

Diocese of Columbus

PROCEDURES FOR REPORTING AN ON THE JOB INJURY

Step One:

Injured employee is to notify his or her supervisor immediately of an accident or illness that occurred at work.

Step Two:

Supervisors:

- Assist injured employee to obtain medical assistance, if needed.
- Provide needed forms and review procedure with injured employee.
- Make sure accident report is completed, reviewed, signed and dated by the employee and you.
- Forward all paperwork immediately to Hunter Consulting Company. It can be mailed to 6600 Clough Pike, Cincinnati, OH 45244, faxed to 1-513-372-8755 or e-mailed to mwagner@hunterconsulting.com.
- You may also notify the Insurance Office at the Diocese and/or forward a copy of the completed forms and documentation via fax (614-241-2573), e-mail (jbialt@columbuscatholic.org), or U.S. mail (198 E. Broad Street, Columbus, OH 43215).

Injured Employee:

- Seek medical treatment first, if needed.
- Complete the Diocese's Incident Report form.
- Complete the **First Report of Injury Form (FROI)**.
- If you did receive treatment for your injury, have your doctor complete the **"Physician's Report of Work Ability"** form and return the completed form to your supervisor immediately after your appointment.
- Sign the **Medical Release**.
- Return all forms and medical documentation to your supervisor immediately.

Step Three:

If it is recommended by the treating physician, and the diocesan location is able to accommodate the injured employee, the supervisor and injured employee should discuss light duty work for a mutually agreed upon temporary period of time.

Step Four:

Forward all information related to the incident to Hunter Consulting Company, via fax at 1-513-372-8755, e-mail to mwagner@hunterconsulting.com, or mail to 6600 Clough Pike, Cincinnati, OH 45244.



Hunter Consulting Company
6600 Clough Pike
Cincinnati, OH 45244



CATHOLIC DIOCESE OF COLUMBUS Self-Insured Risk #2000-3224
INITIAL REPORT ON WORK-RELATED INJURY or ILLNESS

1. Has a fatality occurred? No Yes If yes, date of death (month/day/year) ___/___/___
2. Employee Name (last, first, middle) _____ 3. Date of Birth (month/day/year) ___/___/___
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 (month/day/year) ___/___/___ 10. Job Title _____
11. Location Name _____ 12. Location 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: "Worker slipped on wet floor - no sign visible"; "Worker hurt (R / L) shoulder when attempting to restrain a child"; "Worker developed soreness in (R / L) wrist over time."

29. What object or substance directly harmed the employee? Examples: "concrete floor"; "drill"; "desk." 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 Diocese or its representatives. I understand that falsifying this document may be grounds for corrective 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. _____ Date _____
Employee's Signature

I have reviewed this report, acknowledge its receipt, and confirm the information is true, correct, and complete to the best of my knowledge.

33. _____ Date _____
Supervisor's Signature

Self-Insured Risk #2000-3224

The Diocese of Columbus is a Self-Insured employer for its workers' compensation program and is represented by Hunter Consulting Company.

Please send all medical reports and bills to:



Hunter Consulting Company
6600 Clough Pike, 2nd Floor
Cincinnati, Ohio 45244

All inquiries should be directed to Melissa Wagner at (513) 231-4023 or mwagner@hunterconsulting.com.



This form can be completed and submitted online at
www.bwc.ohio.gov

Report your injury by completing all three sections of this form

- 1 Complete as much of all three sections of this form as possible to reduce the time necessary in determining the claim. If this form is completed by the injured worker at the first visit to a medical provider, the injured worker may give the FROI to the provider to complete the treatment information section. The provider can then submit the FROI to the MCO.
- 2 Deliver, mail or fax the completed document to your employer or your employer's managed care organization (MCO).
- 3 If you do not know your employer's MCO, contact BWC at **1-800-644-6292** and follow the prompts, or use the MCO on BWC's Web site at www.bwc.ohio.gov.
- 4 If you are unable to determine your MCO, mail or fax this form to the BWC customer service office closest to your home. For information on your local customer service office, please visit www.bwc.ohio.gov, or call **1-800-644-6292**.

Injured workers employed by a self-insuring employer

- Complete this form and give to your employer.
- Your employer should be able to tell you if he or she is a self-insuring employer.
- If your employer is self-insuring and you file this information with BWC, processing delays may occur.

For assistance in completing this form, call your BWC customer service office Monday through Friday, 8 a.m. – 5 p.m.

Cambridge

61501 Southgate Road
Cambridge, OH 43725-9114
Phone: 740-435-4200
Fax: 866-281-9351

Dayton

3401 Park Center Drive, Suite 100
Dayton, OH 45414-2577
Phone: 937-264-5000
Fax: 866-281-9356

Mansfield

240 Tappan Drive, N., Suite A
Ontario, OH 44906-1366
Phone: 419-747-4090
Fax: 866-336-8350

Canton

339 E. Maple St., Suite 200
North Canton, OH 44720-2593
Phone: 330-438-0638
Toll free: 800-713-0991
Fax: 866-281-9352

Garfield Heights

4800 E. 131 St., Suite A
Garfield Heights, OH 44105-7132
Phone: 216-584-0100
Toll free: 800-224-6446
Fax: 866-457-0590

Portsmouth

1005 Fourth St.
Portsmouth, OH 45662-4315
Phone: 740-353-2187
Fax: 866-336-8353

Cleveland

615 Superior Ave. W.
Cleveland, OH 44113-1889
Phone: 216-787-3050
Toll free: 800-821-7075
Fax: 866-336-8345

Cincinnati-Governor's Hill

8650 Governor's Hill Drive
Cincinnati, OH 45249-1369
Phone: 513-583-4400
Fax: 866-281-9357

Toledo

P.O. Box 794
1 Government Center, Suite 1136
Toledo, OH 43697-0794
Phone: 419-245-2700
Fax: 866-457-0594

Columbus

30 W. Spring St.
Columbus, OH 43215-2256
Phone: 614-728-5416
Fax: 866-336-8352

Lima

2025 E. Fourth St.
Lima, OH 45804-4101
Phone: 419-227-3127
Toll free: 888-419-3127
Fax: 866-336-8346

Youngstown

242 Federal Plaza, W., Suite 200
Youngstown, OH 44503-1206
Phone: 330-797-5500
Toll free: 800-551-6446
Fax: 866-457-0596

Completion instructions

(continued)

Last name, first name, middle initial			Social Security number		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of birth		
Home mailing address ①				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Number of dependents		Department name ②	
City		State	9-digit ZIP code		Country if different from USA				
Wage rate \$ Per: ③ <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other			What days of the week do you usually work? ④ <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat			Regular work hours From To ④			
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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please explain. ⑤								Occupation or job title ⑥	
Employer name ⑦									
Mailing address (number and street, city or town, state, ZIP code and county)									
Location, if different from mailing address									
Was place of 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									
Date of injury/disease ⑧		Time of injury <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Date last worked ⑨	Date returned to work ⑩
Date hired		State where hired ⑪		Date employer notified ⑫		State where supervised ⑬			
Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death) ⑭							Type of injury/disease and part(s) of body affected (for example: sprain of lower left back, etc.) ⑮		
<p>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.</p>									
Injured worker signature ⑯			Date	E-mail address		Telephone number		Work number	

- ① Home address:** Enter the home address where the injured worker lives. Include the apartment number, if applicable.
- If the post office does not deliver mail to the home address, list the mailing address instead of the home address.
- ② Department name:** Enter the injured worker's department or area name where he/she normally reports for work.
- ③ Wage rate:** Enter the injured worker's rate of pay, and then select how often it is received. (If the pay rate being reported is not hourly, report the gross amount.)
- If eight or more days of work will be missed, BWC needs wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.
- ④ What days of the week do you usually work? What are your regular work hours:** Enter the days and hours the injured worker normally works.
- If the days worked vary from week to week, list the number of hours worked in an average week.
- ⑤ Wages:** If you received wages during disability, please explain.
- ⑥ Occupation or job title:** Enter the injured worker's type of occupation or actual job title at the time of injury, occupational disease or death.
- ⑦ Employer name:** Enter the name of the injured worker's employer at the time of the injury, occupational disease or death.
- ⑧ Date of injury/disease:** Enter the date injured worker was injured. OR
If the injured worker contracted an occupational disease, determine which of the following happened most recently:
- The occupational disease was diagnosed by a medical provider;
 - The first medical treatment;
 - The injured worker first quit work, due to the occupational disease.
- Enter this as the date of occupational disease.**
- ⑨ Date last worked:** Enter the last day worked as a result of this injury, occupational disease or death.
- ⑩ Date returned to work:** Enter the date the injured worker returned to work after the injury or occupational disease.
- ⑪ State where hired:** Enter the state where the injured worker was hired by the employer listed on this application.
- ⑫ Date employer notified:** Enter the date the employer was notified of the injury, occupational disease or death.
- ⑬ State where supervised:** Enter the state where the injured worker was supervised by the employer listed on this application.
- ⑭ Description of accident:** Describe in detail the events that caused the injury, occupational disease or death. Attach additional sheets, if necessary.
- ⑮ Type of injury/disease and part of body affected:** Describe the nature of the injury, occupational disease or death. Indicate the part(s) of body injured, affected or that caused the death.
- Examples:
- Laceration of first toe, left foot;
 - Sprain of lower right back; etc.
- ⑯ Injured worker signature (injured workers only):** Please read the Benefit application/medical release information before signing and dating this form.

Injured worker and injury/disease/death info.

Injured worker and injury/disease/death info.

Instructions continued on last page



First Report of an Injury, Occupational Disease or Death

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)

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.

Last name, first name, middle initial			Social Security number		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of birth	
Home mailing address				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Number of dependents		
City		State	9-digit ZIP code		Country if different from USA		Department name	
Wage rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other _____			What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, give accident location, street address, city, state and ZIP code)								
Date of injury/disease		Time of injury _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work _____ <input type="checkbox"/> a.m. <input type="checkbox"/> 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)		

Injured worker and injury/disease/death info.

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 ()
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
E code				11-digit BWC provider number		Date	
Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Health-care provider signature							

Treatment info.

Employer policy number		Check if <input type="checkbox"/> Employer is self-insuring <input type="checkbox"/> Injured worker is owner/partner/member of firm	
Telephone number ()	Fax number ()	E-mail address	Federal ID number
Manual number		Was employee hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code			
<input type="checkbox"/> Certification - The employer certifies that the facts in this application are correct and valid.		<input type="checkbox"/> Rejection - The employer rejects the validity of this claim for the reason(s) listed below:	
For self-insuring employers only <input type="checkbox"/> Clarification - The employer clarifies and allows the claim for the condition(s) below: <input type="checkbox"/> Medical only <input type="checkbox"/> Lost time			
Employer signature and title		Date	OSHA case number

Employer info.

Completion instructions

(continued)

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)			
	1 _____ _____ _____			
	Will the incident cause the injured worker to miss eight or more days of work? <input type="checkbox"/> Yes <input type="checkbox"/> No		2 Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
E code 3		11-digit BWC provider number 4		Date
Health-care provider signature 5				

- Treatment info.**
- 1 Indicate the diagnosis and ICD codes for conditions being treated as a result of the injury.
 - 2 Indicate the treating provider's medical opinion that the injury sustained is causally related to the industrial incident, that the injury could result from the method (manner) of the accident, as described by the injured worker. It must be clear that the diagnosis in all probability occurred as a result of the injury.
 - 3 Providing a valid E code will enable us to determine the claim more quickly and efficiently.
 - 4 Enter the physician's or health-care provider's 11-digit BWC-assigned provider number.
 - 5 Signature of the health-care provider completing this form.

Employer info.	1 Employer policy number		<input type="checkbox"/> Employer is self-insuring <input type="checkbox"/> Injured worker is owner/partner/member of firm		
	Telephone number () () ()	Fax number () () ()	E-mail address	Federal ID number	Manual number 2
	Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was employee hospitalized as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code				
	<input type="checkbox"/> 3 Certification - The employer certifies that the facts in this application are correct and valid.		<input type="checkbox"/> 4 Rejection - The employer rejects the validity of this claim for the reason(s) listed below:		5 For self-insuring employers only <input type="checkbox"/> Certification - The employer clarifies and allows the claim for the condition(s) below.
	Employer: signature and title			Date	OSHA case number 6

- Employer info.**
- 1 Enter the employer's BWC-assigned policy number, which is located on the BWC certificate of coverage.
 - 2 Enter the four-digit code that indicates the injured worker's job classification, located on the semiannual payroll report.
 - If you do not know the injured worker's manual number, call **1-800-644-6292** and follow the prompts.
 - 3 If certification is selected and the claim is allowed, it will promptly be paid. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.
 - 4 If rejection is selected, use the space provided to list the reasons for rejection. Attach additional sheets, if necessary.
 - 5 Self-insuring employers that choose to clarify certification may use the space provided. Attach additional sheet, if necessary.
 - 6 If this is an OSHA-reportable injury, include the case number assigned by the employer. This form meets OSHA 301 requirements and may be used in lieu of the OSHA 301 when reporting recordable injuries and illnesses to the federal government.
- Note:**
If your employee misses eight or more days of work, BWC will need wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.

Instant Coverage Prescription Drug Program

How Does This Program Work?

Your employer has chosen Modern Medical to provide you with your pharmaceutical needs due to an injury-related claim.

This program enables you to fill prescriptions prescribed by your physician for your injury-related claim. This program does not guarantee certification of a work-related claim or cover prescriptions not related to your injury.

How Much Medication Will I Receive?

You will be restricted to a limited supply determined by your employer until your injury has been reviewed. If your claim is accepted, your medication supply will be based on your physician's treatment plan.

How Do I Use This Program?

1. Take your injury-related prescription to your nearest pharmacy. Please see back for a partial listing of participating pharmacies. If you do not see your pharmacy, please call (800) 547-3330 and ask for the Pharmaceutical Services Department.
2. By presenting this brochure to your pharmacist, it ensures correct billing information to obtain your first fill of your injury-related medications.
3. You will be asked to sign the pharmacy's signature log acknowledging receipt of your prescriptions.
4. Should you or your pharmacist have any questions regarding this program, please call Modern Medical at (800) 547-3330, Monday through Friday, 7:30 a.m. to 9 p.m. EST.

Common Chains Participating in the Pharmacy Network

- Walgreens
- CVS
- Rite Aid
- Wal-Mart
- Giant Eagle Pharmacies
- Kroger
- Meijer
- Costco
- Public Super Markets
- Albertsons
- Farm Fresh
- Access Health
- Target
- Pharmacy Express
- Leader Drug Stores
- K-Mart
- Abold
- The Medicine Shoppe
- Family Care
- Long's Drug Stores
- Bashas
- Harris Teeter
- Kear Drug
- Winn-Dixie Stores
- Major Value
- RxPride
- Safeway Pharmacies
- True Care
- King Scoopers
- Medicap Pharmacies
- Fred's Pharmacy
- Brookshire's
- Albertsons / Sav-On
- Raley's
- Hannaford Brothers
- Hy-Vee
- Ingle's Markets
- Aurora Pharmacy
- Brookshire Brothers Food & Pharmacy
- Savo Meat Supermarkets
- Shopko Stores
- Bi-Lo Pharmacy
- Food Lion
- Dillon Pharmacies
- Life Check
- United Supermarkets
- Smith's Pharmacy
- This Yarn Companies
- Sav-Mor Drug Stores
- Pavilion Plaza Pharmacy
- Kash N' Carry
- Supervalu
- Perfomart
- JH Harvey
- Tom Thumb Randall's Food & Drug
- Wegmans
- Panella Pharmacy
- Northeast Pharmacy Services
- Kinney Drugs
- Bioscip
- Spartan Stores
- U Sava Pharmacy
- Randall's Food & Drug
- Foodarama Supermarkets
- Unity Pharmacies
- City Market
- Thrifty White
- Super D Drugs
- K-WAT Food Stores
- Medicine Chest Pharmacies
- Ross Park Pharmacy

Form 13-2013

Please call (800) 547-3330 for additional participating pharmacies.

Instant Access Card For Your First Prescription Fill



Instant Coverage Prescription Program
for your injury-related claim

Name: _____

Member#: _____

Employer: _____

Group#: _____

RxBIN: _____

RxPCN: _____

Customer Service: (800) 547-3330 **Catamaran**

2013



This form provides important information about the injured worker's ability to work.

- The treating physician must submit this form each time he/she sees the injured worker unless the injured worker has been awarded permanent and total disability, has returned to work without restrictions within seven days of the injury, or is being treated after the treating physician has released him/her to his/her former position without restrictions.
- Please complete this form and provide a copy to the injured worker during his/her office visit. Fax a copy to the appropriate managed care organization (MCO) or to the injured worker's employer if self-insured.
- This form or an equivalent physician-generated document may support a request for temporary total compensation. The equivalent document must contain, at a minimum, the data elements required on this form. If you have submitted previously equivalent data elements that remain the same, indicate the name of the report that reflects the injured worker's current condition, e.g., May 15, 2015, office note.
- You may attach additional medical documentation such as diagnostic test results and a treatment plan to this form.
- Failure to provide complete detailed information may delay or suspend compensation payments to the injured worker.

Instructions

MEDCO-14 submission section: You must select only one of the three choices by selecting the appropriate box. If you previously completed a MEDCO-14 and there are changes, you must indicate the changes in the appropriate section on the form, and select the yes box in that section. For all other sections, you would make no entry, and select the no box.

Employment/occupation section: Please indicate if you have reviewed a description of the injured worker's job held on the date of the injury. Please indicate all sources providing you a description of the injured worker's job. If you do not have a copy of the injured worker's job description, BWC or the MCO can help secure one.

Work status/Injured worker's capabilities section: Please complete this section as accurately and thoroughly as possible, as BWC will use this information to understand the injured worker's work status and help facilitate his/her appropriate and safe return to work either to his/her job held on the date of injury or an alternative job if he/she cannot return to the job held on the date of injury.

3A: Please indicate if the injured worker has any physical or health restrictions **related only to the allowed conditions in the claim**. If there are restrictions, please indicate if the restrictions are permanent or temporary. If there are no related restrictions you should check the release to work box. The date of the exam will be the release to work date.

3B: If there are restrictions **related only to the allowed conditions in the claim**, indicate whether or not the injured worker can return to **the full duties** of his/her job held on the date of injury. If you determine the injured worker cannot return to the full duties of his/her job held on the date of the injury, you must include the date for which you indicate the injured worker could not fully perform the duties of his/her job held on the date of the injury. You must also indicate an estimated date when you believe the injured worker should be able to fully perform the duties of the job held on the date of injury. **It is imperative that you follow all 3B instructions. This will facilitate appropriate processing of the injured worker's claim. Updates to dates in 3B requires 4A to be completed.**

3C: Although an injured worker may not be able to fully return to the job held on the date of injury, understanding the injured worker's capabilities will assist in identifying appropriate and safe work that an injured worker may be able to perform. If an injured worker may return to available and appropriate work with restrictions accommodated, please indicate the possible return to work date. Further, to facilitate BWC's efforts to safely return an injured worker to appropriate work, indicate which of the activities listed in this section, the injured worker can perform. The following definitions apply to the section on Lifting/carrying, Pushing/pulling and Activity with the percentages reflected as they relate to an eight-hour workday:

- Never – 0 percent;
- Occasionally – 1 percent to 33 percent, four to six repetitions per hour;
- Frequently – 34 percent to 66 percent, six to 12 repetitions per hour;
- Continuously – 67 percent to 100 percent, greater than 12 repetitions per hour.

Please note that if the "yes" box is checked in response to the question of whether the injured worker has functional restrictions based only on allowed psychological conditions the MEDCO-16 should be referenced as needed.

We encourage you, in the space provided, to provide any additional information you believe would benefit the injured worker's safety and care relative to any return to work considerations.



Instructions continued

4A: Disability period information section: It is critical that if you answered No to 3B or made changes to dates in 3B this section is fully completed: Please furnish the narrative description of the diagnosis(es), site/location and International Classification of Diseases code for only allowed conditions being treated. You must indicate by checking the appropriate box whether the allowed condition is preventing the injured worker from returning to the job held on the date of injury.

4B: In this area you should list all other relevant conditions that impact treatment of the allowed conditions in the claim.

Clinical findings section: Provide medical rationale for the delay in the injured worker's recovery and the barriers to return to work.

Maximum medical improvement (MMI) section: Provide the MMI date or explain why the injured worker has not reached MMI. Provide the proposed treatment plan, including estimated duration.

Vocational rehabilitation section: If the injured worker is not a candidate for vocational rehabilitation, explain and recommend actions to help the injured worker return to employment.

Treating physician's signature section: Sign and date this form. Your signature indicates you have answered the questions as truthfully and completely as possible.

For more information or assistance

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



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 appropriately checking Yes or No on each section.

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 physical or health restrictions related to allowed conditions in the claim? Yes No
If yes, are the restrictions: Permanent Temporary **Proceed to section 3B.**
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. **Proceed to section 8.**
- 3B If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes No
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. **Proceed to section 8.**
If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
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.**

Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date: ____/____/____.
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, can the injured worker 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				Pushing/pulling				
Activity	N	O	F	C	Activity	N	O	F	C	N	O	F	C
Bend					Reach above shoulder					0 - 10 lbs.			
Squat/kneel					Type/keyboards					11 - 20 lbs.			
Twist/turn					Work with cold substances					21 - 40 lbs.			
Climb					Work with hot substances					41 - 60 lbs.			
										61 - 100 lbs.			
										100 + lbs.			

- 3C How many total hours can the injured worker work: ____ per week ____ per day?
In an eight-hour workday, how many total hours can the injured worker: Sit: ____ hours Continuously With break
Walk: ____ hours Continuously With break Stand: ____ hours Continuously With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? Yes No **If Yes**, please describe in space provided below. Note: **If Yes** is indicated please reference the MEDCO-16 as needed.
Additionally, in this space, please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. _____

Injured worker name		Claim number	Date of injury	
Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed)				(Updates Yes <input type="checkbox"/> No <input type="checkbox"/>)
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.				
4A	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 <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 <input type="checkbox"/>
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: You can reference office notes in lieu of writing clinical findings below.				(Updates Yes <input type="checkbox"/> No <input type="checkbox"/>)
5	The injured worker is progressing: <input type="checkbox"/> As expected <input type="checkbox"/> Better than expected <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>)
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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>)
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 <input type="checkbox"/> No <input type="checkbox"/> 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	
	Treating physician's signature			
BWC provider (Peach) number		Date	Telephone number	Fax number