New York State Workers' Compensation Board Health Insurance Matching Program

Part I – Health Insurer's/Health Benefit Plan's Request for Reimbursement

Claimant's Name		WCB Case Number	Claimant's Social Security Number	Date of Accident
Employer's Name		WC Carrier Case Number	WC Carrier Code	Reimbursement Amount Requested
Date Payment Made	Date Request for Reimbursement Filed (if previously filed for this case)	Health Insurer's Claim ID Number	Date of Full or Partial Match (if applicable)	Was ANCR Established ☐ Yes ☐ No
Name and Address of WC Insurance Carrier/Employer/Special Fund			WCB District Office (Where claim was determined or pending)	Status of Case ☐ Open ☐ Closed
Name and Address of Health Insurer/Health Benefit Plan			Health Insurer's Federal Tax ID No.	Health Insurer's Telephone Number
Health Insurer's Email Contact			HIMP Agent's Email Contact (if applicable)	
Name/Address of HIMP Agent (if applicable)			HIMP Agent's Telephone Number (if applicable)	**INSTRUCTIONS ON REVERSE**

The undersigned Health Insurer/Health Benefits Plan as defined by WCL § 13(d) or HIMP Agent as defined in 12 NYCRR § 325-5.2 hereby requests reimbursement from the carrier for health benefits paid in the workers' compensation case indicated above. A copy of this notice was mailed to the carrier on the date indicated below and proof of service is attached.

Printed Name _____ Signature _____ Title _____ Date Form Mailed _____

Part II – WC Insurance Carrier's/Employer's/Special Funds' Objection to Reimbursement

The carrier named above objects to this reimbursement request ☐ in whole ☐ in part (explain below) for the following reason(s): **Documentation and detailed explanation supporting your objection(s) must be attached. Undisputed amount must be paid.**

1. ☐ The compensability of the claim has not been established, or case was closed without finding of accident, notice & causal relationship, or compensability is issue on appeal.
2. ☐ The request for reimbursement has not been timely served in accordance with 12 NYCRR § 325-6.2 or § 325-6.3(b).
3. ☐ Treatment was on behalf of a person other than the claimant, or for a condition or injury unrelated to the WC claim.
4. ☐ Treatment was not furnished on an emergency basis, and was obtained after authorization was sought and denied by the Board in a hearing, and such determination about authorization was not appealed.
5. ☐ The fee was in excess of the WC fee schedule or the inpatient hospital services rate or the proper rate could not be determined.
   Explanation required: _____
   Proper Amount: _____
6. ☐ The bill should have been pro-rated with another physician or health care provider.
7. ☐ The carrier cannot determine from the documentation served whether it is responsible for payment.
   Explanation required: _____
8. ☐ The carrier has previously reimbursed the health insurer or paid the health care provider with respect to the claim. Proof of payment must be submitted.
9. ☐ The treatment was provided on or after the date that the Board approved a waiver on the part of the claimant for medical treatment pursuant to WCL § 32.
10. ☐ The carrier would not be obligated to pay for the treatment because the claimant recovered proceeds from a third party and the lien has not been extinguished.
11. ☐ The treatment provided by a Board authorized provider was not consistent with the applicable Medical Treatment Guidelines (MTG) contained in 12 NYCRR 324.2(a).
    Specify MTG, section, and page number: _____
12. ☐ Other: _____

A copy of this notice was mailed to the health insurer/health benefit plan/HIMP Agent on the date indicated (proof of service attached). All further correspondence must be delivered, faxed, emailed or mailed to the individual named below:

Printed Name _____ Signature _____ Title _____ Date Form Mailed _____

Address (if different from Part I) _____ Email _____ Telephone Number _____ Fax Number _____

Part III – Request for Arbitration **AAA Case No.:** _____

☐ No objection has been mailed or payment made within 90 days after the date of mailing of the Request for Reimbursement Form.
☐ The undersigned requests impartial examination of the bill(s) to which the workers' compensation carrier objected in Part II above.

Arbitration is requested on ☐ All bills/issues ☐ The following bills/issues only: _____

The undersigned requests (check one): ☐ desk arbitration ☐ oral hearing

Enclosed is arbitration fee of $ _____ (See reverse for filing fee information). Designated locale for oral hearing: _____

Copies of this notice and attached documents were mailed to the above-named carrier or (if objection has been timely received) to the individual named in Part I and proof of service is attached.

Printed Name _____ Signature _____ Title _____ Date Form Mailed _____

Telephone Number _____ Email _____ Fax Number _____

Name of Representative _____ Address of Representative _____ Telephone Number _____ Email _____

HIMP-1 (7-18)

INSTRUCTIONS

Requests for reimbursement by a health insurer or health benefits plan ("Plan") for payments made to health care providers on behalf of injured workers entitled to workers' compensation benefits, and requests for arbitration of disputed requests for reimbursement, shall be submitted and processed in accordance with the provisions of Subpart 325-6 of Title 12 NYCRR. All parties to whom these rules are applicable should thoroughly familiarize themselves with the rules, as the instructions herein are intended as a procedural guide and are not to be construed as a comprehensive interpretation of the requirements.

To All Plans: Requests for reimbursement must be submitted to an employer, workers' compensation carrier or special fund ("carrier") on this form, completed with such information as required on Part I of this form, together with the documentation specified in § 325-6.3(c).

A Plan must send requests for arbitration within 90 days after the date on which a carrier has served a notice of objection on the HIMP-1 form. If the carrier has not made payment or has not served a notice of objection, the Plan must send requests for arbitration within 90 days from the expiration of the period within which an objection or payment was required to be made but no earlier than 95 days from the date which the HIMP-1 form requesting reimbursement was initially sent to the carrier. The parties may mutually agree to extend the period in which the carrier must reply. If the Plan fails to submit its request for arbitration within the prescribed period, it shall be deemed to have waived its right to arbitration, except as otherwise provided in § 325-6.

The Plan shall initiate the request for arbitration by serving two copies of the completed HIMP-1 form requesting arbitration and supporting documents, proof of service of the request for arbitration upon the carrier, and the prescribed filing fee to:

American Arbitration Association
Attention: HIMP Unit
32 Old Slip
New York, NY 10005

If the carrier has failed to serve a timely objection to a request for reimbursement, the Plan shall indicate on the form that no objection has been received. If the Plan requests an oral hearing, the request must be made together with the service of its request for arbitration.

To All Carriers: A carrier objecting to a request for reimbursement must complete Part II and serve such notice of objection together with supporting documentation and explanation to the Plan within 90 days after the form was served. If a carrier does not object or objects only in part, the undisputed amount must be paid to the Plan within such 90 days. The carrier may interpose objections to the request for reimbursement which are specifically set forth in § 325-6.4(b) and Part II of this form, and any objection which is not specifically prohibited by § 325-6.4(d). If the carrier fails to make payment or send timely notice of objections, it will be deemed to have waived all objections, except as provided in § 325-6.11.

If the carrier is the party requesting an oral hearing, it must make such request within 14 days after receipt of its copy of the request for arbitration. Such request must be made in writing to the AAA, and a copy of such request must be simultaneously served on the Plan.

Arbitrations: All hearings shall be desk arbitrations based on documents alone, and the filing fee for all desk arbitrations is $175 per request. If either party requests an oral hearing, the filing fee for the oral hearing is $475, of which $250 shall be paid to the arbitrator. The party requesting the oral hearing shall pay an additional sum of $250 as the arbitrator's fee for any additional day of oral hearing. In the event the request for oral hearing is withdrawn prior to the commencement of the oral hearing, the sum of $250 representing the arbitrator's fee shall be refunded to the party requesting such hearing.

The AAA shall set the location, date and time of oral hearing and shall notify the parties no less than 14 days in advance of such oral hearing. The AAA may utilize video conferencing or such other technology to enable the parties to participate in the oral hearing from separate locations.

The conduct of all desk arbitrations and oral hearings shall be under the auspices of the AAA, and shall be governed by § 325-6 and the AAA's internal rules of procedure, to the extent that such rules are not inconsistent with § 325-6. Enforcement and collection of awards, and allocation of fees, shall be made as set forth in § 325-6.12 and 325-6.13.