You were injured at work. What now?

If you have 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.

For assistance with your claim, call the **Workers' Compensation Board (Board)** at **(877) 632-4996**.

YOUR RESPONSIBILITIES

- Notify your employer, in writing, detailing when, where and how you were injured or became ill. Do this as soon as possible within 30 days of injury or illness. Do not text it; instead send a letter, email or other document that can be saved or printed.
- Advise your health care providers that you have a work-related injury or illness and give the name of your employer's workers' compensation insurer. If you do not know the name of your employer's insurer, either ask your employer or contact the Board immediately. Your health care provider will file medical reports with the Board and with your employer or its insurer. A medical report needs to be filed with the Board for you to access your benefits.
- File an ***Employee Claim (Form C-3)*** reporting your injury or illness to the Board 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 ***Limited Release of Health Information (Form C-3.3)***.
  Citizenship and immigration status are not factors in workers' compensation.

How to file a claim
Quickest method: Visit wcb.ny.gov and select "File a Claim."
For questions about filing a *Form C-3*, or to receive a copy of the form, please call (877) 632-4996. A Board representative will help you.

MEDICAL AND TRAVEL EXPENSES

Medical care to treat your work-related injury or illness is a workers' compensation benefit that is provided at no cost to you. Medical bills for your injury or illness are paid directly by your employer's workers' compensation insurer to your health care provider. If your case is disputed by the insurer, the health care providers will be paid if the Board decides your case in your favor. However, if the Board decides against you, or if you don't pursue a case, you will have to pay the health care provider or hospital (or submit the bill(s) to your own health insurer).

Your employer's workers' compensation insurance covers medically necessary drugs and equipment your health care provider prescribes. You may also be reimbursed for mileage, public transportation or other necessary expenses incurred when traveling for treatment. Submit those expenses (including receipts if you have any) to your employer's workers' compensation insurer and to the Board on a ***Claimant's Record of Medical and Travel Expenses and Request for Reimbursement (Form C-257)***.

Generally, you can choose any health care provider authorized by the Board. You can search for an authorized health care provider in your area using the "Health Care Provider Search" feature at **wcb.ny.gov**. You can also use occupational health clinics. However, if your employer's workers' compensation insurer has a Preferred Provider Organization (PPO) to provide care for workers' compensation injuries, you must get your first treatment from the PPO network. If that insurer also has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them. However, in an emergency, you can see any provider.

BENEFITS FOR LOST WAGES

You are entitled to a portion of your lost wages, which must be paid promptly, if your injury or illness affects you in one or more of the following ways:

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

After you have healed from your injury or illness and when no further medical improvement is expected (typically one year after the date of accident/illness or surgery, if surgery was performed), you can ask your doctor to evaluate whether your accident/illness has resulted in a permanent injury/condition. To learn more about this benefit, please visit **wcb.ny.gov**, click on the "Workers" section, then select "Disability Classifications."

You may hire an attorney or licensed representative for help with your claim, but it isn't required. You or your family should not directly pay your attorney or licensed representative. Their fees are approved by the Board and deducted from your lost wage award.

If your case is disputed, you may receive disability benefits while the case is pending review by the Board. To get a ***Notice and Proof of Claim for Disability Benefits (Form DB-450)***, visit **wcb.ny.gov**; call the Board for assistance; or visit a Board office. If the case is resolved in your favor, the disability benefits will be deducted from your lost wages award.

WHAT'S NEXT?

The workers' compensation insurer will contact you. If your claim is accepted, your health care providers will be paid, and lost wage benefits begin. If your case needs a hearing, the Board will contact you. There are online resources available to make the hearing process easier:

- **eCase:** You can upload and view case-related documents online with the Board's eCase system, which is used to process claims for injured workers. You must register for eCase at **wcb.ny.gov**.
- **Virtual Hearings:** You have the option of attending hearings without having to travel to a Board office by using virtual hearings. Learn more about virtual hearings, and the Board's free app, at **wcb.ny.gov/virtual-hearings**.

HELP IS AVAILABLE

Sometimes you need help getting back to work. Your employer may have alternative or light duty assignments that enable you to work while you heal. An injury or illness can also cause family or financial problems. The Board has vocational rehabilitation counselors and social workers to help. Call the Board for more information on available services and for assistance.

If you are concerned about dependency on opioid pain medications, please call the NYS OASAS HOPELine at **877-8-HOPENY (877-846-7369).**

Important Contact Information		
Workers' Compensation Board	(877) 632-4996	claims@wcb.ny.gov
		wcb.ny.gov

New York State Workers' Compensation Board
PO BOX 5205
Binghamton, NY 13902-5205

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

WCB-Claimant-QuickGuide-v1 (1-21)

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

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: ☐ M ☐ F ☐ X

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): _____

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. Have you had 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 they are 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: _____/_____/_____

Instructions for Completing Employee Claim (Form C-3)

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the end of these instructions. If you need additional help completing this form, contact the Workers' Compensation Board at **1-877-632-4996.** You may also fill this form out online at **wcb.ny.gov**. 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):

In Section A, enter your name, address and other requested information.
Note on Item 7: Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

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. § 552a).

The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.
Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

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

In Section C, enter your job title, work activities and pay information.

Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.
Item 1: Enter the date you were injured or the first date you noticed you became ill.
If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.
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 the date you stopped working. If you have not stopped working, check No and skip to the next section.
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 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 they are 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, their 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 address listed below:
New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

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)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____

_____

7. 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.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. 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 (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on the claimant's behalf must fill out and sign below:

_____

Your name | Relationship to Claimant | Signature (ink only -- use blue ballpoint pen, if possible.) | Date

Versión en español al reverso de la forma.

C-3.1

State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:
For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

_____ _____ _____ _____
Signature of Injured Employee Date Signature of Witness Date

Please note: It is not necessary for you to sign this consent form if your employer is (i) participating in a certified preferred provider organization (PPO) under Article 10-A of the Workers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR) pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance with these statutory programs, except in emergency situations, you must obtain at least initial treatment for any workers' compensation injury or illness from the certified network(s) or providers designated by your employer.

To the Employer:
The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.

NEW YORK STATE INSURANCE FUND
PHARMACY BENEFITS MANAGEMENT

The New York State Insurance Fund (NYSIF) provides workers' compensation insurance coverage to your employer for employee work-related injuries or illnesses. This plan includes a network of more than 67,000 participating pharmacies as an easy and convenient way for you to fill medical prescriptions. If you are prescribed medication for a work-related injury or illness, it must be filled at a pharmacy within the CareComp pharmacy network.

NYSIF also provides a "short-fill" service, which enables you to obtain pharmacy benefits, even before your claim has been accepted. Although we are not required to provide this benefit, we want to help you get through the first, difficult days after your work-related injuries or illnesses by offering a limited number of prescription medication benefits that can be filled within the CareComp pharmacy network.

Please use the form on the reverse of this page – "Workers' Compensation Temporary Prescription Services ID" – to fill prescriptions at any participating pharmacy. To complete the form, please:

Step 1: Have your employer fill in their **business name** and **policy number.**

Step 2: Complete the rest of the form with your **claim** and **contact information**.

Step 3: Bring the **completed form** and **prescription** to a pharmacy in the CareComp pharmacy network.

Step 4: Within 10 days of the confirmed accident, you will receive a **packet from CVS Caremark**. This packet will contain a **permanent identification card** that should be used when filling prescriptions for the work-related injury or illness.

You can find local participating pharmacies by visiting www.wcrxpharmacylocator.com or by calling the 24-hour patient care hotline at **(866) 493-1640**.

If you have questions or need assistance, please visit www.nysif.com/networkbenefits or contact NYSIF at (888) 875-5790.

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 CVS Caremark Customer Service at 1-866-493-1640.

Pharmacist/Employer – When form is completed, fax to CVS Caremark: 1-866-493-1644

Claimant information will be added by CVS Caremark to allow medications to process. This information can also be phoned in by calling 1-866-493-1640.

New York State Insurance Fund	**Group#: NYSIF**
Attention: All items below must be completed.	
EMPLOYER'S NAME: _____	INJURED WORKER'S NAME: _____ FIRST MI LAST
EMPLOYER'S NYSIF WORKERS' COMPENSATION POLICY NUMBER: _____	INJURED WORKER'S MAILING ADDRESS: _____ STREET
DATE OF INJURY: ____ /____ /_____ (MM/DD/YYYY)	_____ CITY, STATE ZIP
INJURED WORKER'S DATE OF BIRTH: ____ / ____ / _____ (MM/DD/YYYY)	
INJURED WORKER'S SOCIAL SECURITY NUMBER: _____	*Help Desk: This is a POS Program through CVS Caremark only. For assistance call CVS Caremark Help Desk at 866.493.1640*

Attention Pharmacist:

NYSIF's prescription program is administered by CVS Caremark. Please follow the action steps listed below to enter the claim. These steps are required to submit a prescription for NYSIF claimants.

Step 1	Enter Bin Number 610235
Step 2	Enter PCN: WRK
Step 3	ID: Injured Worker' Social Security Number

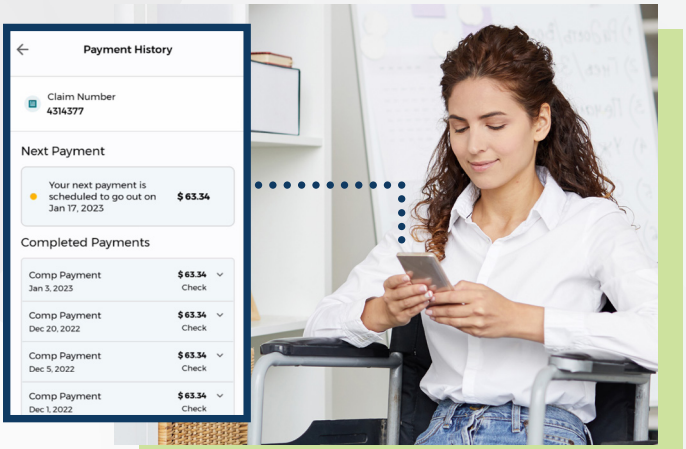
NEED ASSISTANCE? Pharmacist, if you have any questions while processing the claim, please call the CVS Caremark Help Desk at 1-866-493-1640.

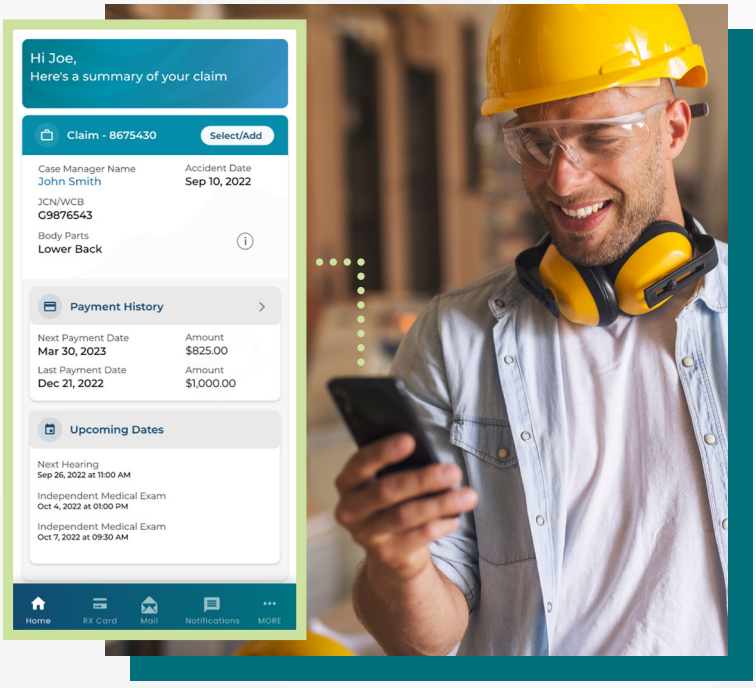
NYSIF

Claim Mobile App

Do you want to check the status of your benefit payment or workers' compensation claim? NYSIF has an app for that! With the **NYSIF Claim Mobile App**, you can easily access real-time information about your claim, including:

- Check & Payment Status
- Case Manager Contact Information
- Claim Status
- Upcoming Hearings and Medical Exams





IMPROVED COMMUNICATION, TRANSPARENCY AND ENGAGEMENT

With the **NYSIF Claim Mobile App**, you can easily complete these administrative tasks:

- Locate Claim Number
- View Payment History
- Link Additional NYSIF Claims to Your Account
- Receive Notifications
- Access Your Rx Card
- Email Your Case Manager
- Sign Up for Direct Deposit

SCAN HERE

Download the NYSIF Claim Mobile App Today!

Learn more at **nysif.com**

PO Box 66699; Albany , NY 12206
nysif.com

Get your workers' compensation payment by direct deposit!

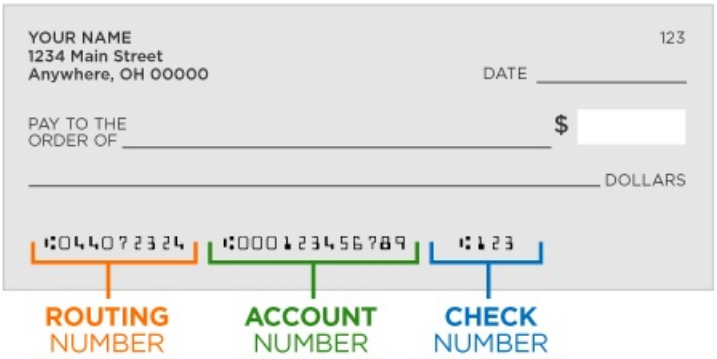
Direct Deposit

New York State Insurance Fund

NYSIF offers direct deposit for claimants to receive workers' compensation benefits. In cooperation with your financial institution, NYSIF can deposit benefit payments directly to your bank account. You can even elect to distribute your payments between two bank accounts (by percentage).

REQUIREMENTS FOR TYPE OF ACCOUNT

You must deposit your payment into a **Checking** or **Savings** account. Complete all information on the direct deposit form, including your bank routing number and account number (see illustration). Contact your bank if you need assistance.



CANCELATION

This agreement remains in effect until canceled. To cancel your agreement, visit **nysif.com**, register as a claimant and select the "unsubscribe from direct deposit" option. In addition, you may cancel by contacting your NYSIF case manager at **nysif.com** by using our Quick Links to "Get Claims Help." This agreement also may be canceled by NYSIF or by your financial institution. In either case, you will receive subsequent checks in the mail. Cancelation may take up to three weeks to process.

CHANGES TO YOUR ACCOUNT

You are responsible for notifying NYSIF if there are any changes to your bank account information (change of account number, financial institution, etc.). Notify NYSIF by submitting a new direct deposit application, available at **nysif.com**.

If you change accounts or financial institutions, you should maintain your old account until your new account receives your next direct deposit payment. If the old account is not maintained, you may experience a delay in payment until your new direct deposit authorization takes effect.

PERIODIC VERIFICATION

NYSIF may contact you periodically to validate information regarding your direct deposit account. If the payee is no longer living, notify NYSIF immediately.

NEW YORK STATE INSURANCE FUND **DIRECT DEPOSIT AUTHORIZATION APPLICATION**

To receive direct deposit of benefits, complete this form in its entirety and return it to the address below. For more information on your rights regarding direct deposit, go to **nysif.com/directdeposit.** All fields must be completed in order to enroll in direct deposit.

NAME (FIRST, MIDDLE, LAST)**:** **NYSIF WORKERS' COMP CLAIM NUMBER:**

HOME ADDRESS (DO NOT USE PO BOX): _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

E MAIL ADDRESS: _____ **PHONE:** _____

Enter all information, including your account number and bank routing number. Contact your financial institution if you need assistance with completing this section. **Optional:** If you wish to split your payments between two bank accounts, complete both sets of bank-related fields. The distribution percentage must total 100% (for example, 75% in account #1 and 25% in account #2). If at any time your bank account becomes unavailable, the amount due to be paid will be sent via paper check.

DIRECT DEPOSIT ACCOUNT #1 (choose either checking or savings)**:** ◯ Checking ◯ Savings Distribution _____ % of check

NAME OF FINANCIAL INSTITUTION: _____

ROUTING # _____ **ACCOUNT #** _____

DIRECT DEPOSIT ACCOUNT #2 (choose either checking or savings): ◯ Checking ◯ Savings Distribution _____ % of check

NAME OF FINANCIAL INSTITUTION: _____

ROUTING # _____ **ACCOUNT #** _____

DEPOSITOR/PAYEE CERTIFICATION & AUTHORIZATION

In signing this form, I authorize NYSIF to direct payments to the financial institution(s) named above for deposit into the designated account(s). I certify that I am entitled to receive the underlying compensation payments or settlement proceeds, and circumstances entitling me to benefits from NYSIF have not changed. In the event that circumstances which would affect entitlement to receive payments have changed, I must notify NYSIF. I understand that to apply for direct deposit, I must provide an email address. By submitting this application, I consent to receiving electronic notifications at the provided email address.

SIGNATURE: _____ **DATE:** _____

MAIL COMPLETED APPLICATION TO:

NYSIF
PO Box 66699
Albany, NY 12206