



The Catholic Diocese of Columbus- Policy Number 20003224

Billing Address:
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Self-Insured Employee Information

What to do in the event of a workplace injury while working for an Ohio self-insured employer.

Your employer's goal is to provide a safe work environment designed to prevent workplace injuries. However, should you sustain a workplace injury the following are answers to typical questions you may have about your on-the-job injury.

What if I need more than First Aid for my injury?

All accidents should be reported to your supervisor immediately, regardless of the level of medical treatment you need. You will be asked to complete an accident report and an Ohio Bureau of Workers' Compensation (BWC) First Report of Injury (FROI) to start your workers' compensation claim. In emergency situations, you should seek immediate medical attention and complete these forms as quickly as you are able. In non-emergency situations, you may seek medical treatment from a BWC-certified licensed provider of your choosing or you may call Hunter Consulting at 1-800-486-6652 to identify quality licensed providers in your area.

What happens to the First Report of Injury (FROI) form that I fill out with my physician?

The FROI will be sent to Hunter Consulting so they may process your claim. In some instances, Hunter Consulting will also file a copy of the FROI with the Ohio BWC.

Who will pay for my Doctor's bills?

Your self-insured employer will pay for authorized physician visits and related treatments if the injury was caused by an on-the-job accident. Hunter Consulting will issue payment for appropriate medical treatment directly to your physician on behalf of your employer.

How do I get my prescriptions filled?

This injury packet contains an M. Joseph first fill card that will allow you to get a first fill on your initial prescription. First fill services are provided through M. Joseph Medical. If you require refills or additional medication for an allowed work-related injury, you will receive additional information from M. Joseph. Additional information on how the prescription program works is available through Hunter Consulting.

What happens if I cannot return to work?

Your Employer's Human Resources and your Hunter Consulting account manager will work cooperatively with you and your doctor to monitor and maintain quality appropriate treatment to ensure the most efficient and safe return to work. We will maintain communication with you throughout the duration of the claim.

Will I be paid for the time I miss from work due to my injury?

Your employer will comply with the Ohio BWC guidelines. If you miss work for more than seven (7) calendar days because of an allowed work-related injury, your time off work will be paid based upon a percentage of your average weekly earnings. In order to receive payments, all of your time off must be supported by your treating physician.

When do I receive my wage payments?

If your treating physician has taken you off work, has submitted the appropriate forms, and your claim is allowed, benefits will be paid within twenty-one (21) days from the date the paperwork is received by Hunter Consulting.

Do I need a doctor's release to return to work?

If you have missed work because of your injury, your doctor must provide a medical release or fit for duty report in order to return to work. BWC's standard release form (Medco-14) is commonly used to identify your work capabilities. Have your doctor complete this form and fax to your employer's Human Resources and your Hunter Consulting account manager.

What happens when my physician releases me to work?

Your employer's Human Resources and the Hunter Consulting account manager will make every effort to help you return to your job as soon as possible. They will help your physician return you to light duty work or a transitional work program if there are restrictions on your activity that prevent you from performing your regular job duties.

What if I am not satisfied with the medical treatment I am getting from my doctor?

If you are dissatisfied with your doctor, we encourage you to talk to your Hunter Consulting account manager. They will work with your treating physician on an appropriate treatment plan or, if necessary, will assist you in finding another doctor with whom you are more comfortable.

You ultimately have the freedom to choose any licensed physician who will accept workers' compensation injuries.

What should I do if medical bills are sent to me?

If you receive bills from your doctor or the hospital, please send them to:

Hunter Consulting Company
6600 Clough Pike
Cincinnati, OH 45244

Why does my employer investigate accidents?

One way to prevent future accidents is to learn more about your workplace injury. After a complete investigation, your manager or supervisor may be able to make meaningful changes, reducing the chance that another employee will be injured in the same manner.

Who do I call if I have questions?

Contact your employer's Human Resources Department.

Any questions concerning physician visits, change of physician or medical treatment requests can be directed to your Hunter Consulting account manager at 1-800-486-6652.

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Hunter Consulting Company
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CATHOLIC DIOCESE OF COLUMBUS – SELF-INSURED RISK NUMBER 20003224

INITIAL REPORT ON WORK-RELATED INJURY or ILLNESS

1. Has a fatality occurred? No Yes If yes, date of death (mo./day/yr.) ____/____/____
2. Employee Name (last, first, middle) _____ 3. Date of Birth (mo./day/yr.) ____/____/____
4. Soc. Sec. # ____ - ____ - ____ 5. Female Male
6. Home Address (# and street, city, state, and zip code) _____
7. Home Phone () _____ - _____ 8. Other Phone () _____ - _____
9. Date Hired (mo./day/yr.) ____/____/____ 10. Job Title _____
11. Department _____ 12. Dept. Phone () _____ - _____
13. Date of injury or illness (mo./day/yr.) ____/____/____ 14. Time of injury am or illness pm 15. Was employee on duty at the time? Yes No
16. Is this a new injury or illness? Yes No 17. Location of Incident (address, if known) _____
18. Name(s) and Phone(s) of Witness(es) _____ or No Witnesses
19. Name of Supervisor Notified _____ Date & Time Notified _____
20. Did employee receive medical Treatment following this incident? Yes No 21. Medical Facility (name, phone, address) Date of Treatment _____
22. Name of medical provider/physician _____ 23. Was employee treated in an emergency room? Yes No 24. Was employee hospitalized overnight as an in-patient? Yes No
25. Check Part(s) of Body Affected and circle Right/Left (or both) Head (R / L) Face and Neck (R / L) Eye (R / L) Chest/Abdomen (R / L) Arm (R / L) Hand (R / L) Leg (R / L) Foot (R / L) Upper Back (R / L) Middle Back (R / L) Lower Back (R / L) Other (R / L) _____
26. Check Specific Type of Injury or Illness Fracture Foreign Body Bruise Cut/Scrape Burn Sprain or Strain Other _____
27. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials; "spraying chlorine from hand sprayer"; "daily computer key entry."

28. What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

29. What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

30. Who completed this form? Injured employee Supervisor Other _____ 31. Date completed _____

I certify the information I have furnished on this form is true, correct, and complete to the best of my knowledge. Furthermore, I understand the information I supplied may be audited by the Company or its representatives. I understand that falsifying this document may be grounds for disciplinary action up to and including termination of employment. In addition, I may be in violation of Federal and/or State laws and subject to prosecution.

32. _____
Employee's Signature **Date**

I have reviewed this report and acknowledge its receipt.

33. _____
Supervisor's Signature **Date**

MAIL THIS FORM TO THE ADDRESS ABOVE, FAX TO 513-372-8748, OR EMAIL TO abehrend@hunterconsulting.com



Submit the form to BWC in one of the following ways. **Online:** bwc.ohio.gov, **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215

Note: If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

Injured worker information									
First name, middle initial, last name				Date of injury/disease		Social Security number		Date of birth	
Mailing address; add apartment number or P.O. Box, if applicable						City		State	ZIP code
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Email address				Home phone number		Cell phone number	
Employer name		Employer address				City		State	ZIP code
Was the injured worker hired through a temp agency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of temp agency				Mark the days of the week you usually work <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat			Regular work hours (include a.m. p.m.) From _____ To _____		
Date hired	Job title		State where hired	State where supervised	Wage rate; \$ per hour	Number of hours scheduled to work the week of this injury			
Work number for call-offs (Number injured worker calls to reach supervisor)				Part(s) of body affected (For example: Left knee, right index finger)					
Accident description (Describe the sequence of events that directly caused the injury or death.)								Will the incident cause the injured worker to miss 8 or more days from work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Injured worker start time _____ <input type="checkbox"/> am <input type="checkbox"/> pm	Time of injury _____ <input type="checkbox"/> am <input type="checkbox"/> pm	Date employer notified		Was any part of a workday missed due to the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date last worked	If the injured worker has returned to work, provide the date.		
Was the place of the accident or exposure on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give accident location, street address, city, state, and ZIP code.								Was injured worker hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Initial treatment date	Health-care office/Facility name		Treating physician/Provider name			Telephone number		Fax number	
Health-care office/Facility Street address						City		State	ZIP code
If the injury resulted in death, answer the following.									
Date of death		Decedent's marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Decedent's number of dependents				
To be completed by the injured worker									
By signing this form, I:									
<ul style="list-style-type: none"> Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws. Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim. Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim. Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim. 									
Furthermore, I understand that:									
<ul style="list-style-type: none"> Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation. Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims. Information or records maintained in my previous or future claims may affect decisions made in this claim. Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48). 									
I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.									
Injured worker signature								Date	
To be completed by the treating provider									
Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). Important: If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".									
Initial treatment date		Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you the physician of record? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Treating physician/Provider's name (Print)			Treating physician/Provider's signature			BWC provider number		Date	
To be completed by the employer									
Employer name		Employer county		Phone number		Fax number		Email address	
Employer policy number		Federal ID number		Injured worker is (Check box, if applicable.) <input type="checkbox"/> Owner/Sole proprietor <input type="checkbox"/> Partner <input type="checkbox"/> Individual incorporated as a corporation					
For all employers: <input type="checkbox"/> Certification – I certify the facts in this application are correct and valid. <input type="checkbox"/> Rejection – I reject the validity of this claim for the reason(s) listed below. For self-insuring employers only: <input type="checkbox"/> Medical only <input type="checkbox"/> Lost time Clarification – I clarify and allow the claim for the condition(s) below.									
Employer signature and title								Date	
To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer									
Signature of person completing this form								Date	



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-funded 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
Submission type (Select one of the options below.)			
1	<input type="checkbox"/> Initial MEDCO-14. Proceed to Section 2. <input type="checkbox"/> Subsequent MEDCO-14, no changes Proceed to Section 6. <input type="checkbox"/> Subsequent MEDCO-14, with changes. Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.		
Job description and work status		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes	
2	<ul style="list-style-type: none"> • Have you reviewed the injured worker's job description? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> ○ If yes, who provided the job description <input type="checkbox"/> Injured worker <input type="checkbox"/> Employer <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> ○ If yes, are the restrictions: <input type="checkbox"/> Permanent? <input type="checkbox"/> 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. <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> ○ If yes, Proceed to Section 6. ○ If no, provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. Proceed to Section 3. 		
Disability information		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes	
Complete the chart below for all work-related allowed conditions being treated.			
3	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? <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
List all other conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet 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
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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. _____