STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC(800)877-1373/Hemp(866)805-3630/Haup(866)681-5354/Peek(866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157
State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604
Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645
130 Main Street W. ROCHESTER 14614 (866) 211-0644
935 James Street SYRACUSE 13203 (866) 802-3730

CARRIER'S/SELF-INSURED EMPLOYER'S OBJECTION TO ATTENDING DOCTOR'S REQUEST FOR MEDICAL AUTHORIZATION DETERMINATION

WCB Case Number	Carrier Case Number	Carrier Code	Date of Injury	Social Security Number

Name	Address
Claimant	
Employer	
Carrier	
Representative, If Any	
Medical Provider Requesting Authorization on Form MD-1	

Insurance Carrier/Self-Insured Employer making objection: _____

Date Form MD-1 Mailed: _____

Basis for Objection: _____

_____

_____

_____

_____

_____

_____

Signature _____ Tel. No.: _____ Date:_____

Signer's Name and Title (Please Print):_____

TO THE SIGNER: The original should be sent directly to the appropriate Board address, as shown at the top of this form. A copy of this objection must be sent to all parties in interest and the medical provider who requested authorization. Complete the Affidavit or Affirmation of Service on the reverse side of this form.

AFFIRMATION OF SERVICE
STATE OF NEW YORK, COUNTY OF _____ ss:

I, the undersigned, am an attorney admitted to practice in the courts of New York State, and on _____, I served a
date
true copy of this form and attachments in the following manner (check one):

Service by Mail ☐ By mailing the same in a sealed envelope, with postage prepaid thereon, in a post-office or official depository of the U.S. Postal Service within the State of New York, addressed to the last known address of the addressee(s) as indicated below:

Personal Service ☐ By delivering the same personally to the persons and at the addresses indicated below:

I affirm that the foregoing statements are true under penalties of perjury.

_____
Signature

Dated: _____ _____
Signer's Name (Please Print)

AFFIDAVIT OF SERVICE
STATE OF NEW YORK, COUNTY OF _____ ss:

_____ being sworn says: I am over 18 years of age and on

_____, I served a true copy of this form and attachments in the following manner (check one):
date

Service by Mail ☐ By mailing the same in a sealed envelope, with postage prepaid thereon, in a post-office or official depository of the U.S. Postal Service within the State of New York, addressed to the last known address of the addressee(s) as indicated below:

Personal Service ☐ By delivering the same personally to the persons and at the addresses indicated below:

Sworn to before me on _____. _____
Date Signature

_____ _____
Notary Public Signer's Name (Please Print