Form C-2 have been held to be binding by the WCB. Contact NYSIF for guidance in use of language in reporting doubtful or questionable claims.

In all cases, immediately notify NYSIF of any new developments or information bearing on a case after Form C-2 has been filed. When there is a change in work status, use WCB Form C-11, "Employer's Report of Injured Employee's Change in Status or Return to Work," and notify your NYSIF case manager.

**Close this Window**



# EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS

# C-2

State of New York - Workers' Compensation Board

If one of your employees has a work-related injury or illness, you must complete and file this form **within 10 days** of the injury/illness or be subject to a penalty. For additional information on filing this form please refer to Workers' Compensation Law Section 110 at the end of this form. Type or print neatly.

WCB Case Number (if you know it): \_\_\_\_\_ Date of Injury/illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

Carrier Case Number (if you know it): \_\_\_\_\_ Date of this Report: \_\_\_\_/\_\_\_\_/\_\_\_\_

## A. EMPLOYER INFORMATION

1. Employer: \_\_\_\_\_ 2. Employer FEIN: \_\_\_\_\_

3. Mailing Address: \_\_\_\_\_

4. Location Address (if different): \_\_\_\_\_

5. Phone Number: (\_\_\_\_) \_\_\_\_\_ 6. Nature of Business or Industry Code: \_\_\_\_\_

7. OSHA Case Number (if known): \_\_\_\_\_ 8. NY UI Employer Reg Number: \_\_\_\_\_

## B. INSURANCE CARRIER / SELF-INSURED EMPLOYER

*If individually self-insured, enter your Board W Number and skip to Section C.*

1. Board W Number: **W** \_\_\_\_\_ 2. Carrier/Group Name: \_\_\_\_\_

3. Policy Number: \_\_\_\_\_ Policy Period: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. If Carrier Unknown, Insurance Agent Name: \_\_\_\_\_ 5. Phone Number: (\_\_\_\_) \_\_\_\_\_

## C. EMPLOYEE'S PERSONAL INFORMATION

1. Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last

3. Mailing Address: \_\_\_\_\_

4. Social Security Number: \_\_\_\_\_ 5. Contact Phone Number: (\_\_\_\_) \_\_\_\_\_ 6. Gender:  Male  Female

## D. EMPLOYEE'S INJURY OR ILLNESS

1. Time of day employee began work on date of injury: \_\_\_\_\_  AM  PM 2. Time of injury: \_\_\_\_\_  AM  PM

3. Has the employee given you notice of injury/illness?  Yes  No

If yes, notice was given to: \_\_\_\_\_  orally  in writing Date notice provided: \_\_\_\_/\_\_\_\_/\_\_\_\_

***If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.***

4. Have you given the employee a Claimant Information Packet?  Yes  No If yes, give date: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door): \_\_\_\_\_

6. Was this location where the employee normally worked?  Yes  No If no, why was the employee there? \_\_\_\_\_

7. Employee's supervisor: \_\_\_\_\_ 8. Did supervisor see injury happen?  Yes  No  Unknown

9. Did anyone else see the injury happen?  Yes  No  Unknown If yes, give name(s): \_\_\_\_\_

10. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, typing annual report)





## **WORKERS' COMPENSATION LAW**

### **Section 13 Treatment and care of injured employees**

(a) "The employer shall promptly provide for an injured employee such medical, surgical, optometric or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, functional assistive and adaptive devices and apparatus for such period as the nature of injury or the process of recovery may require.\*\*\*\*\*"

### **Section 13 Injury to employee's prosthesis**

(a) "Damage to or loss of a prosthetic device shall be deemed an injury except that no disability benefits shall be payable with respect to such injury under section fifteen of this article.\*\*\*\*\*"

### **Section 25 Effect of failure to file reports**

3. (e) "If the employer or its insurance carrier fails to file a notice or report requested or required by the board or chair or otherwise required within the specified time period or within ten days if no time period is specified, the board may impose a penalty in the amount of fifty dollars.\*\*\*\*\*"

### **Section 51 Posting of notice regarding compensation**

"Every employer who has complied with section fifty of this chapter shall post and maintain in a conspicuous place or places in and about his place or places of business typewritten or printed notices in form prescribed by the chairman, stating the fact that he has complied with all the rules and regulations of the chairman and the board and that he has secured the payment of compensation to his employees and their dependents in accordance with the provisions of this chapter, but failure to post such notice as herein provided shall not in any way affect the exclusiveness of the remedy provided for by section eleven of this chapter.\*\*\*\*\*"

### **Section 52 Effect of failure to secure compensation**

1. (a) "Failure to secure the payment of compensation shall constitute a misdemeanor, punishable by a fine of not less than five hundred nor more than two thousand five hundred dollars or imprisonment for not more than one year, or both.

(b) Where any person has previously been convicted of a failure to secure the payment of compensation within the preceding five years, upon conviction for a second violation such person shall be fined not less than one thousand nor more than five thousand dollars in addition to any other penalties including fines otherwise provided by law, and upon conviction for a third or subsequent violation such person may be fined up to seven thousand five hundred dollars in addition to any other penalties including fines otherwise provided by law.

(c) Where the employer is a corporation, the president, secretary and treasurer thereof shall be liable for failure to secure the payment of compensation under this section.\*\*\*\*\*"

### **Section 110 Record and report of injuries by employers**

1. An employer, or a third party designated by the employer, shall record any injury or illness incurred by one of its employees in the course of employment using the form prescribed by the chair for reporting injuries under subdivision two of this section. Such form, a copy of which shall be provided to the injured employee upon request, shall be maintained by the employer, or a third party designated by the employer, for at least eighteen years, and shall be subject to review by the chair at any time. Such form need not be filed with the chair unless the status of such injury or illness changes resulting in a loss of time from regular duties or in medical treatment which would require reporting in accordance with subdivision two of this section.

2. An employer, or a third party designated by the employer, shall file with the chair of the workers' compensation board and with the carrier if the employer is insured, upon a form prescribed by the chair, a report of any accident resulting in personal injury which has caused or will cause a loss of time from regular duties of one day beyond the working day or shift on which the accident occurred, or which has required or will require medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid. Such report shall state the name and nature of the business of the employer, the location of its establishment or place of work, the name, address and occupation of the injured employee, the time, nature and cause of the injury and such other information as may be required by the chair. Such report shall be filed within ten days after the occurrence of the accident. An employer shall furnish a report of an occupational disease incurred by an employee in the course of his or her employment, to the chair of the workers' compensation board, and to the carrier if the employer is insured, upon the same form. The carrier, within fourteen days of receipt of the report or accompanying the initial check forwarded to the employee, whichever is earlier, or a self-insured employer, within fourteen days of transmitting the report to the chair or accompanying the initial check forwarded to the employee, whichever is earlier, shall provide the injured employee or, in the case of death, his or her dependents with a written statement of their rights under this chapter, in a form prescribed by the chair. An employer shall file a report of any other accident resulting in personal injury incurred by its employee in the course of employment, upon the same form, whenever directed by the chair.

3. Any injury or illness which is not required to be reported in accordance with subdivision two of this section, shall not be used as a basis for determining experience modification rates, provided the employer pays in the first instance or reimburses the employer's insurer for the treatment rendered to the employee.

4. An employer who refuses or neglects to make a report or to keep records as required by this section shall be guilty of a misdemeanor, punishable by a fine of not more than one thousand dollars. The board or chair may impose a penalty of not more than two thousand five hundred dollars upon an employer who refuses or neglects to make such report.

5. The chair shall be authorized to promulgate regulations necessary to carry out the provisions of this section.

## Instructions for Completing Form C-2, "Employer's Report of Work-Related Injury/Illness"

Please complete this form and send it directly to your local Workers' Compensation Board district office (DO). The addresses are listed at the bottom of page 3. Also send a copy of the form to your insurance carrier. If you need additional help in completing this form, you may contact the Workers' Compensation Board at 1-877-632-4996 or visit <http://www.web.state.ny.us/>.

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process the form. Fill out the Date of Injury/Illness, to the best of your knowledge, and the Date of this Report at the top of page 1. Remember to enter in the name of the injured employee and the date of injury/illness on the top of page 2 and page 3.

### Section A - Employer Information:

- Item 1:** Indicate the name of the company or the owner's name and DBA name.
- Item 2:** Enter the employer's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number.
- Item 3:** Enter the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
- Item 4:** Enter the physical address of the employer (if different).
- Item 5:** Enter the primary contact phone number for the employer, including area code.
- Item 6:** Indicate the North American Industry Classification System (NAICS) or Standard Industrial Classification (SIC) Code for your business. If you do not know your NAICS or SIC Code, please indicate the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
- Item 7:** Enter the OSHA Case Number, if known.
- Item 8:** Enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.

### Section B - Insurance Carrier / Self-Insured Employer:

- Item 1:** Indicate the Carrier Code Number (W Number) issued by the Workers' Compensation Board. If you do not know the W number, contact your insurance carrier. *If you are self-insured, only enter your Carrier Code Number (W Number) and skip to Section C.*
- Item 2:** Enter the name of the employer's Workers' Compensation Insurance Carrier or Group Name. If you do not know your insurance carrier, please indicate the employer's Insurance Agent Name for item 4 and the Agent's contact phone number for item 5.
- Item 3:** Enter your Workers' Compensation Insurance Policy Number and indicate the policy effective period for coverage at the time of the injury or illness.
- Item 4:** Insurance Agent Name if the carrier is unknown.
- Item 5:** Insurance Agent phone number, including the area code.

### Section C - Employee's Personal Information:

- Item 1:** Indicate the injured employee's full legal name.
- Item 2:** Enter the employee's date of birth.
- Item 3:** Enter the employee's mailing address, including street number, P.O. Box (if applicable), Town or City, State, and Zip Code.
- Item 4:** Indicate the employee's Social Security Number (SSN).
- Item 5:** Enter a contact phone number for the employee, either a home phone number or a cell phone number, including the area code.
- Item 6:** Indicate his/her gender.

### Section D - Employee's Injury or Illness:

If this is an illness or occupational disease and an exact date of illness cannot be determined, then skip items 1 and 2.

- Item 1:** Indicate the time of day when the employee began work on the day the injury occurred.
- Item 2:** Enter the time when the injury occurred.
- Item 3:** Check whether the employee has given notice of his/her injury or illness to the employer. If so, enter the date notice was given and if it was orally or in writing. If written notice was given, please attach a copy of the employee's notice as well as any medical notes you may have received. Also attach the [supervisor's] incident report, if available.
- Item 4:** Check whether you gave the employee a Claimant Information Packet and if so, when.
- Item 5:** Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
- Item 6:** Check if this was the employee's normal work location. If it was not, explain why the employee was at this location.
- Item 7:** Enter the name of the employee's direct supervisor.
- Item 8:** Indicate whether the supervisor was a witness to the injury/illness.
- Item 9:** Check if anyone else witnessed the injury/illness and if so, list their name(s).

### **Section D - Employee's Injury or Illness (cont.):**

- Item 10:** Describe in detail what the employee was doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
- Item 11:** Describe in detail how the injury/illness occurred (e.g., the employee was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
- Item 12:** Indicate fully the nature and extent of the employee's injury/illness, including all body parts injured. Be as specific as possible (e.g., lumbar gluteal muscle strain resulting from sudden straining).
- Item 13:** Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
- Item 14:** Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was the employee's, the employer's, or that of a third party and include the license plate number (if known). If the employer's vehicle was involved, fill out the automobile liability insurance carrier for the vehicle and their address.
- Item 15:** Check if the injury/illness resulted in the death of the employee and if so, indicate the date of death and the nearest relative of the deceased (if known).

### **Section E - Medical Treatment:**

- Item 1:** If the employee did not receive medical treatment for this injury/illness, check None Received and skip to item 4. Otherwise, enter the date the employee first started treatment for this injury/illness, or check Unknown if you do not know, and complete the rest of this section.
- Item 2:** Check the location where initial medical treatment was administered for this injury/illness and whom was responsible for treatment/care of the employee (e.g., Physician, Nurse, EMT, etc.). Include the name of the person and the facility.
- Item 3:** If the employee is still receiving ongoing treatment for the same injury/illness, check Yes and indicate the name and address of the physician providing treatment; otherwise check No or Unknown.
- Item 4:** If the employee had a similar work-related injury to the same body part or a similar work-related illness while working for the same employer, check Yes and if known, indicate the name and address of the physician whom provided care; otherwise check No.

### **Section F - Return To Work:**

- Item 1:** If the employee has stopped working as a result of the work-related injury/illness, check Yes and indicate on what date he/she stopped working.
- Item 2:** If the employee has since returned to work, check Yes. Also indicate on what date the employee started working again, as well as if the employee has returned to his/her Normal Duties or if the employee is on Limited or Restricted Duty. (If the employee has not returned to his/her full pre-injury or illness work duties, then the employee is on Limited Duty).
- Item 3:** If the employee has returned to work on Limited Duty, enter in his/her average gross earnings per week.

### **Section G - Employee's Work Information:**

- Item 1:** Indicate the date the employee was hired by the employer.
- Item 2:** Enter the employee's current job title.
- Item 3:** Describe the employee's typical work activities or enter the employee's job description. If you need more space, you may attach an official job description or additional pages to completely and accurately describe the employee's work activities.

### **Section H - Employee's Payroll Information:**

- Item 1:** Enter the employee's average gross weekly pay before the injury/illness.
- Item 2:** Check if the employee received any tips or lodging in addition to his/her regular pay and if so, describe them.
- Item 3:** Check the type of job the employee had.
- Item 4:** Check which days of the week the employee usually worked. If the employee did not work a standard work week, please explain in Section I or attach an additional page or work schedule in order to fully explain.
- Item 5:** Check if the employee was paid for a full day's work on the day of the injury/illness.
- Item 6:** Indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.

### **Section I - Additional Information:**

Enter any additional information that may be relevant to the employee's work-related injury/illness in this section. You can also use this area to further explain other items in this form, such as G-3 or H-4.

Sign Form C-2 on the last page. If the form was filled out by a third-party on behalf of the employer, that person should sign on the second signature line.



STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD  
100 BROADWAY-MENANDS  
ALBANY, NY 12241  
(877) 632-4996



## You were injured at work. What now?

If you've suffered a workplace injury or illness, you may be eligible for workers' compensation benefits. You may have already received medical treatment. If you haven't, you should seek medical care as soon as possible.

### A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Do this within 30 days of injury.
- *Medical reports are necessary for your case.* Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the Board and with your employer or its insurance carrier. If your case is disputed, the Board needs a medical report on your injury to begin resolving your claim.

### Starting a Case

Once your employer knows of your injury, it must notify this Board by filing a C-2 form. *You should file an employee claim (C-3 form) reporting your injury as soon as possible.* (You must notify the Board of your injury or illness within two years.) If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3.

If you haven't already filed a C-3 or C-3.3 (if necessary), there are three ways to do it.

- Visit [www.wcb.state.ny.us/content/main/onthejob/howto.jsp](http://www.wcb.state.ny.us/content/main/onthejob/howto.jsp) to complete the form.
- Complete the enclosed paper forms, and mail them to the Board.
- Call 1-866-396-8314. A Board employee will complete the form with you.

### Health Care Bills

**Do not pay your doctor or hospital.** Those bills are paid by the insurer unless the Board disallows your case. If your case is disputed, the providers are paid when the Board decides your case. If the Board decides against you, or if *you don't pursue a case, you will have to pay the doctor or hospital.*

Your employer's insurance covers medically necessary drugs and equipment your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. (Get receipts for those expenses.)

Generally, you can choose any doctor authorized by the Board. You can also use occupational health clinics. However, if your employer's insurer has a preferred provider organization to provide care for workers' compensation injuries, you must get your initial treatment from those providers. If that insurer also has a pharmacy or diagnostic network, you must get service within these networks. If the carrier uses these networks, it must also tell you its service providers and how to use them.

### **Benefits for Lost Wages**

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

An employer or insurer can accept your claim and begin paying your lost wage benefit promptly. Sometimes, employers and carriers dispute a claim. When that occurs, the Board strives to resolve most cases within 90 days.

You may hire an attorney or licensed representative, who can be helpful with complex or disputed claims, but it isn't required. The Board sets their fees and they will be deducted from your lost wages award. You or your family should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may receive disability benefits while the case is heard. You'd pay them back out of your lost wages award. To get a DB-450 form, visit [www.wcb.state.ny.us/content/main/forms/db450.pdf](http://www.wcb.state.ny.us/content/main/forms/db450.pdf) or a Board office, or call (800) 353-3092.

### **Help is Available**

People sometimes need help getting back to work. An injury can also cause family or financial problems. The Workers' Compensation Board has rehabilitation counselors and social workers to help. Call (877) 632-4996 for more assistance.

### **What's Next?**

Your employer or its insurance carrier will contact you if your claim is accepted. When that happens, your treatment will be paid and lost wage benefits begin. If your case is challenged, the Board will notify you about resolving the case. If more information is necessary, the Board will contact you and tell you how to file it.

### **Important Contact Information**

Workers' Compensation Board	(877)632-4996	General Information@wcb.state.ny.us
Disability Benefits	(800)353-3092	www.WCB.State.NY.US
NYS Bar Association Lawyer Referral and Information Service	(800)342-3661	lr@nysba.org.



# Employee Claim

# C-3

## State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at [www.wcb.state.ny.us](http://www.wcb.state.ny.us).

WCB Case Number (if you know it): \_\_\_\_\_

### A. YOUR INFORMATION (Employee)

1. Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last

3. Mailing address: \_\_\_\_\_  
Number and Street/PO Box City State Zip Code

4. Social Security Number: \_\_\_\_\_ 5. Phone Number: (\_\_\_\_) \_\_\_\_\_ 6. Gender:  Male  Female

7. Do you speak English?  Yes  No If no, what language do you speak? \_\_\_\_\_

### B. YOUR EMPLOYER(S)

1. Employer when injured: \_\_\_\_\_ 2. Phone Number: (\_\_\_\_) \_\_\_\_\_

3. Your work address: \_\_\_\_\_  
Number and Street City State Zip Code

4. Date you were hired: \_\_\_\_/\_\_\_\_/\_\_\_\_ 5. Your supervisor's name: \_\_\_\_\_

6. List names/addresses of any other employer(s) at the time of your injury/illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Did you lose time from work at the other employment(s) as a result of your injury/illness?  Yes  No

### C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? \_\_\_\_\_

2. What types of activities did you normally perform at work? \_\_\_\_\_  
\_\_\_\_\_

3. Was your job? (check one)  Full Time  Part Time  Seasonal  Volunteer  Other: \_\_\_\_\_

4. What was your gross pay (before taxes) per pay period? \_\_\_\_\_ 5. How often were you paid? \_\_\_\_\_

6. Did you receive lodging or tips in addition to your pay?  Yes  No If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

### D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_ 2. Time of injury: \_\_\_\_\_  AM  PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) \_\_\_\_\_  
\_\_\_\_\_

4. Was this your usual work location?  Yes  No If no, why were you at this location? \_\_\_\_\_  
\_\_\_\_\_

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) \_\_\_\_\_  
\_\_\_\_\_

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YOUR NAME: \_\_\_\_\_  
First MI Last

DATE OF INJURY/ILLNESS: \_\_\_\_/\_\_\_\_/\_\_\_\_

**D. YOUR INJURY OR ILLNESS *continued***

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness?  Yes  No If yes, what? \_\_\_\_\_
9. Was the injury the result of the use or operation of a licensed motor vehicle?  Yes  No  
If yes,  your vehicle  employer's vehicle  other vehicle License plate number (if known): \_\_\_\_\_  
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: \_\_\_\_\_
10. Have you given your employer (or supervisor) notice of injury/illness?  Yes  No  
If yes, notice was given to: \_\_\_\_\_  orally  in writing Date notice given: \_\_\_\_/\_\_\_\_/\_\_\_\_
11. Did anyone see your injury happen?  Yes  No  Unknown If yes, list names: \_\_\_\_\_

**E. RETURN TO WORK**

1. Did you stop work because of your injury/illness?  Yes, on what date? \_\_\_\_/\_\_\_\_/\_\_\_\_  No, skip to Section F.
2. Have you returned to work?  Yes  No If yes, on what date? \_\_\_\_/\_\_\_\_/\_\_\_\_  regular duty  limited duty
3. If you have returned to work, who are you working for now?  Same employer  New employer  Self employed
4. What is your gross pay (before taxes) per pay period? \_\_\_\_\_ How often are you paid? \_\_\_\_\_

**F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS**

1. What was the date of your first treatment? \_\_\_\_/\_\_\_\_/\_\_\_\_  None received (skip to question F-5)
2. Were you treated on site?  Yes  No
3. Where did you receive your first off site medical treatment for your injury/illness?  none received  Emergency Room  
 Doctor's office  Clinic/Hospital/Urgent Care  Hospital Stay over 24 hours  
Name and address where you were first treated: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_
4. Are you still being treated for this injury/illness?  Yes  No  
Give the name and address of the doctor(s) treating you for this injury/illness: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_
5. Do you remember having another injury to the same body part or a similar illness?  Yes  No  
If yes, were you treated by a doctor?  Yes  No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**

6. Was the previous injury/illness work related?  Yes  No  
If yes, were you working for the same employer that you work for now?  Yes  No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

**Any person who knowingly and with INTENT TO FRAUD 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.**

Employee's Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

On behalf of Employee: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.*

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

ID No., if any: R \_\_\_\_\_ If Licensed Representative, License No.: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



# Limited Release of Health Information (HIPAA)

# C-3.3

## State of New York - Workers' Compensation Board

WCB Case No. (if you know it): \_\_\_\_\_

**To Claimant:** If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

**To Health Care Provider:** A copy of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

### A. YOUR INFORMATION (Claimant)

- Name: \_\_\_\_\_ 2. Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- Mailing Address: \_\_\_\_\_
- Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 5. Date of the current injury/illness: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Current injury/illness, including all body parts injured: \_\_\_\_\_
- Your legal representative's name and address (if any): \_\_\_\_\_

Check here if you allow your health care provider(s) to release **mental health care** information.

### B. YOUR HEALTH CARE PROVIDER(S) (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

- Provider: \_\_\_\_\_ 2. Phone Number: (\_\_\_\_) \_\_\_\_\_
- Mailing Address: \_\_\_\_\_
- Other provider (if any): \_\_\_\_\_ 5. Phone Number: (\_\_\_\_) \_\_\_\_\_
- Mailing Address: \_\_\_\_\_

### C. READ AND SIGN BELOW. I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

\_\_\_\_\_  
Claimant's signature

\_\_\_\_\_  
Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

\_\_\_\_\_  
Your name

\_\_\_\_\_  
Relationship to Claimant

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Versión en español al reverso de la forma.



# Divulgación limitada de información sobre la salud (HIPAA)

# C-3.3

## Estado de Nueva York - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB [si lo sabe])

**Al reclamante:** Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

**Al proveedor de salud:** Una copia de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- Información relacionada con el VIH
- Notas de terapia psicológica
- Tratamientos por abuso de alcohol o drogas
- Tratamiento de salud mental (a menos que usted lo indique a continuación)
- Información verbal (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

### A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

- Name (Nombre)
- Social Security Number (Número de seguro social)
- Mailing Address (Dirección postal)
- Date of Birth (Fecha de nacimiento)
- Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
- Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
- Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])  
*Check here if you allow your health provider(s) to release mental health care information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre tratamientos de salud mental.)*

### B. YOUR HEALTH CARE PROVIDERS (List all health care providers who treated you for a previous injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.)

**SU(S) PROVEEDOR(ES) DE SALUD** (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas áreas del cuerpo ó por enfermedades semejantes. Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

- Provider (Proveedor de salud)
- Phone Number (Nº de teléfono)
- Mailing Address (Dirección postal)
- Other provider (if any) (Otro proveedor [si corresponde])
- Phone Number (Nº de teléfono)
- Mailing Address (Dirección postal)

### C. READ AND SIGN BELOW I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. LEA Y FIRME A

**CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (Si el reclamante no puede firmar, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

Claimant's signature (Firma del reclamante) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_

Your name (Su nombre) \_\_\_\_\_ Relationship to Claimant (Relación con el reclamante) \_\_\_\_\_ Signature(Firma) \_\_\_\_\_ Date(Fecha) \_\_\_\_\_

## Instructions for Completing Form C-3, "Employee Claim"

Please complete this form and send it to your local Workers' Compensation Board district office (DO) to apply for workers' compensation benefits. The addresses are listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at 1-877-632-4996. You may also fill this form out online at: <http://www.wcb.state.ny.us/>

**If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.**

### Section A - Your Information (Employee):

- Item 1:** Enter your full name, including first name, middle initial, and last name.
- Item 2:** Enter your date of birth in month/day/year format. Include the four digit year.
- Item 3:** Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
- Item 4:** Enter your Social Security Number. This is very important to help service your claim faster.
- Item 5:** Indicate the primary contact phone number, including area code. This may include a cell phone number.
- Item 6:** Indicate your gender (Male or Female).
- Item 7:** Check Yes if you can speak and understand English. If not, then check No and indicate which language you speak.

### Section B - Your Employer(s):

- Item 1:** Indicate the employer you were working for at the time you were injured or became ill.
- Item 2:** Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
- Item 3:** Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
- Item 4:** Indicate the date you were hired by this employer.
- Item 5:** Enter your direct supervisor's name, whom you report to on a regular basis.
- Item 6:** If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
- Item 7:** Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

### Section C - Your Job on the Date of the Injury or Illness:

- Item 1:** Indicate your current job title or job description (e.g., warehouse worker).
- Item 2:** Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
- Item 3:** Check the type of job you had.
- Item 4:** Enter your gross pay (before taxes) per pay period.
- Item 5:** Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
- Item 6:** Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

### Section D - Your Injury or Illness:

- Item 1:** Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
- Item 2:** Enter the time when the injury occurred. Check whether it was AM or PM.
- Item 3:** Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
- Item 4:** Check whether this was your normal work location. If it was not, explain why you were at this location.
- Item 5:** Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
- Item 6:** Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
- Item 7:** Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible. (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now.)
- Item 8:** Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
- Item 9:** Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
- Item 10:** Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
- Item 11:** Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

### Section E - Return to Work:

- Item 1:** If you stopped working as a result of your work-related injury/illness, check Yes and indicate on what date you stopped working. If you have not stopped working, check No and skip to the next section.

### Section E - Return to Work (cont):

- Item 2:** If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)
- Item 3:** If you have returned to work, indicate who you are working for now.
- Item 4:** Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

### Section F - Medical Treatment for This Injury or Illness:

- Item 1:** If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.
- Item 2:** Check if you were first treated on the job for this injury or illness.
- Item 3:** Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).
- Item 4:** If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.
- Item 5:** If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**
- Item 6:** If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for "Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

### What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

### Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. **DO NOT** pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

**This form should be filed by sending directly to the appropriate WCB district office (DO) at the address listed below:**

**Albany DO - 100 Broadway-Menands, Albany NY 12241 (866) 750-5157** (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)

**Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY 13901 (866) 802-3604** (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)

**Buffalo DO - Statler Towers, 107 Delaware Avenue, Buffalo NY 14202 (866) 211-0645** (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)

**Rochester DO - 130 Main Street West, Rochester NY 14614 (866) 211-0644** (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)

**Syracuse DO - 935 James Street, Syracuse NY 13203 (866) 802-3730** (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence)

**Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC (800) 877-1373; in Hempstead (866) 805-3630; in Hauppauge (866) 681-5354; in Peekskill (866) 746-0552** (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

**C-3.0 (3-09)**



Your company's workers' compensation insurance carrier is The New York State Insurance Fund (NYSIF) which has a contract with Express Scripts, Inc (ESI), a pharmacy benefits manager (PBM) which offers convenient prescription filling services.

NYSIF has implemented an instant enrollment or "short-fill" service with Express Scripts, Inc. The new service allows injured workers immediate acceptance by any pharmacy in the PBM network. Although New York law does not require us to provide this benefit, we have elected to provide a limited number of cost-effective medication benefits for new claims filed for **work-related injuries or illnesses** in order to help injured workers get through those first difficult days after an injury and before the claim is accepted.

When an employee sustains a work place injury, the form on the other side of this page (**Workers' Compensation Temporary Prescription Services ID**) may be used to fill prescriptions at any participating pharmacy in the Express Scripts Workers' Compensation Network. It makes getting **prescriptions for your work-related injury** very easy.

**Step 1: Employer fills in:**

- Employer's Name
- Policy Number

**Step 2: Injured employee fills in his/her:**

- Social Security Number
- Date of Injury
- Date of Birth
- Name
- Mailing Address

**Step 3: Injured employee brings to pharmacy:**

- Completed temporary ID form
- Prescriptions for work-related injury

**Step 4:** Within 10 days of the New York State Insurance Fund's confirmation of the accident, the injured employee will receive a packet from Express Scripts, Inc. The packet will contain a permanent ID card which should be used when filling prescriptions for the work-related injury.

Note: Injured workers can quickly find local participating pharmacies by visiting: <http://www.express-scripts.com/custom/expresscomppharm>, or by calling the ESI 24-hour patient care hotline at (866) 533-7011.

If you have any questions about this form, please contact NYSIF, your workers' compensation carrier, at (866) 303-7737.



Workers' Compensation Temporary Prescription Services ID
Important Information

ATTENTION: INJURED WORKER

This Workers' Compensation Temporary Prescription Services ID form MUST BE PRESENTED to your pharmacist when you fill your initial prescription(s). If you have questions or need to locate a participating pharmacy, please contact Express Scripts Customer Service at 1-866-533-7011.

ATENCIÓN: TRABAJADOR LESIONADO

Este formulario temporero de identificación para Servicios de Indemnificación Laboral para Recetas Médicas DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es). Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención al Consumidor de Express Scripts, al teléfono 1. 877.274.8018.

Pharmacist/Employer – When form is completed, fax to Express Scripts: 719-553-4153 ATTN: Work Comp Claimant information will be added by Express Scripts to allow medications to process. This information can also be phoned in at 1-866-533-7011.

Form with fields for New York State Insurance Fund, Group#: NYSIF, Attention: All items below must be completed, EMPLOYER'S NAME, INJURED WORKER'S NAME, EMPLOYER'S WORKERS' COMPENSATION POLICY NUMBER, INJURED WORKER'S MAILING ADDRESS, DATE OF INJURY, STREET, INJURED WORKER'S DATE OF BIRTH, CITY, STATE, ZIP, ID#, Injured Worker's Social Security Number, and HelpDesk information.

Attention Pharmacist:

New York State Insurance Fund's prescription program is administered by Express Scripts. The following are the steps necessary to submit a prescription for New York State Insurance Fund's claimants.

Please follow the action steps listed below to enter the claim. Be sure you are using NCPDP version 3.2 for faster service.

Table with 2 columns: Step number and Action step description (e.g., Step 1: Enter Bin Number 003858, Step 2: Enter Processor Control A4, etc.)

NEED ASSISTANCE? Pharmacist, if you have any questions while processing the claim, Please call the Express Scripts Help Desk at 1-866-533-7011.