STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

Disputed Medical Bills Unit

1-800-781-2362

PROVIDER'S REQUEST FOR JUDGMENT OF AWARD
SECTION 54-b, Enforcement on Failure to Pay Award or Judgment

Upon issuance of an administrative award and/or arbitration decision you must wait at least 30 days before requesting consent for judgment. To avoid the complications of filing unnecessary requests, waiting 60 days is recommended. The 60 day time period will allow for the insurer's billing/payment cycles.

This form may be used by an authorized workers' compensation provider whenever an insurer has not paid for an award or decision (for awards/decisions made on or after March 13, 2007). Section 54-b of Workers' Compensation Law provides that in the event an insurance carrier or self-insured employer defaults in the payment of an award made by the Board, any party to an award may, with the Chair's consent (or the consent of the Chair's designee), file with the County Clerk for the county in which the injury occurred or the county in which the insurer has its principal place of business, a certified copy of the decision that awarded compensation.

Request for Consent and Certified Copy of Unpaid Award or Decision for Medical Care

I request consent for judgment and a certified copy of the unpaid award or decision for WCB dispute number(s):

ATTACH A COPY OF THE ORIGINAL AWARD(S)

Name and Address of Health Care Provider

Name 1					
Name 2					
Address					
City		State		Zip Code	

Name and Address of Insurer

Name 1					
Name 2					
Address					
City		State		Zip Code	

WCB Case Number	WCB Authorization Number
Date of Injury or Illness	**Claim Admin Claim Number**
Insurer ID W#	**County in Which Injury Occurred**

Employer: ____________________

Affirmation of Non-Payment

PHYSICIANS COMPLETE THE FOLLOWING:

I affirm, under the penalties of perjury under the laws of New York, which may include a fine or imprisonment, that I am a physician, authorized by law to practice in the State of New York, am not a party to this proceeding, am the physician not remunerated for the above award(s) or decision(s), have read and know the contents thereof; that the same is true to my knowledge, except as to the matters stated to be on information and belief, and as to those matters I believe it to be true. I understand that this document may be filed in an action or proceeding in a court of law.

Written Signature (Facsimile not Accepted) ____________________ Date ____________________

ALL OTHERS COMPLETE THE FOLLOWING:

I affirm, under the penalties of perjury under the laws of New York, which may include a fine or imprisonment, that I am an acupuncturist, audiologist, chiropractor, dentist, nurse practitioner, optometrist, pharmacist, physician assistant, physical or occupational therapist, podiatrist, or psychologist, or a representative for a durable medical equipment company or laboratory, authorized by law to practice in the State of New York and/or authorized to represent a hospital, am not a party to this proceeding, am the provider or representative of a hospital not remunerated for the above award(s) or decision(s), have read and know the contents thereof; that the same is true to my knowledge, except as to the matters stated to be on information and belief, and as to those matters I believe it to be true. I understand that this document may be filed in an action or proceeding in a court of law.

Written Signature (Facsimile not Accepted) ____________________ Date ____________________

Mail completed form to: Workers' Compensation Board
Disputed Medical Bills Unit
PO Box 5205
Binghamton, NY 13902-5205