PLEASE COMPLETE SECTIONS A, B AND D

Workers' Compensation Board

# Doctor's Initial Report

**C-4**

Use this form to report the *first* time you treated the patient. (To report continued treatment, use Form C-4.2. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

## A. Patient's Information

1. Name: ______ (Last / First / MI) 2. Social Security #: ___ - ___ - ___
3. Home phone #: (____)______ 4. WCB Case # (if known): ______ 5. Carrier Case #: ______
6. Mailing address: ______ (Number and Street / City / State / Zip Code)
7. Date of injury/onset of illness: ___/___/___ 8. Date of Birth: ___/___/___ 9. Gender: ☐ Male ☐ Female
10. On the date of injury/illness what was the patient's job title or description: ______
11. On the date of injury/illness what were the patient's usual work activities: ______
12. Patient's Account #: ______

## B. Employer Information

1. Employer when injury occurred: ______ (Company/Agency Name) 2. Phone #: (____)______
3. Employer Address: ______ (Number and Street / City / State / Zip Code)

## C. Doctor's Information

1. Your name: ______ (Last / First / MI) 2. WCB Authorization #: 112796-8
3. WCB Rating Code: COS 4. Federal Tax ID #: 13-3018219 The Tax ID # is the (*check one*): ☐ SSN ☒ EIN
5. Office address: 3010 WESTCHESTER AVE SUITE 104 (Number and Street) PURCHASE (City) NY (State) 10577 (Zip Code)
6. Billing group or practice name: DR ROBERT CRISTOFARO AND DR JOHN NELSON ORTHOPAEDIC SURGERY
7. Billing address: 3010 WESTCHESTER AVE SUITE 104 (Number and Street) PURCHASE (City) NY (State) 10577 (Zip Code)
8. Office phone #: (914) 967-8708 9. Billing phone #: (914) 967-8708 10. Treating Provider's NPI #: ______
11. You are a (*check one*): ☒ Physician ☐ Podiatrist ☐ Chiropractor

## D. Billing Information

1. Employer's insurance carrier: ______ 2. Carrier Code #: W ______
3. Insurance carrier's address: ______ (Number and Street / City / State / Zip Code)
4. Diagnosis or nature of disease or injury:

| | Enter ICD10 Code: | ICD10 Descriptor: |
|---|---|---|
| (1) | | |
| (2) | | |
| (3) | | |
| (4) | | |

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column on page 2 by line.


THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION