NEW YORK STATE Workers' Compensation Board

REQUEST FOR FURTHER ACTION BY LEGAL COUNSEL
RFA-1LC

CASE INFORMATION

WCB Case ID	Date of Injury	Claim Admin Claim #
55555555	01/01/2020	555

Claimant Name Fake, Case

Claimant Counsel Name Jane Testing **Representative ID** [redacted]

Employer Name NYS WCB Fake Case Primary Employer

Insurer Name WCB Test Insurer Attn: Michael [redacted] **Insurer ID** [redacted]

Claim Admin Name WCB Test Insurer Attn: Michael [redacted] **Claim Admin ID** [redacted]

RFA-1LC SUMMARY

Summary of selected request reason(s):

1. Prior Authorization Request (PAR) was denied or granted in part by the Insurer

Additional proposed findings:

1. Establish case (ANCR/ODNCR) as accepted on a First Report of Injury (FROI)

RFA–1LC REQUEST DETAILS

1. Prior Authorization Request (PAR) was denied or granted in part by the Insurer

PAR ID	Form ID	Medical Provider Name	Document ID	Received Date
PA-00-0285-[redacted]	MG1-CD	TestOOSProvider, WCB	[redacted]	[redacted]

ADDITIONAL PROPOSED FINDINGS

1. Establish case (ANCR/ODNCR) as accepted on a First Report of Injury (FROI)

Injury Location	Toe(s)/Finger(s)	Body Part(s)/Condition(s)
		Neck
		Vertebrae
Bilateral	Index	Fingers other than thumb

SUPPORTING DOCUMENTATION

Uploaded Document(s):

Type	File Name	Description	Medical Provider Name	Date of Service
Correspondence	Test document for RFA upload.pdf	sample upload		

CERTIFICATION

The following request(s) require certification:

1. *Additional Proposed Findings: Establish case (ANCR/ODNCR) as accepted on a First Report of Injury (FROI)*

I certify that I have discussed the reason(s) selected with the opposing party(ies) or its representative(s) and no settlement could be reached.

CERTIFICATION

First Name	Last Name	Organization Name	Date
John	Tester	ABC LLC	10/30/2024

ATTESTATION

I affirm that:

(1) my statements are true and correct, and

(2) I am authorized to submit this request, and

(3) this request for Board action is based upon reasonable grounds, has been submitted with my client's consent, and that this form with attachment(s) has been provided to the opposing party(ies), and

(4) I accept that the electronic submission of this form to the Workers' Compensation Board is equivalent to placing my signature on the request.

Claimant Counsel Name: Jane Testing **Date:** 11/01/2024

Phone Number: 5184570000 **Ext.:** 2

Test document for RFA upload.