STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
Medical Director's Office
1-800-781-2362

NOTICE TO CHAIR
WORKERS' COMPENSATION BOARD
WITHDRAWAL OF REQUEST FOR ARBITRATION

PLEASE TYPE OR PRINT THIS FORM IN BLACK OR BLUE INK ONLY. See other instructions on reverse.

TYPE OF CARE: ☐ Medical ☐ Outpatient Hospital ☐ Inpatient Hospital ☐ Chiropractic ☐ Physical Therapy ☐ Occupational Therapy ☐ Psychology ☐ Podiatry ☐ Osteopathic

Name and Mailing Address of Health Provider *(MAXIMUM 30 CHARACTERS)*

Name				
Lines 1&2				
Address				
City		State	Zip Code	–

WCB Dispute Number:

Name and Billing Address of Health Provider *(MAXIMUM 30 CHARACTERS)*

Name				
Lines 1&2				
Address				
City		State	Zip Code	–

WCB Authorization Number

Carrier or Self-Insured Employer I.D. W

WCB Case Number

Carrier Case Number

Name and Mailing Address of Carrier *(MAXIMUM 30 CHARACTERS)*

Name				
Lines 1&2				
Address				
City		State	Zip Code	–

Claimant's Social Security Number - -

Date of Accident M M / D D / Y Y

Name of Claimant (First, Middle Initial, Last Name)

Name of Employer *(MAXIMUM 30 CHARACTERS)*

HAS THIS BILL(S) BEEN SCHEDULED FOR ARBITRATION PRIOR TO SUBMISSION OF THIS FORM? ☐ YES ☐ NO IF YES, GIVE DATE OF ARBITRATION:

Date Set For Hearing M M / D D / Y Y

LIST BELOW BILL(S) THAT ARE BEING WITHDRAWN:

	A				B	C	D (USE WCB CODE)		E	F	G	H	I
	Date of Service MM	DD	YY	Leave Blank	Leave Blank	Leave Blank	Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	Leave Blank	$ Charges	Leave Blank	Leave Blank	Dollar Amount Agreed To
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													

IS ARBITRATION NEEDED FOR OTHER BILLS LISTED ON HP-1 PREVIOUSLY SUBMITTED? ☐ YES ☐ NO

We herewith certify that any dispute(s) associated with the above bill(s) has been resolved.

Health Provider's Signature | Date | Telephone No.

Representative from Insurer | Representative's Title | Date | Telephone No.

FILING INSTRUCTIONS

THIS ORIGINAL FORM SHOULD BE FILED IMMEDIATELY, BY THE INSURER, OR HEALTH PROVIDER, WITH THE:

WORKERS' COMPENSATION BOARD
Medical Director's Office
Riverview Center
150 Broadway - Suite 195
Menands, NY 12204

WHEN THE FOLLOWING CONDITIONS EXIST:

1. BY THE INSURER

- THE INSURER AND HEALTH PROVIDER HAVE RESOLVED PAYMENT DISPUTE(S) RELATED TO THE VALUE OF THE MEDICAL AID RENDERED BY THE PROVIDER; AND

- THE BILL(S) RELATED TO THE RESOLVED DISPUTE(S) WERE PREVIOUSLY SUBMITTED TO THE DISPUTED BILL UNIT, ALBANY FOR ARBITRATION; AND

- THE INSURER AND HEALTH PROVIDER HAVE AFFIRMED THEIR AGREEMENT TO THE WITHDRAWAL OF THESE BILL(S) FROM ARBITRATION BY SIGNING IN THE APPROPRIATE AREA ON THE FRONT OF THIS FORM.

OR

2. BY THE HEALTH PROVIDER

- THE HEALTH PROVIDER ON HIS/HER OWN VOLUNTARILY AGREES TO WITHDRAW THE BILL(S) FROM ARBITRATION BY SIGNING IN THE APPROPRIATE AREA ON THE FRONT OF THIS FORM.