MG-1.1

CONTINUATION TO FORM MG-1, ATTENDING DOCTOR'S REQUEST FOR OPTIONAL PRIOR APPROVAL

Doctor's Name	WCB Case Number	Carrier Case Number	Date of Accident

Patient	Patient's Social Security Number	Doctor's WCB Authorization Number

INSTRUCTIONS TO ATTENDING DOCTOR: **This form is not to be filed separately**. Attach to completed Form MG-1 if requesting optional prior approval for additional treatment(s) or procedure(s) in the same case.

A. *The undersigned requests additional optional approval under the WCB Medical Treatment Guidelines as indicated below:*

		CARRIER'S/EMPLOYER'S RESPONSE *(Carrier/employer must complete certification on reverse of this form.)*
2.	Treatment/Procedure Requested:..... Guideline Reference: ☐ - ☐ ☐ ☐ ☐ *(In first box, indicate body part: K=**K**nee, S=**S**houlder, B=Mid and Low **B**ack, **N**=Neck In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)* Date of Supporting Medical in WCB Case File:..... (please attach if not in file) Comments:.....	❑ Granted ❑ Granted without Prejudice ❑ Denied
3.	Treatment/Procedure Requested:..... Guideline Reference: ☐ - ☐ ☐ ☐ ☐ *(In first box, indicate body part: K=**K**nee, S=**S**houlder, B=Low and Mid **B**ack, N=**N**eck In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)* Date of Supporting Medical in WCB Case File:..... (please attach if not in file) Comments:.....	❑ Granted ❑ Granted without Prejudice ❑ Denied
4.	Treatment/Procedure Requested:..... Guideline Reference: ☐ - ☐ ☐ ☐ ☐ *(In first box, indicate body part: K=**K**nee, S=**S**houlder, L=Low and Mid Back, N=**N**eck In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)* Date of Supporting Medical in WCB Case File:..... (please attach if not in file) Comments:.....	❑ Granted ❑ Granted without Prejudice ❑ Denied
5.	Treatment/Procedure Requested:..... Guideline Reference: ☐ - ☐ ☐ ☐ ☐ *(In first box, indicate body part: K=**K**nee, S=**S**houlder, L=Low and Mid Back, **N**=Neck In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines.)* Date of Supporting Medical in WCB Case File:..... (please attach if not in file) Comments:.....	❑ Granted ❑ Granted without Prejudice ❑ Denied

I certify that I am making the above request(s) for optional prior approval and my affirmative statements are true and correct. I ❑did / ❑did not contact the carrier by telephone to discuss this request(s) before making it. I contacted the carrier by telephone on (date)_____ and spoke to (person spoke to or was not able to speak to anyone) _____.

❑ A copy of this form was sent to the self-insured employer/carrier/Special Fund by (fax, email) _____, a copy was sent (see addresses and fax number on Form MG-1) to the Workers' Compensation Board, and copies were provided to the claimant's legal counsel, if any, and to any other parties of interest on the date below.

❑ I am not equipped to send or receive forms by fax or email. This form was mailed to the parties indicated above on .....

Provider's Signature: ..... Date: .....

B. CARRIER'S /EMPLOYER'S RESPONSE (Response is due in 8 business days from receipt of this request or medical care is deemed approved (12 NYCRR 324.4(c)). IF ANY REQUESTS ARE DENIED, GIVE REASON(S) IN THE SPACE PROVIDED BELOW. Identify reasons according to Request No. 2-5 on the front of this form.

Name of the medical professional who reviewed the denial(s):_____

I certify that copies of this form were sent to the Treating Medical Provider requesting optional prior approval, the Workers' Compensation Board (see mailing and email addresses and fax number on Form MG-1), the claimant's legal counsel, if any, and any other parties of interest, on the date below.

By:..... Title:.....

Signature:..... Date:.....

C. MEDICAL PROVIDER'S REQUEST FOR BOARD REVIEW OF DENIAL

❑ I hereby request review by a medical arbitrator designated by the Chair of the carrier's decision to deny optional prior approval of the request(s) checked below. I understand that resolution by the medical arbitrator is binding and is not appealable under Workers' Compensation Law Section 23. (Request is due within 14 calendar days of the date of denial.) Supporting medical report(s) dated _____ is/are attached or is/are available in the WCB case file.

❑ Request No. 2 ❑ Request No. 3 ❑ Request No. 4 ❑ Request No. 5

Provider's Signature ..... Date:.....

D. CARRIER / EMPLOYER IS APPROVING ADDITIONAL REQUEST(S) FOR OPTIONAL PRIOR APPROVAL AFTER AN INITIAL DENIAL

❑ I certify that the provider's request for optional prior approval given above, **which was initially denied on**....., is now granted for the following request(s):

❑ Request No. 2 ❑ Request No. 3 ❑ Request No. 4 ❑ Request No. 5

By:..... Title:.....

Signature:..... Date:.....