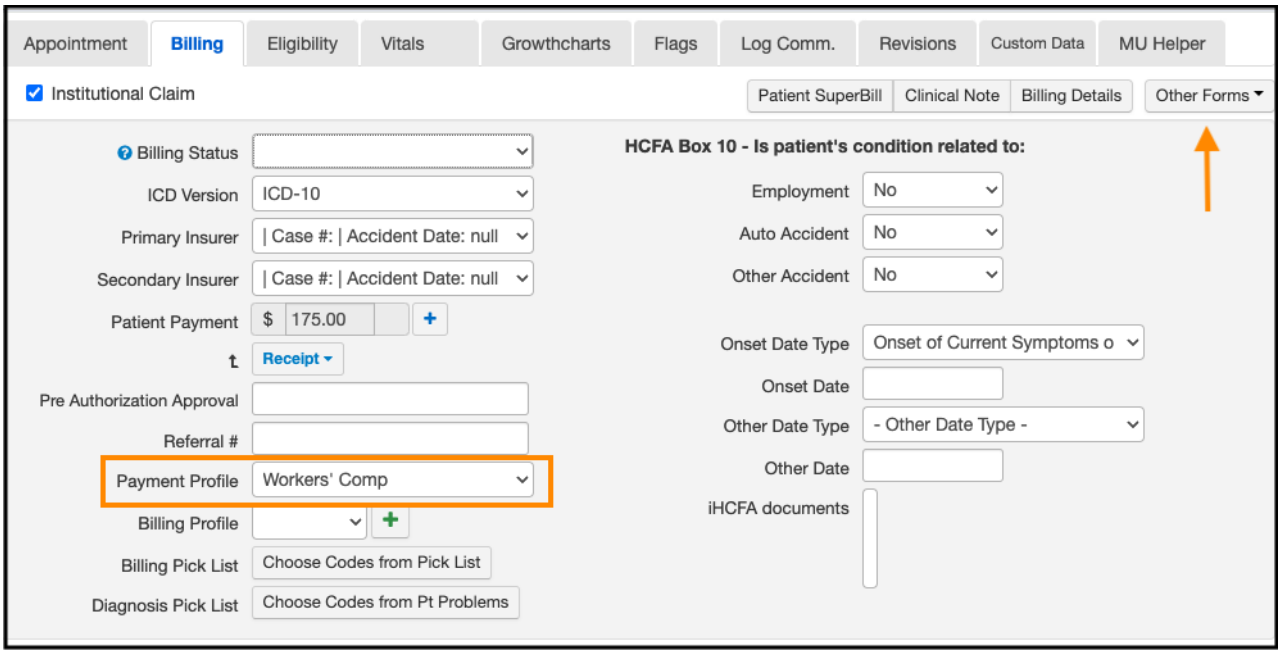
New York Form C4.3 - Doctor's Report of MMI/Permanent Impairment

Last modified on 09/28/2026 1:45 pm EDT

For workers' claims in New York that result in the permanent impairment of a patient, the C4.3 form, or *Doctor's Report of MMI/Permanent Impairment* form, is required. This form is built into your DrChrono account and is easily accessible through the patient's appointment.

1. Navigate to the patient's appointment
2. Make sure the payment profile is set to Workers' Comp. Also, ensure all fields are filled in under the Workers' Comp section under the patient's insurance.
3. Select **Other Forms** on the right side of the screen



Here you can select and print a couple of related forms.

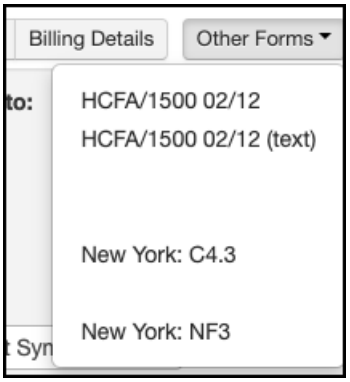
HCFA/1500 - This is a regular 1500 form that will print on plain white 8.5" X 11" paper

HCFA/1500 (text) - This will print just the text. Select this option if you have the red pre-printed HCFA paper in your printer.

New York: C4.3 - Doctor's Report of MMI/Permanent Impairment

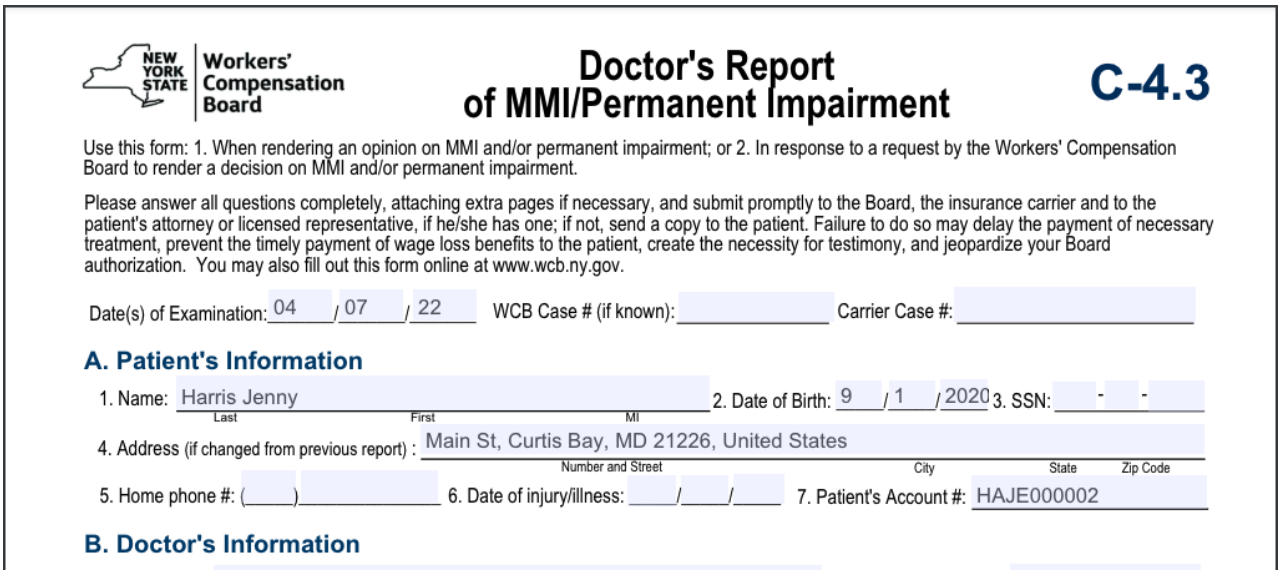
New York: NF3 - New York Motor Vehicle No-Fault Insurance Law Verification of Treatment by Attending

Physician or Other Provider of Health Service



Doctor's Report of MMI/Permanent Impairment

When you select the C4.3 form from the dropdown, many fields will pre-populate if the information is listed in the patient's Workers' Compensation insurance section. If it is not, or you need to update the information shown, you can click into the box and it will let you free text.



NEW YORK STATE | Workers' Compensation Board

Doctor's Report of MMI/Permanent Impairment **C-4.3**

Use this form: 1. When rendering an opinion on MMI and/or permanent impairment; or 2. In response to a request by the Workers' Compensation Board to render a decision on MMI and/or permanent impairment.

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the patient, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 04 / 07 / 22 WCB Case # (if known): Carrier Case #:

A. Patient's Information

1. Name: Harris Jenny (Last, First, MI) 2. Date of Birth: 9 / 1 / 2020 3. SSN: - -

4. Address (if changed from previous report) : Main St, Curtis Bay, MD 21226, United States (Number and Street, City, State, Zip Code)

5. Home phone #: ( ) 6. Date of injury/illness: / / 7. Patient's Account #: HAJE000002

B. Doctor's Information

All patient data listed in this article is sample data. This is not a real person or real patient data.

Source: https://www.dfs.ny.gov/apps_and_licensing/property_insurers/nofault