

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.
CLAIMANT		NAME		ADDRESS	APT. NO.
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.

**STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
EMPLOYEE'S CLAIM FOR COMPENSATION**

IMPORTANT: Your Social Security Number Must Be Entered:
 IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado:

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**ANSWER ALL QUESTIONS
FULLY - TYPE OR PRINT
CLEARLY**

WCB Case No. (If known) _____ Carrier Case No.(if known) _____

A. Injured Person	1. Name..... <small>First Name Middle Name Last Name</small>
	2. Mailing Address..... <small>Number and Street (include Apartment No.) City State Zip Code</small>
	3. Residential Address (if different from mailing address)
	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth.....Telephone No. ().....
	5. Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what language do you speak?.....
	6. Name of union and local number, if member.....
	7. State what your regular work/occupation was.....
	8. Wages or average earnings per day, including overtime, board, rent and other allowances.....
	9. Were you paid full wages for the day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
	10. Your work week at time of injury was: <input type="checkbox"/> Five day <input type="checkbox"/> Six day <input type="checkbox"/> Seven day <input type="checkbox"/> Other.....
B. Employer(s)	1. Employer.....Telephone No. ().....
	2. Employer's Address.....
	3. Were you employed by any other employer or employers at the time of your injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
	4. If yes, did you lose time from work at this other employment as a result of your injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Place/Time	1. Address where injury occurred.....County.....
	2. Date of Injury.....at.....o'clock, <input type="checkbox"/> AM <input type="checkbox"/> PM
D. The Injury	1. How did injury/illness occur?.....
	2. Did anyone witness the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name(s).....
	3. Is the injury the result of the use or operation of a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> your vehicle <input type="checkbox"/> employer's vehicle If your vehicle was involved, give name & address of your motor vehicle (No-Fault) insurance carrier.....
E. Nature and Extent of Injury/ Illness	1. State fully the nature of your injury/illness, including all parts of body injured.....
	2. Date you stopped work because of this injury/illness?.....
	3. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, on what date?.....
	4. Does injury/illness keep you from work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Have you done any work during period of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Have you received any wages since your injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
F. Medical Benefits	1. Did you receive or are you now receiving medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Are you now in need of medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Name of attending doctor..... Doctor's address.....
	4. If you were in a hospital, give the dates hospitalized..... Name of hospital..... Hospital's Address.....
G. Comp. Payments	1. Have you received or are you now receiving workers' compensation payments for the injury reported above? <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Do you claim further workers' compensation payments? <input type="checkbox"/> Yes <input type="checkbox"/> No
H. Notice	1. Have you given your employer (or supervisor) notice of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. If yes, notice was given <input type="checkbox"/> orally <input type="checkbox"/> in writing, on..... to

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

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.

Signed by..... Dated.....
(Claimant)

SEE OTHER SIDE FOR IMPORTANT INFORMATION - VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

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. You are entitled to a hearing. You are not required to obtain anyone to represent you at a hearing, but you have the right to be represented by an attorney or licensed representative, if you so choose. If you obtain representation, do not pay your attorney or representative directly. When the Workers' Compensation Board rules on your case, the attorney's or representative's fee will be set by the Board and paid to him or her by your employer or by your employer's insurance carrier. The amount so paid will be deducted from your award.
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.

LO QUE TODO TRABAJADOR DEBE HACER EN CASO DE LESION O ENFERMEDAD OCUPACIONAL.

1. Avisar inmediatamente a su patrono ó a su supervisor cuando, donde y como sufrió la lesión.
2. Obtener atención médica inmediatamente.
3. Pedirle a su médico que presente informes a la Junta y a su patrono, ó a la compañía de seguros.
4. Llenar esta forma de reclamación para compensación y enviarla a la oficina mas cercana de la Junta de Compensación. (vease abajo.) El no presentar reclamación dentro de dos años a partir de la fecha de la lesión puede ser motivo de que se le rechace la reclamación. Si necesita que le ayuden a llenar esta forma, llame por telefono o vaya a la oficina mas cercana de la Junta de Compensación Obrera.
5. Acudir a todas las audiencias cuando se le notifique que comparezca.
6. Volver a su trabajo lo mas pronto que le sea posible; la compensación nunca es tan alta como su sueldo.

SUS DERECHOS:

1. Por lo general usted tiene derecho a ser atendido por el médico de su preferencia, siempre y cuando esté autorizado por la Junta. Si su patrono está participando en un acuerdo de organización de proveedores con preferencia (P.P.O.) su tratamiento inicial deberá obtenerlo de la entidad que su patrono haya designado para proveer cuidado médico para lesiones relacionadas con la compensación obrera.
2. NO PAGUE NADA a su médico ni al hospital. Esas facturas seran pagadas por la compañía de seguros si su caso no ha sido cuestionado. Si el caso es disputado, su médico y el hospital deberan esperar hasta que la Junta decida el caso. Si usted dejara de proseguir su caso o si la Junta fallara en su contra, le corresponde pagar a su médico y al hospital.
3. Tambien tiene usted derecho a ser reembolsado por gastos de medicamentos, muletas o cualquier aparato apropiadamente prescrito por su médico por transportación u otros gastos necesarios para visitar el consultorio de su médico ó el hospital. (Obtenga comprobantes de esos gastos.)
4. Usted tiene derecho a compensación si su lesión le deja impedido de trabajar por mas de siete dias, o le obliga a trabajar a sueldo mas bajo ó resulta con incapacidad permanente en alguna parte de su cuerpo.
5. La compensación es pagadera directamente y sin tener que esperar la decisión, excepto cuando se cuestione la reclamación.
6. Usted tiene derecho a una audiencia. Usted no está obligado a conseguir quien le represente en la audiencia, pero tiene derecho a ser representado por un abogado o por un representante licenciado, si usted lo prefiere. En caso de obtener usted representación, no pague nada directamente a su abogado o representante. Cuando la Junta de Compensación Obrera decida su caso los honorarios de su abogado o representante seran fijados por la Junta y seran pagados por el patrono ó por la compañía de seguros. La suma pagada en esta forma sera deducida de la cantidad adjudicada a usted.
7. Si necesita ayuda para volver al trabajo, ó si tiene problemas familiares o economicos por motivo de su lesión, comuníquese con la oficina de la Junta de Compensación Obrera que le quede mas cerca y pida una reunión con un consejero de rehabilitación o con un trabajador social.

WORKERS' COMPENSATION BOARD DISTRICT OFFICES AND COUNTIES SERVED

OFICINAS DE DISTRITO DE LA JUNTA DE COMPENSACION OBRERA Y LOS CONDADOS SERVIDOS

- ALBANY 12241 - 100 Broadway, Menands. (866) 750-5157** For all accidents in following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington.
- BINGHAMTON 13901 - State Office Building, 44 Hawley Street. (866) 802-3604** For all accidents in following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins.
- BUFFALO 14202 - Statler Towers, 107 Delaware Ave. (866) 211-0645** For all accidents in following counties: Cattaraugus, Chautauqua, Erie, Niagara.
- ROCHESTER 14614 - 130 Main Street West. (866) 211-0644** For all accidents in following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates.
- SYRACUSE 13203 - 935 James Street. (866) 802-3730** For all accidents in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.
- DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill district offices) - PO Box 5205, Binghamton, NY 13902-5205. NYC (800) 877-1373 Hemp. (866) 805-3630 Haup. (866) 681-5354 Peek. (866) 746-0552** For all accidents in following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester.

(Claims for compensation, inquiries, medical and other reports should be sent to the District Office of the County in which the accident occurred. Be sure to notify this office of any change in your address.)

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. Sec. 552a).

The Workers' Compensation Board's ("Board") authority to request personal information from claimants is derived from Sections 20 and 142 of the Workers' Compensation Law. This information is collected to assist the Board in processing claims in an efficient manner and to help it maintain accurate claim records.

The Board is strongly committed to protecting the confidentiality of all personal information that it collects. Such information will be disclosed within the agency only to Board personnel and agents in furtherance of their official duties. Personal information will be disclosed outside the agency only in accordance with applicable state and federal law.

The Board's Director of Operations, located at 100 Broadway, Menands, New York 12241 (518-474-6674), is primarily responsible for the maintenance of agency records containing personal claimant information.

Failure to provide the information requested on this form will not result in the denial of your claim, but may delay the processing of your claim. 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 claim.

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.

The Workers' Compensation Board assures hearing locations accessible to the disabled. Contact the nearest Board office if you have special accessibility needs.

Notificación conforme a la Ley de Protección de la Privacidad de Nueva York [Ley de Servidores Públicos 6-A] y el Acta Federal de Privacidad de 1974 [5 U.S.C. Sec. 552a].

La autoridad de la Junta de Compensación Obrera para requerir información personal de los reclamantes surge de las Secciones 20 y 142 de la Ley de Compensación Obrera. Esta información se utiliza para ayudar a la Junta a procesar reclamaciones en forma eficiente y mantener expedientes precisos.

La Junta guarda celosamente la información confidencial de la información personal que requiere. Esa información solo se comparte con personal de la Junta y sus agentes en relación al cumplimiento de sus deberes oficiales. Información personal recopilada por la Junta solo sera compartida con personas o entidades fuera de la Junta cuando sea requerido por leyes estatales o federales.

El Director de Operaciones de la Junta con oficinas en 100 Broadway, Menands, New York 12241 [518-474-6674], es responsable directo del mantenimiento de los expedientes de la agencia que contienen información personal de los reclamantes.

Si usted no suministra la información requerida en ésta forma, esto no quiere decir que su reclamación sera denegada, pero puede retrasar el procesamiento de su caso. El tener su seguro social permite a la Junta tomar acción rápida en todo lo concerniente a la información relacionada con su reclamación.

Aviso de HIPAA

Como requisito para adjudicar una reclamación, la ley de compensación obrera WCL 13-a(4) {a} y 12 NYCRR 325-1.3 requiere a los proveedores de salud radicar regularmente ante la Junta, el asegurador o el patrono informes sobre el tratamiento médico. Conforme a 45CFR 164.512 estos informes médicos requeridos por ley estan exentos de las restricciones sobre información médica impuestos por HIPAA.

Proveemos locales accesibles para la vista de sus casos. Comunícate con nuestra oficina mas cercana si tienes algun requerimiento especial de acceso.

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