# Injury Reporting Kit

## XENIA SCHOOLS

compmanagement
health systems

**CompManagement Health Systems**

**Workers' Compensation Identification Card**

1 (888) 247-7799 Customer Service
1 (888) 247-4800 Injury Report Number

State Insured Employer
**XENIA SCHOOLS**
**32905551-0**

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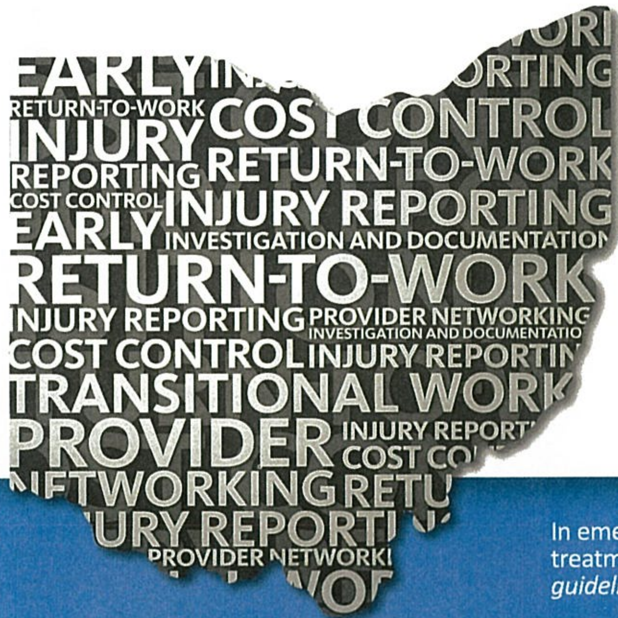
Prescription questions: contact the Pharmacy Benefits Manager at 1 (800) 644-6292 press 0, select option 3, then select option 2.

# steps to take
## when a workplace injury occurs




## Injured employee

1. Immediately report the injury to your supervisor
2. Complete the BWC First Report of Injury form
3. Seek medical treatment
4. Take your ID card to all appointments
5. Let your supervisor know that you have received medical treatment for your work-related injury

## Employer

1. Complete the Employment section of the BWC First Report of Injury form
2. Fax the completed form to CHS toll-free at 800.334.4229
3. Stay in touch with the injured worker while they are off work

In emergency cases, injured workers should immediately notify their employer and seek treatment at the nearest medical facility. *According to Health Partnership Program (HPP) guidelines, injured workers may seek treatment from any BWC-certified medical provider.*

888.247.7799 | www.**chsmco**.com

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# key contact information

## Medical management

FAX medical information:
800.334.4229

MAIL medical information:
CHS
PO Box 1040
Dublin, OH 43017

Prior authorization:
Fax C-9 form to 800.334.4229

## Medical bill payment

MAIL medical bills:
CHS
PO Box 1040
Dublin, OH 43017

Billing questions:
Call CHS Customer Service toll-free at 888.247.7799

## Other

Prescriptions:
For questions regarding prescriptions, contact Catamaran at 877.615.6330

Provider search:
Visit www.chsmco.com for provider searches

PO Box 1040, Dublin, OH 43017 | 7731 E. Kemper Road, Cincinnati, OH 45249
5700 Lombardo Center Drive, Ste 150, Seven Hills, OH 44131 | 3130 Executive Pkwy, Ste 2F, Toledo, OH 43606

888.247.7799 | www.**chsmco**.com

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Bureau of Workers' Compensation

# First Report of an Injury, Occupational Disease or Death

**By signing this form, I:**

- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 2913.48)

## Injured worker and injury/disease/death info.

Last name, first name, middle initial

Social Security number

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of birth

Home mailing address

Sex ☐ Male ☐ Female

Number of dependents

City | State | 9-digit ZIP code

Country if different from USA

Department name

Wage rate $ ________ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other ______

What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat

Regular work hours From ______ To ______

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.

Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease | Time of injury ______ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work ______ ☐ a.m. ☐ p.m. | Date last worked | Date returned to work

Date hired | State where hired | Date employer notified | State where supervised

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)

Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

**Benefit application release of information** – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature | Date | E-mail address | Telephone number | Work number ( )

## Treatment info.

Health-care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date

Street address | City | State | 9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No

Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code | 11-digit BWC provider number | Date

Health-care provider signature

## Employer info.

Employer policy number

Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No

Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

**For self-insuring employers only**
☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title | Date | OSHA case number

Bureau of Workers' Compensation

# Physician's Report of Work Ability

| Injured worker name | | | Claim number |
|---|---|---|---|
| Date of injury | Date of last appointment/examination | Date of this appointment/examination | Date of next appointment/examination |

**MEDCO-14 submission** (Select one of the options below.)

**1**
- ☐ I have never completed a MEDCO-14. Proceed to section 2.
- ☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
- ☐ I have previously completed a MEDCO-14, and I am providing updates to each section checked.

**Employment/Occupation** Complete this section and proceed to section 3 (Updates Yes ☐ No ☐)

**2** Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
**If yes** - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

**Work status/Injured worker's capabilities** (Updates Yes ☐ No ☐)

**3A** Does the injured worker have any work restrictions related to allowed conditions in the claim? Yes ☐ No ☐
**If yes,** proceed to section 3B.
If no restrictions, please indicate release to work date ____/____/____. ***Proceed to and complete sections 6 and 8.***

**3B** If there are work restrictions, can the injured worker return to his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐

**If yes,** please indicate release to work date: ____/____/____. ***Proceed to sections 3C, 5, 6, and 8.***

**If no,** please indicate when the injured worker initially could not do the job held on the date of injury. Date:____/____/____.

Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty. Date:____/____/____.

**Proceed to section 3C.**

**3C** **Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is "no".)**

The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker's dominant hand is: ☐ Left ☐ Right

The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both If the injured worker is taking prescribed medications for the allowed conditions in this claim, is the injured worker able to safely:

*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

| Please indicate the following: N=Never, O=Occasionally, F=Frequently, C=Continuously | | | | | | | | | | Lifting/carrying | N | O | F | C | Pushing/pulling | N | O | F | C |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity | N | O | F | C | Activity | N | O | F | C | 0 - 10 lbs. | | | | | 0 to 25 lbs. | | | | |
| Bend | | | | | Reach above shoulder | | | | | 11 - 20 lbs. | | | | | 26 to 40 lbs. | | | | |
| Squat/kneel | | | | | Type/keyboard | | | | | 21 - 40 lbs. | | | | | 41 to 60 lbs. | | | | |
| Twist/turn | | | | | Work with cold substances | | | | | 41 - 60 lbs. | | | | | 61 to 100 lbs. | | | | |
| Climb | | | | | Work with hot substances | | | | | 61 - 100 lbs. | | | | | 100 + lbs. | | | | |

In an eight-hour workday, how many total hours is the injured worker able to:

Sit: ____ hours ☐ Continuously ☐ With break Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break

In the space below please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. ______________________________

**Proceed to section 4.**

| Injured worker name | Claim number | Date of injury |
|---|---|---|
| | | |

## Disability period information (If 3B above is NO you must address all fields, including site/location if applicable) (Updates Yes ☐ No ☐)

**4A** Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

| Narrative description of the work-related allowed condition | Site/location if applicable | ICD code | Is the condition preventing full duty release to the job injured worker held on the date of injury? |
|---|---|---|---|
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |
| | | | Yes ☐ No ☐ |

**4B** List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

## Clinical findings: Office notes can be referenced in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

**5** The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected

Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

## Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

**6** MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? Yes ☐ No ☐

If yes, give MMI date: ______/______/______. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

## Vocational rehabilitation (Updates Yes ☐ No ☐)

**7** Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?

Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

## Treating physician signature - mandatory

**8** I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

| Treating physician's name (please print legibly) | | Address, city, state, nine-digit ZIP code, telephone and fax numbers |
|---|---|---|
| Treating physician's signature | | |
| BWC provider (Peach) number | Date | |