**IN THE EVENT OF AN EMERGENCY PROCEED TO THE NEAREST HOSPITAL OR CALL 911**

In the packet you will find the following:

Accident Reporting Procedures Form – Please read this form carefully. It contains information on reporting procedures and locating a provider. NOTE: If you have indicated that you have not sought medical attention on your incident report and are now seeking medical attention you must notify Jeanne Ralston in the Treasurer's Office at jeanneralston@foresthills.edu or 231-3600 x 2998 in order for the claim to be processed appropriately.

Workers' Compensation ID Card – The employee must present this to all providers servicing the claim. The Forest Hills School District is self-insured. Claims will be processed by Sedgwick CMS, not the Bureau of Workers' Compensation.

MEDCO-14 (Physician's Report of Work Ability) – The physician must complete this form at the time of service. The completed form must be e-mailed or faxed to Jeanne Ralston in the Treasurer's Office at jeanneralston@foresthills.edu or 513-231-3830.

C-101 (Authorization to Release Medical Information) – This form must be completed by the employee. Leave the claim number blank as it will not be available immediately. List the Employer MCO or QHP as SEDGWICK CMS. Be sure to list all providers servicing the claim in the body of the form. Sign and date the form and forward it to Jeanne Ralston as listed above.

Temporary Rx Letter - The employee should present this information to a participating pharmacy to obtain medication related to the claim and have it billed to the claim.

C-9 (Request for Medical Services Reimbursement or Recommendations for Additional Conditions for Industrial Injury or Occupational Disease) – This form is to be completed by the provider if applicable and faxed to Sedgwick CMS at 855-223-9836.

C-84 (Request for Temporary Total Compensation) - Please contact Jeanne Ralston prior to completing this form.

## EMPLOYEE ACCIDENT AND EXPOSURE REPORTING PROCEDURES

The following procedures are applicable to all **work-related** accidents, injuries, near misses and blood exposure incidents. Adherence to these instructions will facilitate your care and return to work. If you have any questions, talk to your supervisor.

**Step 1: Your health is the first priority! Don't hesitate to seek professional care for a medical emergency.**
*A medical emergency is defined as: a) medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to a serious physical or mental disability or death, or b) medical services that are immediately necessary to alleviate severe pain.*

**Step 2: IMMEDIATELY submit an Employee Accident/Exposure Incident Report and report the incident to your supervisor. Print an Injury Reporting Kit from the district website (www.foresthills.edu under Resource Center, click on forms, click on Workers' Compensation, click on injury reporting kit) and take it with you to the provider (doctor, urgent care, hospital, etc.).**

To submit an employee incident report, go to the district website (www.foresthills.edu), click on the Resource Center, under Forms, click on Workers' Compensation, click on Report an Injury. Your user name is your first name and last name with no space between and your password is the last four digits of your Social Security number. Enter all information requested and follow the steps to submit your report.

For assistance, contact your supervisor. The Employee Accident/Exposure Incident Report should be completed by the injured/affected employee, however, if necessary, another employee can complete the report with the assistance of the affected employee.

**Step 3: OPTIONS FOR MEDICAL CARE**

When obtaining medical care, the employee MUST TELL THE PHYSICIAN it is a work-related injury.

**FIRST VISIT**

The first visit to any medical provider, whether an emergency or non-emergency, is covered for a work-related injury considered compensable by the Bureau of Workers' Compensation (BWC).

**ALL OTHER VISITS**

Although the first visit may be to any medical provider, whether an emergency or non-emergency, subsequent visits must be with a BWC Certified Provider specializing in work-related injuries, treatment and follow-up, including proper reporting, transitional work, physical therapy, and other occupational services. **It is incumbent upon the injured worker to verify that the provider is BWC Certified and is accepting new patients.**

To get the name of a BWC Certified Provider:
Call 1-800-OHIOBWC, Mon. - Fri., 7:30 AM to 5 PM OR
Log on to www.ohiobwc.com, click on Find a Provider and fill in the criteria.

**NOTE: If medical services are provided, the injured worker must present a return to work notice to his/her supervisor upon returning to work.**

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## ADDITIONAL REQUIREMENTS FOR BLOOD EXPOSURES

If you are exposed to the body fluids of another person, the following documents must be given to the medical provider (items 1 & 2 can be found in Public SchoolWorks in the Safety Document Library under Program Plans & Policies and Government Regulations):

1. A copy of the district Bloodborne Pathogens Exposure Control Plan.
2. A copy of the OSHA Bloodborne Pathogens regulations (29 CFR 1910.1030).
3. A copy of the completed Employee Accident/Exposure Report.
4. Results of the source individual's blood testing (if available).
5. All medical records applicable to treatment of the employee, including vaccination status.
6. For additional information regarding the procedures associated with an exposure to the body fluids of another person, the employee should read the district Bloodborne Pathogens Exposure Control Plan.

**Workers' Compensation Identification Card**
***This person's employer is self-insured***
***Policy #20005716***

**FAX all information within 24 hours of visit to Sedgwick at (855) 223-9836. Employer requires release from physician at the time of your return to work.**

**Send bills to:**
**Sedgwick**
**PO Box 14661**
**Lexington, KY**
**40512-4661**

**Sedgwick for:**
**Forest Hills Local School**
**District Board of Education**
**Phone: (800) 267-4001**
**Fax: (855) 223-9836**

**Sedgwick provides administrative services and Network access only and does not assume any financial risk or obligation with respect to claims. This card does not guarantee claim approval.**

## NOTE FROM THE BUREAU OF WORKERS' COMPENSATION

Effective May 8, 2017, BWC will discontinue use of all toll-free fax numbers attached to our customer service offices. **Please remind medical providers, emergency rooms, urgent care centers, walk-in clinics and the legal community to file self-insured claims directly to the self-insuring employer, not BWC.**

Bureau of Workers' Compensation

# Physician's Report of Work Ability (MEDCO-14)

**Instructions**

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - Have been awarded permanent and total disability.
  - Have returned to work without restrictions within seven days of the injury.
  - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

**Note:** Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- **Important:** Failure to provide complete information may delay compensation payments to the injured worker.

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

| Date of ***last*** appointment/examination | Date of ***this*** appointment/examination | Date of ***next*** appointment/examination |
|---|---|---|
| | | |

**1 Submission type (Select one of the options below.)**

☐ Initial MEDCO-14. ***Proceed to Section 2.***
☐ Subsequent MEDCO-14, **no** changes ***Proceed to Section 6.***
☐ Subsequent MEDCO-14, **with changes.** Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.

**2 Job description and work status** ☐ Reporting changes from last evaluation ☐ No changes

- Have you reviewed the injured worker's job description? ☐ Yes ☐ No
  - **If yes,** who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC
- Does the injured worker have any physical or health restrictions **related to the allowed conditions in the claim** on the date of this exam? ☐ Yes ☐ No
  - **If yes,** are the restrictions: ☐ Permanent? ☐ Temporary?
  - **If no,** check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ ***Proceed to Section 6.***
- If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No
  - **If yes,** ***Proceed to Section 6.***
  - **If no,** provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. ***Proceed to Section 3.***

**3 Disability information** ☐ Reporting changes from last evaluation ☐ No changes

Complete the chart below for all **work-related allowed conditions being treated**.

| 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 |

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

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

**4 Abilities, clinical findings, and recovery progression** ☐ Reporting changes from last evaluation ☐ No changes

- Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard? ☐ Yes ☐ No
- Dominant hand: ☐ Right ☐ Left
- Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.

| Frequency scale | Strength level (lbs.) | Body side indicator |
|---|---|---|
| **N** = Never<br>**S** = Seldom 0-1 hour<br>**O** = Occasional 1-3 hours<br>**F** = Frequent 3-6 hours<br>**C** = Constant 6-8 hours | **S** = Sedentary 0-10<br>**L**= Light 0-20<br>**M** = Medium 0-50<br>**H** = Heavy 0-100<br>**VH** = Very heavy >100 | **L** = Left<br>**R** = Right<br>**B** = Both<br>*Indicate **limitations ONLY** |

| Activity | Frequency | Activity | Strength | Frequency | Activity | Side |
|---|---|---|---|---|---|---|
| Sit | N S O F C | Floor lift (0-17") | S L M H VH | N S O F C | Front/Lateral reach | L R B |
| Stand/Walk | N S O F C | Knee lift (18-29") | S L M H VH | N S O F C | Overhead reach | L R B |
| Climb stairs | N S O F C | Waist lift (30-36") | S L M H VH | N S O F C | Wrist flex/extension | L R B |
| Squat/Kneel | N S O F C | Chest lift (37-60") | S L M H VH | N S O F C | Grasp | L R B |
| Crawl | N S O F C | Overhead lift (>60") | S L M H VH | N S O F C | Finger manipulation | L R B |
| Twist | N S O F C | Push/Pull | S L M H VH | N S O F C | Keyboarding | L R B |
| Bend/Stoop | N S O F C | Carry | S L M H VH | N S O F C | Operate foot controls | L R B |

- Injured worker can work _____hours per day and _____ hours per week.
- Are there any functional restrictions based only on the allowed psychological conditions? ☐ Yes ☐ No
  - If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.
- Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).

**Comments:**

**Health and Behavioral Assessment:** (HBA evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.)

- Is the injured worker's recovery not progressing, or progressing slower than expected? ☐ Yes ☐ No
- Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing? ☐ Yes ☐ No

**Vocational rehabilitation** is a voluntary program for an eligible injured worker who needs assistance to remain at work or return to work. Is the injured worker currently able to participate in a vocational rehabilitation program? ☐ Yes ☐ No

**5 Maximum medical improvement (MMI) status** ☐ Reporting changes from last evaluation ☐ No changes

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

**6 Treating physician's signature – mandatory (See exceptions at the top of the form.)**

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 (Print legibly.) | | Address, city, state, nine-digit ZIP code | |
|---|---|---|---|
| Treating physician's signature | | | |
| BWC provider (PEACH) number | Date | Telephone number | Fax number |
| | | | |

Bureau of Workers' Compensation

# Authorization to Release Medical Information

**Instructions**

*You can obtain this form online at **bwc.ohio.gov***

- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

**C-101 - Authorization to Release Medical Information:** Injured workers should use this form to authorize the release of medical records relative to their work-related injury(s). By signing this form, the injured worker authorizes medical providers who have rendered services relative to the injury to release information to BWC, the Industrial Commission, the employer, the managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives. The form is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), although BWC is exempt from HIPAA requirements.

| Injured worker name (first, M.I., last) | | Date of injury | Claim number |
|---|---|---|---|
| Address | City | State | Nine-digit ZIP code |
| Employer name | Employer MCO or QHP | | |

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (_____

_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

  _____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

| Injured worker (or guardian or personal representative) signature | Date |
|---|---|

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____

Optum
PO Box 152539
Tampa, FL 33684-2539

# MAKING IT EASY...

## TO GET YOUR WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

### Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

**Questions? Need Help?**

**1-866-599-5426**

OPTUM® sedgwick® FHSD Forest Hills School District ENGAGE • EMPOWER • EXCEL

**WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM**

| Sedgwick | Forest Hills School District |
|---|---|
| CARRIER/TPA | EMPLOYER |

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER | DATE OF INJURY (YYMMDD)

**Notice to Cardholder:** Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

**Attention Pharmacists:** Call 1-800-964-2531 to establish First Fill benefit eligibility and to obtain the ID# for online adjudication of approved benefits for the injured individual.

Tmesys is the designated PBM for this patient.

**Tmesys Pharmacy Help Desk**
**1-800-964-2531**

| | NDC | | ENVOY |
|---|---|---|---|
| RxBIN | 004261 | or | 002538 |
| RxPCN | CAL | or | Envoy Acct. # |

***NOTE:*** *This First Fill card is only valid for your workers' compensation injury or illness.*

### Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.



tmesys®

IMP14-1614-76_SEDGWCFFOP

Ohio | Bureau of Workers' Compensation

# Completing the Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease

## Instructions

- Please print or type this report.
- **If injured worker is employed by a self-insuring employer, complete this form and mail or fax it to his or her employer.**
- If injured worker is employed by a state-fund employer, complete this form and mail or fax it to the appropriate managed care organization (MCO).
- To determine the appropriate MCO, ask the injured worker or employer to visit BWC's Web site at www.bwc.ohio.gov, or call BWC at 1-800-644-6292, and listen to the options.
- Use this form if this is a request for services even if services are being provided under the 60-day presumptive authorization, if recommending additional condition(s) or if diagnosis has changed.
- Complete all applicable sections of the form to avoid possible delays in processing this request.
- You can obtain additional copies of this form at www.bwc.ohio.gov or by calling BWC at 1-800-644-6292 and listening to the options.

## Section I – Injured worker

1. Enter the injured worker's name, BWC claim number, the date the injured worker was injured or contracted an occupational disease.

## Section II – Requested services

2. Treating diagnosis for this request to include body part/levels.
3. Indicate the beginning and ending date of the requested service. Indicate the last exam or treatment date.
4. List the requested services and CPT codes, including frequency and duration. Attach copies of current medical reports necessary to support request. Include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment and office notes that contain subjective and objective findings and pre-existing conditions.

   * Failure to add CPT codes may delay processing.
5. Provide the two-digit facility site of service code as used by the Centers for Medicare and Medicaid Services (CMS), if applicable.

## Section III – Additional conditions

6. Complete if you are recommending additional conditions to the claim. Provide a narrative diagnosis. Supporting medical documentation is required for all conditions listed. Include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment and office notes that contain subjective and objective findings and pre-existing conditions. **You may not use the C-9 to request additional conditions for claims of self-insuring employers.**

   • BWC will notify all parties and the MCO of the decision.
7. This refers to the establishment of a relationship between the injury or occupational disease and the industrial accident or exposure. An explanation is required when answering yes or no.

## Section IV – Physician/provider information

8. Identify the provider who will render the requested services and the address where he or she will provide the services (required). Travel reimbursement may not be authorized when the service provided is available within 45 miles round trip from the injured worker's residence.
9. Print, type or stamp requesting physician/provider name and address.
10. Physician/provider signature, individual BWC provider number and date of this report are mandatory.

## Section V – MCO/Self-insuring employer decision

- **If completed by self-insuring employer, refer to self-insuring employer section.**
- If the C-9 is not faxed or mailed back to the submitting physician/provider within three business days of receipt or within five business days of receipt of the C-9-A, a request for additional information, BWC shall deem the authorization for service granted subject to our policy, excluding retroactive requests.
- Claim inactive (further investigation required) — The MCO cannot make a decision on this C-9 request. Further investigation is required, and BWC will issue a decision in writing within 28 days. The MCO will notify the provider of the BWC decision.
- An MCO can only use the disclaimer box on the C-9 or any other physician generated service request when BWC/IC is considering the claim or the condition for which the service is requested as of the date of the MCO's signature. Disclaimers shall not be used when authorizing treatment for allowed claims and conditions that are within the statute of limitation.

BWC-1113 (rev. 12/28/2011)
**C-9** (Combines C-1-A & C-161)

Ohio | Bureau of Workers' Compensation

# Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease

• **Instructions for completing the C-9 on reverse side.**

**Fax note**

| To | Toll-free fax number | Phone number |
|---|---|---|
| From | Phone number | Fax number |

**IW**

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

**II. Requested services**

| ❷ Treating diagnosis for this request to include body part/levels. | ❸ Date service begins / / | Date service ends / / | Date of last exam or treatment / / |
|---|---|---|---|

| ❹ Requested services with CPT/HCPCS codes (required) | Frequency | Duration |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

❺ Provide the two-digit facility site of service code as used by the Centers for Medicare and Medicaid Services (CMS), if applicable.

**III. Additional conditions**

If you are recommending additional conditions to the claim, supporting documentation is required. **You may not use the C9 to request additional conditions for claims of self-insuring employers.**

❻ Provide diagnosis (narrative description only), and location and site for conditions you are requesting.

❼ In your opinion, based on the history from the injured worker, your clinical evaluation and expertise, is the diagnosis or condition causally related, either directly or proximately, to the alleged industrial accident or exposure?

☐ Yes, please attach explanation. ☐ No, please attach explanation.

**IV. Physician/provider information**

❽ Identify the provider who will render the requested services and the address where he or she will provide the services (required). Travel reimbursement may not be authorized when the service provided is available within 45 miles round trip from the injured worker's residence.

| ❾ Requesting physician/provider name and address (please print, type, or stamp) | ❿ Physician/provider/authorized signature (required) | ☐ POR ☐ Not POR — but treating physician/provider |
|---|---|---|
| | Individual BWC provider number (required) | Date (M/D/Y) (required) |

I certify the above information 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, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

**V. MCO/Self-insuring employer decision**

**Managed care organization (MCO)** — If this page is not faxed or mailed back to the submitting physician/provider within three business days of receipt or within five business days of receipt of information requested on the C-9-A, BWC shall deem the authorization for treatment granted subject to our policy, excluding retroactive requests.

☐ **Approved with disclaimer** — This medical payment authorization is based upon a claim or additional condition that BWC/IC is considering as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, BWC may not cover the services/supplies to which this medical payment authorization applies. These services/supplies may be the responsibility of the injured worker (for MCO use only).

☐ Approved Date service begins _____ /_____ /_____ Date service ends _____ /_____ /_____

☐ Amended approval: _____

☐ Denied explanation: _____

You may file disputes to the decision in writing with supporting documentation to the MCO.

☐ Pending: The documentation requested must be submitted to the MCO case manager within 10 business days to allow for a treatment decision. Failure to respond may result in denial.

☐ Claim inactive: MCO cannot make a decision on this request, further investigation required. BWC will issue a decision in writing within 28 days.

☐ Withdrawn ☐ Dismissed _____

**BWC claim status:** ☐ Allowed ☐ Denied ☐ Pending

| MCO company/Self-insuring employer name (please print, type or stamp) | MCO name and signature (print, type or stamp and sign) | | |
|---|---|---|---|
| | MCO number | Telephone number ( ) | Date / / |

**Self-insuring employer**

**Self-insuring employer use only** — Fax or mail this page to the submitting physician/provider within 10 days of receipt or the authorization for treatment shall be deemed granted, per Ohio Administrative Code 4123-19-03 (K)(5).

| Self-insuring employer signature | Date / / |
|---|---|

Bureau of Workers' Compensation

# Instructions for Completing the Request for Temporary Total Compensation

This *Request for Temporary Total Compensation* (C-84) is the application you complete to request temporary total disability benefits.

You must complete the entire form and sign it. It is your responsibility to secure supporting medical documentation from your treating provider for the requested period of disability using the MEDCO-14 form or equivalent documentation. You must complete this form every time you make a request for an initial period of temporary total compensation or an extension of an existing period of temporary total compensation.

| Instructions | | |
|---|---|---|
| **Section** | **1** | **Injured worker demographics:** BWC will use the address provided to mail all correspondence to you. A home and/or cell phone number is helpful if we need to contact you. Providing your email address allows you to communicate with your claims specialist electronically, if you choose to do so. |
| **Section** | **2** | **Disability information:** Please mark if this current period of disability is a new period of disability or an extension. If this is an application for a new period of disability, please list the last day you worked. For both new periods and requests for extensions of disability, list all providers currently treating you for this claim. |
| **Section** | **3** | **Employment information:** BWC will use this information to help facilitate your return to work and ensure proper payment. |
| **Section** | **4** | **Vocational rehabilitation information:** BWC will use this information to help facilitate your return to work. |
| **Section** | **5** | **Benefits/earnings received or requested during the period of disability:** Indicate if you have received any of the listed benefits. If you answer yes to any of the benefits on the list, provide the requested information. |
| **Section** | **6** | **Injured worker signature:** Please sign and date this form when requesting temporary total disability compensation. If you cannot sign, please mark the form and have a witness sign the form next to your mark. Signing the form means you have answered the questions truthfully and completely. It also means you are aware that you are not knowingly making a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or knowingly accepting compensation to which you are not entitled. Providing false information or concealing information to obtain compensation may subject you to felony criminal prosecution, and may be punished by a fine, imprisonment, or both. |

## Where do I file the C-84?

**For injured workers whose employer is self-insured**: If your employer is self-insured, send the form to your employer. If you are not sure if your employer is a self-insuring employer, contact your employer.

**For all other injured workers:** You may also complete this form online at bwc.ohio.gov. If you have completed a hard copy of this form, fax it to 1-866-336-8352, or send it to the BWC customer service office where the claim is assigned.

## Where do I find more information or assistance?

**For injured workers whose employer is self-insured:** Call your employer, or contact BWC's self-insured department at 1-800-644-6292, and listen to the options to reach a customer service representative.

**For all other injured workers:** Please call 1-800-644-6292, or contact your service office.

You can obtain BWC forms at bwc.ohio.gov, by calling 1-800-644-6292 and listening to the options to reach a customer service representative, or at your service office.

Bureau of Workers' Compensation

# Request for Temporary Total Compensation

## Injured worker demographics

**1**

| Name | | Claim number | | Date of injury |
|---|---|---|---|---|
| Address | City | | State | Nine-digit ZIP code |
| Email address (optional) | | Home phone number — — | | Cell phone number — — |

## Disability information

**2**

- Is this application requesting a new period of temporary total compensation or an extension? ☐ New ☐ Extension
- If this is a new period, what was the last date worked due to the current period of work-related disability? ____/____/____
- List all providers **currently** treating you for this work-related disability claim. _____

## Employment information

**3**

What was your occupation at the time of the injury/disease? _____

- Do you have a job to return to? ☐ Yes ☐ No ☐ I don't know
  - o If yes, who is your employer? _____
  - o If yes, does your employer offer modified (light-duty) work? ☐ Yes ☐ No ☐ I don't know
  - o If yes, do you feel capable of performing any of your job duties at this time? ☐ Yes ☐ No

    If yes, what duties? _____

Working includes full or part-time, self-employment, income-producing hobbies, commission work, or unpaid activities that are not minimal and directly earn income for someone else.

- Are you currently working in any capacity (as defined above)? ☐ Yes ☐ No
  - o If yes, who is your employer? _____
- Have you previously worked in any capacity (as defined above) during this requested period of disability? ☐ Yes ☐ No
  - o If yes, who is your employer? _____
  - o If no, when was the last date you worked anywhere? ____/____/____ Reason for leaving _____
- What do you feel is preventing you from returning to work at this time? Please describe physical, employment and personal barriers.

## Vocational rehabilitation information

**4**

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.

- If appropriate, would you consider participating in vocational rehabilitation? ☐ Yes ☐ No If no, why not? _____

## Benefits/earnings received or requested during the period of disability

**5**

| Type of benefit | Receiving | Beginning date of benefit |
|---|---|---|
| Unemployment<br>**If yes, from which state are you receiving benefits?** _____ | ☐ Yes ☐ No | |
| Social Security retirement | ☐ Yes ☐ No | |
| Public assistance<br>**If yes, include case number:** _____ | ☐ Yes ☐ No | |
| Sick leave<br>**If yes, name of company paying the benefit:** _____ | ☐ Yes ☐ No | |
| Wage/salary continuation<br>**If yes, name of company paying the benefit:** _____ | ☐ Yes ☐ No | |
| Disability<br>**If yes, name of company paying the benefit:** _____ | ☐ Yes ☐ No | |
| Earnings **(to include full or part time, self employment, income-producing hobbies or commission work)**<br>**If yes, name of employer and job duties.** _____ | ☐ Yes ☐ No | |

## Injured worker signature

**6**

I understand I am not permitted to work while receiving temporary total compensation. I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

| Signature | Date |
|---|---|
| | |