# Checklist of Documents required by Medical Office For Workers Compensation Patients

- ◯ Patient's demographics including correct spelling of name, address, telephone number DOB and social security number.
- ◯ Workers Compensation Insurance name and Case number
- ◯ Pickup medications at the pharmacy or Delivery? (Home delivery or Doctors office delivery?)
- ◯ Attorney's Information
- ◯ HIPAA-1 Form
- ◯ OC-110A Form
- ◯ NY-WCB A9 Form
- ◯ C-3 Form
- ◯ Original prescription signed by MD. Rx must include legible name, date, compound and number of refills. Referral Form may also be used however **ORIGINAL PRESCRIPTION IS REQUIRED!**

Please keep original paperwork and prescription(s) in a **Express Health Mart Pharmacy** folder for our driver to pick up. If you have any questions please feel free to call **Express Health Mart Pharmacy** at **347-221-1100**.

# Worker's Compensation Forms

Insurance Information Form

**PRACTICE NAME:** ____________________

**Patient Referred by: Dr's NPI #** ____________________

**Other:** **Name / ID Number** ____________________

**Patient Info:**

| Full Name: | | | Date of Accident: |
|---|---|---|---|
| Address: | | | |
| Sex: | DOB: | SS#: | Type of Case: |
| Home Tele#: | | Work#: | Cell#: |

**No Fault Insurance Information**

| Policy Holder's Full Name: | |
|---|---|
| Insurance Company's Name: | |
| Insurance Company's Address: | |
| Policy #: | |
| Claim #: | |
| Adjuster's Name: | Adjuster's Tele. #& EXT |
| Date NF-2 Filed: | Filed By: |

**Worker's Comp. Insurance Information:**

| Employer Name: | |
|---|---|
| Employer Address: | |
| Insurance Company Name: | |
| Insurance Company Address: | |
| WCB #: | Carrier Case#: |
| Claim Handler Name: | Claim Handler Tele # & EXT |

**Attorney Information:**

| Attorney Name: | | |
|---|---|---|
| Address: | Tele #: | Fax #: |

Express Health Mart
PHARMACY

DR. NAME: ______________________

Company: ______________________

Address: ______________ City: ______________ State: ______________ Zip: ______________

Phone: ______________ Fax: ______________ NPI#: ______________ DEA#: ______________

**FAX ALL COMPOUND PRESCRIPTIONS TO 929-234-5501**

Patient: ______________ DOB: ______________

Driver's License #: ______________ Driver's License Expiration: ______________

Address: ______________ Telephone: ______________

City: ______________ State: ______________ Zip: ______________ Allergies: ______________

## ATTENTION PHYSICIANS

* Please provide the appropriate Diagnosis Code
* Please Fax Patient Insurance Information

Diagnosis Code: ______________ ICD 9/10 Code ______________

### PAIN CREAM

| | |
|---|---|
| Flurbiprofen | 20% |
| Baclofen | 2% |
| Clonidine | 0.2% |
| Gabapentin | 10% |
| Lidocaine | 5% |

### MUSCULOSKELETAL PAIN CREAM

| | |
|---|---|
| Ketamine | 15% |
| Gabapentin | 6% |
| Baclofen | 2% |
| Cyclobenzaprine | 10% |
| Flurbiprofen | 5% |

### WOUND CREAM

| | |
|---|---|
| Mupirocin | 5% |
| Fluticasone Propionate | 1% |
| Itraconazole | 5% |
| Urea | 40% |
| Spira-Wash | |

### ECZEMA CREAM

| | |
|---|---|
| Tacrolimus | 0.5% |
| Mometasone | 0.5% |
| Vitamin E Acetate | 0.5% |
| Glycerine to levigate | |

### SCAR CREAM

| | |
|---|---|
| Mometasone | .05% |
| Levocetirizine | 2.0% |
| Tranilast | 1.0% |

### ORAL RINSE

| | |
|---|---|
| Mometasone | 0.05% |
| Doxepin | 0.05% |
| Lidicaine (120mL 2% Lidpcaine Viscous) | 0.26% |
| Fluconazole | 2% |
| Diphenhydramine | 0.225% |

Inactives: Glycerin, Sterile water, Flavoring, Products for Preservation & Stability 900 ccs/month supply

### GOUT PAIN CREAM

| | |
|---|---|
| Indomethacin | 6% |
| Bupivacaine | 2% |
| Mometasone | .20% |
| Flurbipiofen | 10% |

### ANTI FUNGAL THERAPY

| | |
|---|---|
| Urea | 40% |
| Fluconazole | .20% |
| Mometasone | .20% |

### ABDOMINAL HERNIA

| | |
|---|---|
| Ketamine | 10% |
| Flurbiprofen | 5% |
| Gabapentin | 6% |
| Bupivacaine | 1% |
| Dicyclomine | 1% |
| Ondansetron | 0.5% |

### SINUS/ALLERGY SPRAY

| | |
|---|---|
| Fluticasone | 3mg |
| Itiaconazole | 50mg |
| Tobramycin | 120mg |
| NeilMed Sinus Rinse Bottle | |

### ALLERGY

| | |
|---|---|
| Fluticasone | 3mg |
| Itiaconazole | 50mg |
| Levofloxacin | 125mg |
| NeilMed Sinus Rinse Bottle | |

### NASAL SPRAY

| | |
|---|---|
| Fluticasone | 1mg |
| Itiaconazole | 3mg |
| Levofloxacin | 5mg per 60ML |

### PLANTAR FIBROMATOSIS

| | |
|---|---|
| Verapamil | 10% |
| Diclofenae | 5% |
| Baclofen | 2% |
| Mometasone | 0.10% |
| Bupivacaine | 1% |

### MIGRAINE TRANSDERMAL GEL

| | |
|---|---|
| Sumatriptan | 3.33% |
| Ketamine | 2.50% |
| Flurbiprofen | 2.5% |
| Gabapentin | 3% |
| Amitriptyline | 1.5% |
| Ondansetron | 0.25% |

### NEUROPATHIC PAIN CREAM

| | |
|---|---|
| Ketamine | 10% |
| Clonidine | 0.20% |
| Gabapentin | 6% |
| Amitriptyline | 3% |
| Mefenamic Acid | 3% |
| Bupivacaine | 1% |

### ANTI-AGEING FACIAL CREAM

| | |
|---|---|
| Melatonin | 1% |
| Ubiquinone | 0.5% |
| Glycine Soya Protien 5% Facial | |

## PRESCRIPTIONS SIG

☐ 360 Grams (Three Hundred Sixty)
☐ 30 Day Supply
☐ Refills

Circle One

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 12

**Tropical Pain Cream Direction for:**
Joint - Musculoskeletal - Neuropathic - Gout
Apply 1-2 pumps 4x daily to the affective area

**Tropical Therapy Directions:**
Scar Therapy - Anti- Fungal Therapy
Planter Fibromatosis
Apply to the affected area 2x daily

**Migraine Transdermal Directions**
Apply I pump you wrist and I pump to the top of the back of the neck. Just below the skull
* May repeat in 12 hours
* Do not exceed 4 pumps in 24 hours
Apply to the affected area 2x daily

## ORAL RINSE SIG

☐ Sig. 5ML Six times a day, Dispense 1000mL 30 Day Supply
☐ Sig. 5ML Five times a day, Dispense 750mL 30 Day Supply
☐ Sig. 5ML Four times a day, Dispense 600mL 30 Day Supply

## ORAL RINSE DIRECTIONS

1. Swallow
2. Inhale with open mouth to dry oral cavity
3. Inject entire 5ML syringe into mouth
4. Swish in mouth undiluted for 30 seconds
5. Lean over sink and excess drain from mouth - DO NOT SPIT
6. Use twice daily up to 6 time per day
7. Preferably, use after breakfast and before bedtime after brushing teeth
8. Or, use as directed

## PHYSICIAN

**Physician Name** ______________ **Physician Signature** ______________

Date: (Circle Months)

○ January ○ February ○ March ○ April ○ May ○ June ○ July ○ August ○ September ○ October ○ November ○ December

______________ ,20 ________
Day

# CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to HIPAA)

INSTRUCTIONS
**To the Claimant:** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers' Compensation Board, your employer's insurance carrier, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

**IMPORTANT: Failure to execute this authorization may interfere with your ability to obtain workers' compensation benefits.**

| CLAIMANT'S NAME | CLAIMANT'S SOCIAL SECURITY NUMBER | CLAIMANT'S DATE OF BIRTH |
|---|---|---|
| LIST ALL WCB CASE NUMBER(S) AND CORRESPONDING DATE(S) OF ACCIDENT FOR WHICH YOU ARE GRANTING AUTHORIZATION | | |

I, ____________________, hereby authorize my treating health provider
Claimant's Name

____________________, to disclose the following described health
i Health Provider's Name

____________________

____________________

____________________

This information can be disclosed to the following parties: *(check all that apply; give names and addresses, if known)*

- ☐ New York State Workers' Compensation Board
- ☐ My current/former employer ____________________
- ☐ Workers' compensation insurance carrier(s) ____________________
- ☐ Third-party administrator ____________________
- ☐ My attorney/licensed representative ____________________
- ☐ The Uninsured Employer's Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)
- ☐ Special Funds Conservation Committee (for cases under Section 25-a or 15-8 of the Workers' Compensation Law)

**Section 25-a:** If your claim is being reopened after being previously closed, the Special Fund for Reopened Cases may be responsible for paying your medical bills and lost wage benefits.

**Section 15-8:** If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer's insurance carrier after a period of time has elapsed.

**Redisclosure:** I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.

**Expiration Date:** This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

**I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes.**

____________________ ____________________ ____________________
Printed Name of Claimant or Legal Representative | Signature of Claimant or Legal Representative | Date

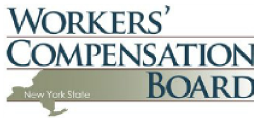
If Authorization signed by a legal representative on behalf of claimant, state relationship to claimant ____________________ and basis for authority (e.g. claimant is a minor; patient is deceased and representative is the claimant in a workers' compensation proceeding or represents the state)

____________________

____________________

**TO THE HEALTH PROVIDER:** Keep the original of this Authorization on file. A copy must be given to the patient/claimant upon request.

DO **NOT** SEND TO THE NEW YORK STATE WORKERS' COMPENSATION BOARD.



**CENTRALIZED MAILING PO Box 5205, Binghamton, NY 13902-5205**

State of New York
WORKERS' COMPENSATION BOARD

# CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

**PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.**

| Claimant's Name | Claimant's Social Security No. | Case Number ❑ WCB ❑ DB ❑ Discrimination and/or Date of Accident |
|---|---|---|
| | | |

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

**CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.**

**INSTRUCTIONS:**

**Submit original to the Workers' Compensation Board and retain a copy for your records.** ***Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.*** **This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.**

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT
OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, ______________________________,
Claimant's Name

represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

__________________________________________________________________, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

__________________________________________________________________.
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

______________________________ ______________

Claimant's Signature (ink only -- use blue ballpoint pen if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

# NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

| WCB CASE NO. (If Known) | CARRIER CASE NO. (If Known) | DATE OF INJURY | NATURE OF INJURY OR ILLNESS | INJURED PERSON'S SOC. SEC. NO. |
|---|---|---|---|---|
| | | | | |

| | NAME | ADDRESS | APT. NO. |
|---|---|---|---|
| CLAIMANT | | | |
| EMPLOYER | | | |
| INSURANCE CARRIER | | | |

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature ______________________ Date ____________

Provider's Name and Address ______________________

______________________

**TO THE CLAIMANT**

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

**Workers' Compensation Law Section 32**

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

**TO THE HEALTH CARE PROVIDER**

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

**Workers' Compensation Board**

# 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.ny.gov.

**WCB Case Number (if you know it):** ______________________

## A. YOUR INFORMATION (Employee)

1. Name: ______________________ (First) ______ (MI) ______ (Last) ______ 2. Date of Birth: ____/____/____

3. Mailing address: ______________________ (Number and Street/PO Box/Apartment No.) ______ (City) ______ (State) ______ (Zip Code) ______

4. Social Security Number: ____-____-____ 5. Phone Number: (____)__________ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? __________

## 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): ______________________



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

**YOUR NAME:**__________________________________________ **DATE OF INJURY/ILLNESS:** _____/_____/_____
First MI Last

## 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 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.**

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: ______/______/______