



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.

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.



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**

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

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.**



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.

Form with sections: Injured worker name, Claim number, Date of injury, Date of last appointment/examination, Date of this appointment/examination, Date of next appointment/examination, Submission type (Select one of the options below.), Job description and work status, Disability information, and a table for work-related allowed conditions.



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

Instructions

- 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

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

	<u>NDC</u>		<u>ENVOY</u>
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.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."



IMP14-1614-76_SEDGWCCFFOP



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.



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 section with fields for To, From, Toll-free fax number, Phone number, and Fax number.

I. Injured worker name, Claim number, Date of injury

II. Requested services section with fields for treating diagnosis, date service begins/ends, requested services with CPT/HCPCS codes, frequency, duration, and facility site code.

III. Additional conditions section with instructions and field for diagnosis and location/site.

IV. Physician/provider information section with fields for provider name, address, signature, and BWC provider number.

V. MCO/Self-insuring employer decision section with checkboxes for MCO status and decision options.

V. MCO/Self-insuring employer name and signature section with fields for company name, MCO number, telephone number, and date.

Self-insuring employer use only section with fields for signature and date.



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?
<p>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.</p> <p>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.</p>

Where do I find more information or assistance?
<p>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.</p> <p>For all other injured workers: Please call 1-800-644-6292, or contact your service office.</p> <p>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.</p>



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
 - If yes, who is your employer? _____
 - If yes, does your employer offer modified (light-duty) work? Yes No I don't know
 - 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
 - If yes, who is your employer? _____
- Have you previously worked in any capacity (as defined above) during this requested period of disability? Yes No
 - If yes, who is your employer? _____
 - 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

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