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Basic Accident Report

Date of Report:_____ Report Completed By:_____

Last Name of Injured Person:	First Name:	Job Title:
Date of Accident:	Time of Accident:	Location of Accident:
Supervisor's Name & Job Title:	Name of Witnesses:	
Full Description of Injuries:		
Description of accident/incident or employee's account, including sequence of events preceding the accident:		
Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, other:		
Recommended Corrective Measures:		Action By:
Names of Inspection Team Participants:		
Management Review By:	Date to be Completed By:	

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Informe Básico de Accidentes

Fecha Del Informe:_____Informe Completado Por:_____

Apellido De La Persona Lesionada:	Primer Nombre:	Puesto De Trabajo:
Fecha Del Accidente:	Hora Del Accidente:	Lugar Del Accidente:
Nombre Del Supervisor Y Cargo:	Nombre De Los Testigos:	
Descripción Completa De Las Lesiones:		
Descripción del accidente / incidente o versión del empleado, incluyendo la secuencia de eventos que preceden al accidente:		
Causas básicas y causas contributivas. Explique el tipo de situación ya sea si fue una situación insegura, condición insegura, factor personal, otros:		
Medidas Correctivas Recomendadas:		Acciones Tomadas Por:
Nombres De Los Participantes Del Equipo De Inspección:		
Revisión Por Parte De La Gerencia:	Fecha Límite De Entrega:	

Notice That Claimant Must Arrange for Diagnostic Tests & Examinations through a Network Provider

State of New York- Workers' Compensation Board

Claimants are required to obtain Diagnostic Tests and Examinations through the Carrier's Diagnostic Testing Network(s) identified below. This Notice is supplied to the Claimant and Treating Medical Provider pursuant to Workers' Compensation Law §13-a(?) and 12 NYCRR 325-7. Failure to provide the required notice relieves the Claimant of his/her obligation to use the diagnostic testing network(s.)

Employers Ins.

Date of Notice: _____

Check the applicable box below:

☐ **Notice to the Claimant**

Claimant: _____ (First Name) _____ (Middle Initial) _____ (Last Name) WCB Case Number: (If Available) _____

Mailing Address: _____

Carrier Case Number: _____

☐ **Notice to the Treating Medical Provider**

Name of Treating Medical Provider: _____ Authorization No.: _____

Mailing Address: _____

Identify the Diagnostic Examination or Test that the Claimant must schedule using the Diagnostic Testing Network (check all applicable boxes)

☐ All ☐ MRI ☐ CT ☐ EMG/NCS ☐ Diagnostic Ultrasound ☐ X-Ray

☐ Other: _____

To schedule a diagnostic examination or test, contact the Diagnostic Testing Network listed below:

Diagnostic Testing Network

Identify the diagnostic testing network name, address, toll-free telephone number and any web address or e-mail contact information below:

Diagnostic Testing Network: Streamline Imaging LLC

Mailing Address: (Billing) 4651 Salisbury Rd, suite 250, Jacksonville FL 32256

Phone Number: 855 – 877 - 9292 Fax Number: 855 – 877 - 9595

Web Address www.streamlineworkcomp.com E-mail Address: referral@streamlineworkcomp.com

STATEMENT OF RIGHTS AND OBLIGATIONS - DIAGNOSTIC TESTING NETWORKS (WCL §13-a(7) and 12 NYCRR §325-7)

1. The claimant will receive the name, address, and phone number of at least five [5] providers. The providers must be located within a reasonable distance from the claimant's home or work. The network must provide the claimant with all providers if there are fewer than five [5] within a reasonable distance.
2. The test must be scheduled and performed within five [5] business days of the request. If the network asks the carrier to approve the test, it must still be performed within five [5] business days of the request from claimant's doctor
3. The claimant may select *any* network provider to perform the test.
4. The claimant may discuss with his or her doctor which provider to choose.
5. The claimant should share this notice with all of his or her doctors.
6. The claimant does not have to use a network provider under these circumstances:
   a. The provider can't schedule the test within five [5] business days.
   b. The carrier has challenged (controverted) or will controvert the claim.
   c. In a medical emergency.
   d. For x-rays taken during an office visit and used for diagnosis and treatment of: fractures, possible fractures, joint dislocations, tumors, infections, loosening of surgical implants, dislocation of prosthetic joints, spinal instability, or follow-up to surgery.
7. If the carrier doesn't provide the required notice, the carrier must pay for tests outside of the network.
8. On written request, the network will provide the actual test film, data or digital images to the claimant's doctor These items will be sent to the claimant's doctor with the report or within three [3] business days of receipt of the written request. A doctor may order a second test from the network for the purpose of obtaining an accurate diagnosis as set forth in the Medical Treatment Guidelines if the quality of the test is inadequate.
9. The claimant is entitled to reimbursement for reasonable travel costs to and from the provider.

More information on diagnostic testing networks is available in Subject Number 046-480, located on the Board's website under Board Bulletins and Subject Numbers.

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EIG Services, Inc.
In California, dba
EIG Insurance Services

EMPLOYER'S REQUEST FOR REIMBURSEMENT

CLAIMANT: _____ NYSIF Claim No: _____

EMPLOYER: _____ WCB No: _____

EMPLOYER ADDRESS: _____ Date of Accident: _____

To the Workers' Compensation Board:

The undersigned employer hereby requests FULL REIMBURSEMENT, in accordance with the Workers' Compensation Law, for wages advanced during a period of absence due to disability.

The total amount advanced was _____ dollars and _____ cents (total: $_____)

for the period from _____ through _____.

Employer's representative: (Print Name) _____

(Title) _____

Employer's signature: _____ Date: _____

INSTRUCTIONS

1. This form is used principally as evidence of a claim for reimbursement by an employer for monies advanced to a claimant on account of compensation due under the provisions of the Workers' Compensation Law.
2. Attention is drawn specifically to Section 25 of the Workers' Compensation Law, from which the following is extracted: "...If the employer has made advance payments of compensation, or has made payments to an employee in like manner as wages during any period of disability, he shall be entitled to be reimbursed out of an unpaid installment or installments of compensation due, provided his claim for reimbursement is filed before award of compensation is made, or, if insured, by the insurance carrier at the direction of the board, unless he shall file a waiver of reimbursement with the chairman, in which event compensation will be paid to the claimant notwithstanding the advance payments..."
3. It is recommended that, while payments are being advanced, this form be completed monthly **and mailed to the Workers' Compensation Board at the address below.** A copy of this form should be sent to EMPLOYERS.

New York State Workers' Compensation Board
Centralized Mailing - PO Box 5205
Binghamton, NY 13902-5205

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

NOTE TO EMPLOYER:

Under current interpretations of Section 25 of the Workers' Compensation Law, in cases involving temporary disability, an employer may not recover more than the compensation benefit rate for the period during which compensation or wages were advanced, nor may there be any reimbursement for the first week if the disability does not exceed two (2) weeks.

One good reason to think twice about workers' compensation fraud

EMPLOYERS® actively investigates suspected workers' compensation fraud and reports such cases to law enforcement authorities.

fraud costs

Workers' compensation fraud costs $7.2 billion annually.[1]

Filing a fraudulent workers' compensation claim could lead to serious civil or criminal consequences, such as fines, incarceration and/or restitution.

If you suspect workers' compensation fraud, please contact EMPLOYERS' Fraud Investigations Department. Call the Fraud Hotline at 1-800-750-3939 or e-mail fraudfighters@employers.com.

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1 Source: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

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Una buena razón para pensarlo dos veces antes de cometer fraude en una demanda de indemnización laboral

EMPLOYERS® investiga de manera activa casos sospechosos de cometer fraude en una demanda de indemnización laboral y reporta dichos casos a las autoridades policiales.

costos del fraude

Fraude en demandas de indemnización laboral cuesta $7.2 mil millones al año.[1]

Presentar una demanda de indemnización laboral fraudulenta puede acarrear graves consecuencias civiles o penales, tales como multas, cárcel y/o indemnizaciones.

Si sospecha que existe fraude en una demanda de indemnización laboral, póngase en contacto con el Departamento de Investigación de Fraude de EMPLOYERS. Llame a la línea directa de fraude al 1-800-750-3939 o escriba al correo electrónico fraudfighters@employers.com.

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1 Fuente: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

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New York State Disability Benefits
STATEMENT OF RIGHTS

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

If you are unable to work due to a non-occupational illness or injury, you may be entitled to disability benefits.

1. You may be entitled to statutory disability benefits for a non-work-related injury or illness (including disability due to pregnancy) beginning with the eighth consecutive day of disability. Disability benefits are paid **directly to you** by your employer's insurer, **not** through your employer, unless your employer is an approved self-insurer. You can take up to 26 weeks of disability at 50% of your average weekly wage, capped at $170 per week. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting disability. Your employer or union may provide different benefits, at least as favorable as statutory, under an approved disability benefits plan or agreement.
2. If you also take Paid Family Leave, your combined total disability leave and Paid Family Leave in any consecutive 52-week period may not exceed 26 weeks. You cannot take Paid Family Leave and disability leave at the same time.
3. You can be treated by any physician, podiatrist, chiropractor, dentist, nurse midwife, or psychologist who can certify your disability. Your medical bills are not covered, unless your employer and/or union provides for the payment of medical bills under an approved disability benefits plan or agreement.
4. Your employer may **not** ask you to waive your right to disability benefits. Employers may collect a maximum contribution of 60 cents/week to offset the insurance premium (unless the additional contribution is part of an approved plan). **You cannot be discriminated or retaliated against for requesting or taking disability benefits.**
5. If your claim is denied, your employer or employer's insurer is required to send you a ***Notice of Rejection (Form DB-451)***, within 45 days of your claim filing, with the reason(s) benefits are not being paid. If you disagree, you have a right to request a review by the NYS Workers' Compensation Board (Board), which you can request by writing the Board at the bottom right address.

   IMPORTANT: If, within 45 days of filing your claim, you do not receive benefits and do not receive a ***Form DB-451***, promptly contact the Board at **(877) 632-4996**.

To file a claim:

1. Obtain a ***Notice and Proof of Claim for Disability Benefits (Form DB-450)***, either from the Board at **wcb.ny.gov**, or from your employer, your employer's insurer, or your health care provider.
2. Follow instructions to complete/submit the form, which includes a section your health care provider must complete.
3. Submit the form within 30 days of your first day of disability. If your claim is not paid promptly, contact your employer or their insurer. If you file late, you may not be paid for any disability period more than two weeks before the date you filed. Late filings may be excused if you can show it wasn't reasonably possible to file earlier. No benefits are payable if you file more than 26 weeks after your disability begins, or after you return to work.

Do not assume that your employer has filed a claim on your behalf: filing a claim is your responsibility.

Note: If your disability is the result of an automobile accident, and you have filed a claim for no-fault benefits, **you must** also file a ***Form DB-450*** for disability benefits. If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments.

IMPORTANT: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurer.

FOR HELP OBTAINING A CLAIM FORM OR FILLING IT OUT, OR OTHER QUESTIONS ABOUT BENEFITS FOR YOUR NON-WORK-RELATED INJURY OR ILLNESS, PLEASE CALL (877) 632-4996. A BOARD REPRESENTATIVE WILL HELP.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's disability benefits insurance carrier is:

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board
Disability Benefits Bureau
PO Box 9029, Endicott, NY 13761-9029

WCB.NY.GOV

DB-271S (10/22)