

**NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF  
FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF  
AGREEMENT PURSUANT TO WCL §32 IS APPROVED**

WCB CASE NO. (If Known)		CLAIM ADMIN CLAIM NUMBER (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	CLAIMANT'S SOC. SEC. NO.
CLAIMANT	NAME			ADDRESS	APT. NO.
EMPLOYER					
INSURANCE CARRIER					

You may become responsible for the medical costs of treatment for your illness or condition with the health care provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation insurer/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Name and Address \_\_\_\_\_

**TO THE CLAIMANT**

Workers' Compensation Board Regulation 325-1.23 permits your health care provider to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or insurer may not be required to pay the provider's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of their bills.

**Workers' Compensation Law Section 32**

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with their employer or its insurance carrier settling their case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or insurer of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of their bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

**TO THE HEALTH CARE PROVIDER**

This notice is meant to advise the workers' compensation claimant that they may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the insurer of liability for medical treatment is approved.

# WORKER'S COMPENSATION

(On -the-Job Injury)

Name and address of Compensation Carrier: \_\_\_\_\_

STREET

CITY

ZIP

Employer's Name & Address \_\_\_\_\_

Type of Business \_\_\_\_\_ Your Occupation \_\_\_\_\_

Date injured \_\_\_\_\_ Hour \_\_\_\_\_ AM / PM Last Date Worked \_\_\_\_\_

Are you off work? \_\_\_\_\_ Other Doctors seen for this injury \_\_\_\_\_

Accident reported to employer \_\_\_\_\_ Name of person you reported accident to \_\_\_\_\_

Injured at: \_\_\_\_\_  
ADDRESS

Give a description of the accident \_\_\_\_\_

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## GROUP INSURANCE

Name of Employer (company name) \_\_\_\_\_

Address \_\_\_\_\_  
CITY ZIP

Name of the insured (unless "self") \_\_\_\_\_

If BLUE CROSS:

Certificate # \_\_\_\_\_ Group # \_\_\_\_\_ Coverage Code \_\_\_\_\_

Will you also be submitting this claim to another insurance company?  
(i.e., spouse's insurance company, etc.) \_\_\_\_\_

If so, give name of:

Insured \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

Additional Insurance \_\_\_\_\_  
NAME

ADDRESS

Additional Insurance \_\_\_\_\_  
NAME

ADDRESS

Additional Remarks: \_\_\_\_\_