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FRANKLIN COUNTY INJURY PACKET

AUGUST 2023

In This Packet You Will Find:

- What to do if you are injured
- Who to call if you have questions
- Answers to FAQs
- Accident Report Form for Injured Employees *(ARFIE)*
- Authorization to Release Medical Records Form
- Workers' Compensation & Injury Identification Card
- Optum First Fill Pharmacy Card
- Important Ohio BWC Forms including by not limited to:
  - First Report of an Injury
  - Occupations Disease or Death Form *(FROI-01)*
  - Ohio BWC Physician's Report of Work Ability Form *(MEDCO-14)*
- A list of Certified Medical Providers by Location

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INTRODUCTION

Our goal is to keep you safe as you move throughout your workday. If you happen to sustain a workplace injury or illness, we want you to have immediate access to quality medical attention. We are committed to working with you and your health care providers to ensure you are getting the care that you need so you can return to work and your normal routines as soon as it is safe to do so.

Franklin County is self – insured for Worker's Compensation claims which means you will receive timely and individualized attention. We follow all the requirements set forth by the State of Ohio's Bureau of Worker's Compensation but at the same time, we can review and act on medical requests quickly. In addition to our Risk Management Team, the County has contracted with a company called Sedgwick to manage all worker's compensation claims for the employees of Franklin County. Medical billing, lost wages and medical reports are paid and / or processed through Sedgwick. A company called Helios is the company that processes bills for prescriptions that are needed.

The information that follows is intended to help you navigate the worker's compensation process. Please contact us with any questions you may have.

- *The Franklin County Risk Management Team*

How to Contact the Risk Management Team:

- **Kimberly Kimmel** – Risk Manager
  Phone Number: (614) 525 – 4642
  Email Address: kakimmel@franklincountyohio.gov
- **Kaylyn Leckrone** – Employee Risk & Development Administrator
  Phone Number: (614) 525 – 5829
  Email Address: Kaylyn.Leckrone@franklincountyohio.gov
- **Phil Koontz** – Senior Safety & Health Specialist
  Phone Number: (614) 525 – 5725
  Email Address: pekoontz@franklincountyohio.gov
- **Michael Stephens** – Senior Safety & Health Specialist
  Phone Number: (614) 525 - 4520
  Email Address: michael.stephens@franklincountyohio.gov
- **Tyra Womack** – Senior Safety & Health Specialist
  Phone Number: (614) 525 - 6629
  Email Address: tyra.womack@franklincountyohio.gov

Address – Franklin County Department of Human Resources
Attn: Risk Management
373 South High Street – 25th Floor
Columbus, Ohio 43215
Fax Number: (614) 525 – 5715

Email Address - risk@franklincountyohio.gov

INJURED EMPLOYEE

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WHAT DO I DO IF I AM INJURED AT WORK?

SEEK MEDICAL TREATMENT IMMEDIATELY, IF NECESSARY, AND NOTIFY YOUR SUPERVISOR.

- When seeking medical treatment, please take the **Workers' Compensation and Injury Identification Card** *(included in this packet)* to all appointments. This information provides our account billing information and explains how medical bills should be processed so you don't personally receive a bill. This information is available at:
  - *https://portal.co.franklin.oh.us/hr/pdf/Worker-Compensation-Identification-Card.pdf*
- Be sure your medical provider is BWC Certified. Refer to the **BWC Certified Medical Providers** *(included in this packet)* for a list of providers near you. These providers will treat you immediately on a walk - in basis and serve as your Physician of Record *(POR).* A complete list of BWC Certified Medical Providers can be found at:
  - *https://www.bwc.ohio.gov/provider/services/providerlookup/nlbwc/ProviderSearch.aspx*
- Use the **Optum First Fill Pharmacy Card** *(included in this packet)* to cover any prescriptions you need. This information is also available on the Franklin County website:
  - *https://portal.co.franklin.oh.us/F/HMRS/public/documents/PDF/69366897-A29B-3B05-26350600710A4493.pdf*
- You will be required to complete a **First Report of Injury** *(FROI)* **Form** and submit it by mail to: Sedgwick CMS, P.O. Box 14661, Lexington, Kentucky 40512 - 4661 or by fax to: (855) 223 - 9836. You may also send the completed FROI to Risk Management and we will be sure to submit the document to Sedgwick for you. This form can be found within the Injury Packet or at the Franklin County website at:
  - *https://www.bwc.ohio.gov/downloads/blankpdf/froi-20020723.pdf*
- Please ask your medical provider to fill out a **BWC MEDCO – 14** form *(included in this packet).* This form gives us important information about your medical status including when you can return to work, or if you can return to work with restrictions. These forms can be found within the Injury Packet and are also available on the Franklin County website at:
  - *https://www.bwc.ohio.gov/downloads/blankpdf/medco-14.pdf*

As soon as possible, fill out a **Franklin County Accident Report for Injured Employees** *(ARFIE)*, as well as the **Authorization to Release Medical Records** and forward the completed documents to your supervisor. The supervisor will complete the ARFIE and forward to Risk Management so that a worker's compensation claim can be opened.

Contact Risk Management if you have questions or require additional information:

Call: (614) 525 - 4642 or (614) 525 - 6629

Fax: (614) 525 - 5715

Email: *risk@franklincountyohio.gov*

SUPERVISORS

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WHAT HAPPENS IF YOUR EMPLOYEE IS INJURED AT WORK?

- As soon as possible, have your employee complete an Accident Report for Injured Employees Form *(ARFIE)*, as well as the Authorization to Release Medical Records form and return to their supervisor.

PLEASE NOTE: An ARFIE should be filled out even if the injured employee does not seek medical treatment

- A supervisor, or other management representative, needs to review the ARFIE, complete the Supervisor's Section *(page 3 / 4 of 5)*, and then email or fax the forms to Risk Management so that a workers' compensation claim can be opened. In the event the employee is unable to complete the ARFIE due to the nature of the injury or illness, the supervisor SHALL complete the Accident Report *(ARFIE)* on behalf of the injured employee with as much demographic and accident information as possible.

***** IMPORTANT LEGAL REQUIREMENT *****

State Law requires that all workplace fatalities, hospitalizations, amputations, or loss of an eye be reported to the Public Employers' Risk Reduction Program *(PERRP)*. Franklin County must adhere to strict reporting procedures and tight reporting timelines for any of the events listed above. Follow these steps IMMEDIATELY - failure to do so is a serious violation with serious consequences.

All Franklin County agencies must comply with this requirement as follows:

1. The Agency Elected Official, Director, or other designated management representative shall report within 8 hours to the County Administrator any death of an employee from a work - related incident.
2. The Agency Elected Official, Director, or other designated management representative shall report within 24 hours to the County Administrator a work – related incident resulting in:
    a. the hospitalization of one or more employees
    b. an amputation
    c. the loss of an eye
3. If the Agency Elected Official, Director, or other designated management representative does not learn of a reportable incident at the time it occurs, the incident shall be reported to the County Administrator within 8 hours of the time the incident is discovered.
4. The County Administrator shall consult with the County Prosecutor in regard to any workplace death, incidents resulting in hospitalization, and / or any amputation or loss of an eye, after which a determination will be made as to whether the work – related incident is reportable to PERRP.

*** IMPORTANT NOTE:** The determination as to whether the incident is work - related and / or reportable resides exclusively with the County Administrator and County Prosecutor. All incidents which appear to apply to the above (A) and (B) or (C) should be reported in a timely manner as directed above. *****

5. After the County Administrator has consulted with the County Prosecutor, the County Administrator shall contact Risk Management and provide authorization for Risk Management to report the work – related incident to PERRP.
    a. Each report shall relate the following information: establishment name, location of the incident, time of the incident, number of fatalities, hospitalized employees, or injured employees, contact person for the employer, phone number, and a brief description of the incident.
    b. When reporting fatalities:
        i. Risk Management will call PERRP at 1 (800) 671 - 6858 and choose option #1.
        ii. Risk Management will complete the notification form and submit to *PERRPFatality@bwc.state.oh.us*

Pertinent OAC 4167 - 1 - 01 Definitions:

(D) "Amputation" means the traumatic loss of a limb or other external body part. Amputations include a part, such as a limb or appendage that has been severed, cut off, amputated *(either completely or partially);* fingertip amputations with or without bone loss; medical amputations resulting from irreparable damage; amputations of body parts that have since been reattached. Amputations do not include avulsions, enucleations, degloving, scalping, severed ears, or broken or chipped teeth.

(M) "Hospitalization" means the hospitalization of a public employee as the result of a work – related incident. Such hospitalization must be:

1. An admission to a hospital or equivalent facility *(an employee that is treated then released is not considered hospitalized for purposes of this rule).*
2. Occurring within thirty days of an incident.

An inclusive list of PERRP definitions can be found at OAC 4167 – 1 – 01.

Agency Directors have been provided with the direct – line contact numbers for:

- County Administrator, Kenneth N. Wilson
- Assistant County Prosecutor, Tom Ellis
- HR Director/ Risk Management, Laura Repasky

If you have questions or require additional information regarding any worker's compensation or a PERRP reporting issue, please contact the Risk Management team.

FAQs FOR EMPLOYEES & SUPERVISORS

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What does it mean for Franklin County to be self-insured for workers' compensation?

- Beginning on April 1st, 2012, Franklin County became self – insured for workers' compensation coverage. The privilege to self – insured provides Franklin County with the ability to provide greater oversight of the workers' compensation claims processes. Whereas, prior to this privilege, the Ohio Bureau of Workers' Compensation *(BWC)* provided direct oversight of all claim decisions and Temporary Total Disability *(TTD)* and other related indemnity payments.

Do I still have to complete an Accident Report for Injury Employee *(ARFIE)* Form when I've experienced an accident, injury, or illness on the job?

- Yes, all accidents, injuries or illnesses that arise from or are a result of the course of the employee's employment, MUST have an Accident Report Form for Injured Employee *(ARFIE)* completed by the employee within 24 hours of the said, accident, injury, or illness.

How do I obtain the Injury Packet?

- You can obtain and Injury Packet which includes all the forms you need as follows:
  - Online at: *ARFIE Packet*
  - Ask your Agency Supervisor
  - Contact Risk Management at (614) 525 - 4642 or (614) 525 - 6629 or email at *risk@franklincountyohio.gov*

Can I see any medical provider and how can I locate a medical provider?

- If you receive treatment beyond your initial medical treatment, you MUST see an Ohio BWC Certified Provider for ALL treatment. If your injury*(s)* requires that you be off work for an extended period of time, you also need to establish a Physician of Record *(POR).* The POR is very similar to your primary care provider in that the POR directs and requests all treatments such as physical therapy, diagnostic procedures, specialist referrals, etc. Before you seek medical treatment, please ask if the doctor you want to see is BWC certified and if that doctor will serve as your POR. A BWC certified POR is trained in the requirements of Ohio Workers' Compensation insurance *(i.e. Understands the correct forms and regulations).*
  - Please contact Risk Management at (614) 525 - 6629 or (614) 525 - 4642 or email *risk@franklincountyohio.gov* if you need any assistance.

Can I use my County health insurance instead of filing a workers' compensation claim?

- **Workplace injuries and illnesses are not covered under the County's health insurance plan because they are covered as part of your workers' compensation benefit.**

Will the Ohio BWC continue to make the decision regarding my workers' compensation claim and allowance*(s)*?

- No, Franklin County will be fully responsible for making an initial claim determination, within 30 days from the filing of a claim, based on the facts of the claim, including supporting medical evidence. Franklin County's Third – Party Administrator, Sedgwick Claims Management Services, Inc. *(Sedgwick)* will submit a letter informing you of the County's decision.

FAQs FOR EMPLOYEES & SUPERVISORS

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What is a "Medical Only" claim?

- An injury or illness resulting in seven *(7)* or fewer calendar days of missed work is defined as a Medical Only claim. For self – insured employers, these claims do not need a BWC claim number, unless Franklin County contests your claim.

What is a "Lost Time" claim?

- An injury or illness resulting in eight *(8)* or more calendar days of missed work is defined as a Lost Time claim. Lost Time claims must be filed with the Ohio Bureau of Workers' Compensation *(BWC)* and assigned a BWC claim number. You will be required to complete a First Report of Injury *(FROI)* Form and submit by mail to: Sedgwick CMS, P.O. Box 14661, Lexington, Kentucky 40512 - 4661 or via fax to: (855) 223 - 9836.

Will I be protected under Family and Medical Leave *(FML)* if I miss time away from work due to my injury or illness?

- Yes, as long as you meet the eligibility criteria for FMLA, your time away from work will run concurrently with your workers' compensation claim.

Who do I contact to file a FMLA claim?

- Contact your Agency Human Resources Department for all matters regarding FMLA.

If I have a Lost Time Claim, who pays for my salary when I am unable to work?

- With an approved claim, Sedgwick will issue all compensation payments including Temporary Total Disability *(TTD)* benefits to you on the behalf of Franklin County. You must provide documentation through a C – 84 Form signed by your treating physician before benefits will be initiated.

Will my employee medical benefit plan and OPERS be affected if I am off work receiving temporary total disability benefits?

- Yes, while receiving temporary total disability benefits, you will need to coordinate with your payroll team to pay your employee contribution. The OPERS benefit is affected, and no contribution is made during your disability leave. Please contact your Agency Human Resources Department for further information.

How long until I receive Temporary Total Disability *(TTD)* ?

- With an approved claim TTD begins on the eighth *(8^{th})* calendar day following the injury or illness. However, if you are off work for fourteen *(14)* consecutive days, Franklin County will pay you for the first seven *(7)* days of missed work. If Franklin County determines that payments are directly related to the allowed conditions in your claim, we / Sedgwick will issue compensation on a bi – weekly basis within 21 days upon receipt of supporting medical documentation and an approved claim determination. Once you return to work or have reached Maximin Medical Improvement *(MMI)*, TTD payments will terminate.

FAQs FOR EMPLOYEES & SUPERVISORS

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Who do I contact when I have a question about my claim or my compensation payments?

- You may contact the Risk Management Department at (614) 525 - 4642 or (614) 525 - 6629 or Franklin County's Third – Party Administrator, Sedgwick Claims Management Services Inc., *(Sedgwick)* at 1 (800) 267 - 4001 for questions concerning physician visits, change of physician or medical treatment requests.

Are my workers' compensation benefits taxable?

- Generally, worker's compensation benefits are not taxable, but please consult your accountant, financial advisor, or attorney if you have questions.

What happens if my claim is denied?

- If Franklin County denies your workers' compensation claim, your claim will be filed by Sedgwick with Ohio Bureau of Workers' Compensation. You will be notified of the denial. The claim will then be referred to the Industrial Commission *(I.C.)* of Ohio for a hearing.

Who is the Industrial Commission *(I.C.)* ?

- The IC is independent from BWC where a hearing officer will hear all disputed issues arising from your claim. A hearing is typically scheduled within 45 days from the date of referral or appeal to the IC.

What happens when I need to have a prescription filled for my injury or illness?

- When you receive the Franklin County Injury Packet it will contain a Optum First Fill Pharmacy Card. This card will allow you to have a 7 – 10 day supply of your prescription filled at a local network retail pharmacy, at no out – of – pocket costs to you. Prescriptions will be filled, even if Franklin County has not yet certified your claim. If your claim is denied, you will not be responsible for that initial fill.

Will I owe a copay or deductible payment for my medical treatment?

- You will NOT be responsible for any copays or deductibles under your workers' compensation claim.

Who pays for my medical bills?

- Franklin County will pay for health – care services directly related to your workplace injury or illness through our contracted an – agreement with Sedgwick. Below further illustrates the bill payment guidelines for a self – insured employer:
    - Prior authorization is usually required for medical services, such as consultations, surgery, and physical therapy, except for emergency situations.
    - The provider or you must submit all medical bills within two years of the date of service to be considered for payment.
    - Franklin County must pay medical bills within 30 days of receipt, unless additional information is needed, or the bill is being denied.
    - If Franklin County denies a medical bill, you may file a C – 86 Motion to request a hearing before the LC.
    - If the health – care provider treats you for a condition not recognized in your claim, neither BWC nor Franklin County is responsible for payment. If you believe the condition is related to your claim, you may file a C – 86 Motion with Franklin County Risk Management to have the condition recognized. If Franklin County denies the C – 86 Motion, the County's third – party Administrator, Sedgwick, will submit copies of your denied C – 86 Motion to the LC.

FAQs FOR EMPLOYEES & SUPERVISORS

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

- If you receive bills from your physician, WorkHealth, Urgent Care, the hospital, etc. please send them via mail to SedgwickCMS, P.O. Box 14661, Lexington, Kentucky 40512 - 4661 or fax to Sedgwick at (855) 223 - 9836 or you can email them to *risk@franklincountyohio.gov* or fax them to Risk Management at (614) 525 - 5715. Please include your BWC and / or Sedgwick Claim Number when sending any medical bills.

Is Vocational Rehabilitation an option that will be available to me?

- If you are interested in vocational rehabilitation services, please contact the Risk Management Department. Our office will work with a team of professional licensed vocational rehabilitation counselors that can provide services to you, such as Job Development / Seeking Skills training, Job Placement, Resume Writing, on – site physical therapy, Functional Capacity Examinations, Transitional Work, and Remain at Work services.

What if I feel like I am able to return to my regular duties faster than the estimated return to work date on my MEDC0 - 14?

- The County always recommends that you listen to the advice of your POR and take adequate time to heal to avoid reinjuring yourself, however, if you feel as though you are completely healed and able to perform your regular job duties, then you will need to schedule a follow up visit with your POR and have them issue you an updated MEDC0 - 14 that releases you to full duty or reduces the restrictions that were preventing you from returning to your regular job.

When my employee is injured on the job, what are my responsibilities?

- You are responsible for making sure that your employee*(s)* receive the Franklin County Injury Packet and complete the ARFIE within 24 hours of the accident, injury, or illness. After the employee has completed their portion, you must complete the Supervisor's Section of the ARFIE, sign this form, and ensure that it is filed immediately with the Risk Management Department via fax or email.
    - IMPORTANT: State Law requires that all workplace fatalities, hospitalizations, amputations, or loss of an eye be reported to the Public Employers' Risk Reduction Program *(PERRP).* Franklin County must adhere to strict reporting procedures and tight reporting timelines for any of the events listed above. Follow the steps listed in the injury packet about how to report such situations. Failure to comply is a serious violation of law and could result in major consequences.

When my employee needs medical treatment, where do we instruct them to go to seek appropriate treatment?

- If the situation is an emergency, then please help the injured employee seek treatment at the closest hospital emergency department. For less serious incidents we encourage supervisors and managers to instruct employees to first seek treatment at Urgent Care or Occupational Medicine facilities as most of these providers are BWC certified and familiar with the workers' compensation process. You will find a more extensive and geographical list of providers within the injury packet.

FAQs FOR EMPLOYEES & SUPERVISORS

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What is Modified Duty and when does it apply?

- Modified duty *(Sometimes Called Light Duty)* is when the injured worker is able to return to their regular job with the County, but the Agency may have to make some adjustments to accommodate whatever restrictions the physician of record *(POR)* has placed on the injured worker on the Physician's Report of Workability Form *(MEDCO - 14).*
    - An example of this may be that the injured worker must be allowed to sit while working rather than standing all day. If the Agency can accommodate the injured worker by allowing them sit in a chair while still doing their regular job, then the Agency has accommodated the injured workers restrictions with modified duty.

Can my employee*(s)* be able to continue to participate in the County's Transitional Work Program?

- Yes. In transitional duty situations, the Agency is unable to accommodate the injured worker's restrictions on the MEDCO - 14, and so the injured worker cannot return to their regular job with the County. In these cases, the Agency is looking for something the injured worker can do that is within the restrictions imposed by their POR on the MEDCO - 14. Transitional Duty is a time-limited program *(the County program is 12 weeks)* where the goal is to gradually transition the injured worker back towards their regular work duties.
    - Example: a mechanical engineer with fleet management who is under the restriction that they can't lift more than 5 lbs. could come work for the Document Imaging Center where they can scan files or shred documents until they are able to return to their regular job duties.

Will sick time used by my employee*(s)* still be an off set to TTD or any additional work-related payments?

- Yes, any sick time used or paid during the period in which TTD is paid will be off set. It is critical that open lines of communication continue between Risk Management and Agency Directors / Supervisors to ensure that overpayments do not occur. Additionally, some employees may be eligible for working or non – working wage loss; whereas supplemental payments occur when employees are not able to return to their regularly performed jobs or perform the essential functions of their job*(s)* on a full – time basis. This generally occurs when the employee is working reduced hours or off work working in the County's Transitional Work Program. Again, any supplemental sick time paid during these payments will be off set.

Can I get back sick leave or vacation time I used for my work - related injury?

- The County cannot replenish any vacation you used while off work due to a workplace injury. However, please check with your agency regarding whether they offer sick leave replenishment and once you determine the amount of sick time you used, please contact Risk Management with this information to see if you qualify for sick leave replenishment.

FAQs FOR EMPLOYEES & SUPERVISORS

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Who do I call if I have questions regarding family medical leave *(FMLA),* return to work, transitional work, remaining at work, vocational rehabilitation and / or physical therapy services?

- The Risk Management Department can assist with all questions EXCEPT for questions regarding FMLA. All FMLA questions should be directed toward the Human Resources Department at your Agency.

What is the timeframe for approval of a new claim?

- Self – insured employers have up to 30 days from the date of First Report of Injury *(FROJ)* receipt to approve, deny or take other action on the claim request.

What is the timeframe for approval of C - 9 requests for treatment?

- Self – insured employers have 10 days from the receipt of the C – 9 request to approve, deny, or take other action on the C – 9 *(If the 10th day falls on a state holiday, the response is due the next business day).*

If the C - 9 is denied, what are the next steps?

- If the request has been denied, the self – insured employer must document the reason for denial, and notify the provider, the injured worker, and their authorized representative the decision. The injured worker has a right to file a C – 86 Motion with the IC to resolve the disputed matter.

How are requests for additional allowances submitted?

- A request for additional allowance must be supported by medical evidence and requested in writing. The self – insured employer can accept the additional condition or deny the condition. The self – insured employer will notify the injured worker in writing if the condition is not supported. The injured worker has the right to file a C – 86 Motion with the Industrial Commission if the employer does not agree with the additional condition.

Who can the provider's office contact regarding pharmacy issues such as medication authorization?

- Contact the Risk Management Department at (614) 525 - 4642 or (614) 525 - 6629.

Where Can I Obtain Additional Information?

- Your questions can be answered by:
  - Visiting - *"How to Report an Injury and File a Workers' Compensation Claim"*
  - Contact the Risk Management Department by email at *risk@franklincountyohio.gov*
    - By Phone at (614) 525 - 4642 and (614) 525 – 6629
    - By Fax at (614) 525 - 5715.

ACCIDENT REPORT FOR INJURED EMPLOYEES *(ARFIE)*

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INJURED EMPLOYEE INFORMATION

Employee Full Name | *Social Security Number* | *DOB (Month / Date / Year)*

Home Street Address | *City* | *State* | *Zip Code* | *County*

Work Phone Number (Including Area Code) | *Personal Phone Number (Including Area Code)* | *Gender*

Work Email Address | *Personal Email Address*

Agency Name | *Position Title* | *Date of Hire (Month / Date / Year)*

ACCIDENT INFORMATION:

To be completed by injured employee, or the supervisor in the event the employee is incapacitated.

1. When did your work shift begin? *Date / Time:* _____
2. When did the accident / injury occur? *Date / Time:* _____
3. Did the accident / injury occur on County property? ☐ Yes ☐ No
4. Where did the accident occur? *(Be specific, i.e. address, floor, room number)*
5. What were you doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material you were using. Be specific. *(Examples: climbing a ladder while carrying roofing materials; spraying chlorine from hand sprayer)*
6. How did this happen? Tell us how the injury occurred *(Examples: when ladder slipped on wet floor, I fell 10 feet on my back; I was sprayed with chlorine in the eyes when gasket broke during replacement).*
7. What was your injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than just using the words "hurt, " "pain" or "sore" *(Examples: strained lower back; chemical burn on right hand).*
8. What object or substance directly harmed you? *(Examples: concrete floor; chlorine; radial arm saw).* If this question does not apply to the incident, leave it blank.
9. Date accident / injury was reported to Supervisor: _____
10. Supervisor's name or person accident was reported to: _____
11. Supervisor's work phone number *(including area code):* _____

ACCIDENT REPORT FOR INJURED EMPLOYEES *(ARFIE)*

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12. Was Medical Treatment Sought? ☐ Yes ☐ No

If yes, please provide the following medical provider information.

Medical Provider Name | *Name of Practice / Hospital / Urgent Care* | *Phone Number (Including Area Code)*

Address | *City* | *State* | *Zip Code* | *County*

13. Were you treated in an emergency room? ☐ Yes ☐ No

14. Did you receive treatment classified as beyond first aid at the hospital / medical facility? ☐ Yes ☐ No

15. Were you admitted to the hospital for an overnight stay as an in – patient? ☐ Yes ☐ No

16. Was there a death, amputation, hospitalization, or loss of an eye as a result of your injury? ☐ Yes ☐ No

If Yes, please check all that apply: ☐ Death ☐ Amputation ☐ Hospitalization ☐ Loss of Eye

17. Were you injured as a result of an auto accident? ☐ Yes ☐ No

If yes, please attach a copy of the motor vehicle accident report to this report or send a copy of the report via fax to (614) 525 - 5715 or via email to risk@franklincountyohio.gov when the report is available.

18. List the names of anyone who witnessed your accident / injury. *Attach additional page(s) if necessary.*

Witness One: _____ *Full Name* _____ *Phone Number*

Witness Two: _____ *Full Name* _____ *Phone Number*

Witness Three: _____ *Full Name* _____ *Phone Number*

Witness Four: _____ *Full Name* _____ *Phone Number*

19. Employee Signature and Acknowledgement

I confirm that the information supplied on this form is accurate and truthful and that the accident / injuries described herein were not self – inflicted. I understand that the Franklin County Risk Management staff will investigate the circumstances of the events / accident related to my accident / injury. Further, I understand that I am applying for benefits under the Ohio Bureau of Workers' Compensation Act. I affirm that I elect to receive compensation and benefits under the Workers' Compensation Laws to which I am entitled, and I waive my right to file for and receive compensation under the laws of any other state for this claim. I request payment for compensation and / or medical benefits as allowed and I authorize direct payment*(s)* to my medical provider*(s)*. I permit and authorize any provider who attends to, treats, or examines me to release medical, psychological, psychiatric, vocational, or social information that is casually or historically related to my physical or mental injuries relevant to the issues necessary for the administration of my claim to the Industrial Commission of Ohio, the Ohio Bureau of Workers' Compensation, the employer of record, and any employer authorized representatives. I understand that my previous or future Workers' Compensation claims may affect decisions made in this claim. I understand that proper administration of this claim may require parties to the claim to share this information for any and all such previous and / or future claims. The released claims information may include any record maintained in my claims files.

Employee Printed Name | *Employee Signature* | *Date*

Forward ARFIE to Supervisor / Management Representative for completion once pages 1 and 2 are completed.

ACCIDENT REPORT FOR INJURED EMPLOYEES *(ARFIE)*

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SUPERVISOR SECTION:

Please review pages 1 and 2 of the accident report as submitted by the employee. In the space below, please provide relevant information such as additional details, comments and / or dispute of any or all of the injured employees' statements. Include details of the accident / injury as you saw it or as it was reported to you *(noting who reported the accident to you).*

1. Was the injured employee able to return to work the same day the accident / injury occurred? ☐ Yes ☐ No ☐ Unknown

   If no, what was the last date employee worked? _____

2. Did the injured employee complete page 1 and 2? ☐ Yes ☐ No

If no, the employee's Supervisor should fill out pages 1 and 2 of this form to the best of their ability and explain why the employee was unable to complete pages 1 and 2. Please provide as much detail as possible.

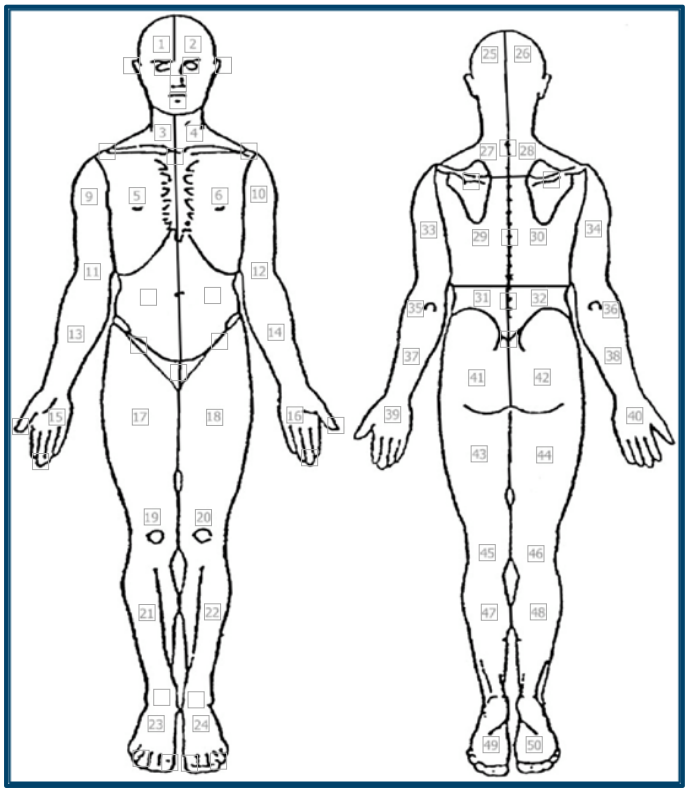
3. Did the injury result in a death, amputation, hospitalization, or loss of an eye? ☐ Yes ☐ No

4. What is the date of death if death occurred? _____

IF YES, PLEASE REVIEW AND EXECUTE THE PROPER REPORTING PROCEDURE LISTED WITHIN THE INJURY PACKET IMMEDIATELY!

5. Injured Employee *(Complete this section for each injured employee)*

Part of the Body Affected *(Shade All Areas that Apply)*



Nature of Injury *(Check all Injuries that Apply)*

☐	Abrasion *(Scrapes)*	☐	Hearing Loss
☐	Acid Reflux	☐	Hematoma
☐	Allergic Reaction	☐	Hernia
☐	Amputation	☐	Illness
☐	Anxiety	☐	Inflammation
☐	Arthritis	☐	Insomnia
☐	Blurred Vision	☐	Laceration
☐	Burn - Chemical	☐	Loss of Consciousness
☐	Burn - Electrical	☐	Lyme Disease
☐	Burn - Heat	☐	Memory Loss
☐	Carpal Tunnel Syndrome	☐	Multiple Physical Injuries
☐	Cellulitis	☐	No Physical Injury
☐	Chipped / Broken Tooth	☐	Other
☐	Closed Head Injury	☐	Pinched Nerve
☐	Concussion	☐	Poisoning / Toxic Effects
☐	Contusion *(Bruising)*	☐	Pre - Existing Medical Condition
☐	COVID-19	☐	PTSD
☐	Crushing Injury	☐	Puncture
☐	Damage to a Bodily System	☐	Radial Styloid Tenosynovitis
☐	Dehydration	☐	Radiculopathy
☐	Dermatitis *(Poison Ivy)*	☐	Rupture
☐	Detachment	☐	Sciatica
☐	Disease	☐	Shortness of Breath
☐	Dislocation	☐	Sprain
☐	Dizziness	☐	Strain
☐	Exposure to Foreign Bodily Fluid / Blood	☐	Swelling
☐	Exposure to Unknown Substance	☐	Tear
☐	Foreign Body in Eye	☐	Tendinitis
☐	Fracture	☐	Unspecified Injury
☐	Gunshot Wound	☐	Vision Loss
☐	Headache	☐	Whiplash

ACCIDENT REPORT FOR INJURED EMPLOYEES *(ARFIE)*

6. How can future incidents be prevented?

What changes do you suggest to prevent this incident from happening again?

- ☐ Guard the Hazard
- ☐ Train the Employee*(s)*
- ☐ Train the Supervisor*(s)*
- ☐ Redesign Task Steps
- ☐ Routinely Inspect for the Hazard
- ☐ Personal Protective Equipment
- ☐ Consideration of New Policy / Procedures
- ☐ Other: _____

Comments or Suggestions:

7. List of names of additional witnesses to the accident / injury. *Provide witness statements. See page 5 of ARFIE*

Witness Five: _____ *Full Name* _____ *Phone Number*

Witness Six: _____ *Full Name* _____ *Phone Number*

Witness Seven: _____ *Full Name* _____ *Phone Number*

Witness Eight: _____ *Full Name* _____ *Phone Number*

8. Supervisor's Certification and Signature:

As supervisor or other management representative of the injured employee, I have reviewed this accident report and confirm that my statements are complete and truthful to the best of my knowledge.

_____ *Supervisor Printed Name* _____ *Supervisor Signature* _____ *Date*

Please return completed ARFIE to Risk Management via email *risk@franklincountyohio.gov* or via fax to (614) 525 – 5715.

If you have questions or require additional information, please call (614) 525 – 4642 or (614) 525 – 6629.

Case No. From PERRP Log: _____

ACCIDENT REPORT FOR INJURED EMPLOYEES *(ARFIE)*

Franklin County BOARD OF COMMISSIONERS 1803 Service. Progress. Excellence.

WITNESS STATEMENT

Name of Injured Employee: _____

Name of Witness: _____

Location Where Incident Occurred: _____

Date & Time of Incident: _____

1. What were you *(the witness)* doing at the time of the incident?

2. How and when did you become aware of the incident?

3. What did you hear at the time of the incident?

4. Describe what you saw at the time of the incident:

5. Who else was present?

6. Please relate any additional information you have pertaining to the incident:

Witness Signature: _____ Date Signed: _____

Please return completed ARFIE to Risk Management via email *risk@franklincountyohio.gov* or via fax to (614) 525 – 5715. If you have questions or require additional information, please call (614) 525 – 4642 or (614) 525 – 6629.

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND DISCLOSE PROFESSIONAL AND PERSONAL INFORMATION

Franklin County BOARD OF COMMISSIONERS
Service. Progress. Excellence.

Employee Name	*Social Security Number*	*DOB (Month / Day / Year)*

Home Street Address	*City*	*State*	*Zip Code*	*Day of Injury (Month / Day / Year)*

TO WHOM IT MAY CONCERN:

I hereby authorize you and / or any other hospital, medical institution, doctor or medical practitioner, insurance company, pharmacy, school board, employer, U.S. Defense Department, Veteran's Administration, Social Security Administration, or any agency of any state, county or municipality, or employee of any of the above or any provider who has given me medical and / or psychological treatment, to furnish and release to the Franklin County Board of Commissioners, or any of its authorized representatives or agents, any and all reports, records, files, and information pertaining to treatment of injuries sustained on date above.

This Authorization includes, but is not limited to, x – ray films, x – ray reports, pathology slides, tissue blocks, nurses' notes, diagnostic testing results, emergency room records and bills for services and applies from the past fifteen years from the date of this signed release to the present. This Authorization also applies to files and information regarding alcohol, drug and psychiatric / psychological reports, records, HIV test result, AIDS and AIDS related conditions. The sole purpose of this release is to further the administration of a workers' compensation claim*(s)* by my employer.

I waive and release the attached list of sources or facilities from any restriction imposed by law thereof, in disclosing any record, observation, diagnosis or communication to the Franklin County Commissioners or any of its authorized representatives or agents. I understand and agree that the information I have authorized to be released is exempt from the privacy requirements of the Health Information Portability and Accountability Act *(HIPAA),* pursuant to 45 CFR §164.512*(e)* and *(I).*

This Authorization is valid for five years from date hereof. I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. I understand that a copy of this Authorization shall serve in lieu of the original.

Date	*Employee Signature*

Attention Medical Providers - Please Remit Medical Records to:	Sedgwick, CMS P.O. Box 14661 Lexington, KY 40512 - 4661 Fax (855) 223 - 9836

ATTENTION:

Franklin County
BOARD OF COMMISSIONERS
Service. Progress. Excellence.

THIS IS YOUR WORKERS' COMPENSATION IDENTIFICATION CARD

PLEASE TAKE THIS WITH YOU IF YOU SEEK MEDICAL TREATMENT AND PROVIDE THIS INFORMATION TO YOUR MEDICAL PROVIDER*(S)*.

Employer Risk number: 20005728 - 0

Attention Provider:

Fax all information within 24 hours of visit to:
Sedgwick at (855) 223 - 9836

Send bills to: SedgwickCMS

P.O Box 14661
Lexington, Kentucky 40512 - 4661

Customer Service *(Claims Adjuster):*

(614) 658 - 0761 or (614) 658 - 0576 or 1 (800) 267 - 4001
Fax (855) 223-9836

OPTUM® sedgwick Franklin County Board of Commissioners HUMAN RESOURCES

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET YOUR WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

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

Injured Employee:

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

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

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

Questions? Need Help?
1-866-599-5426

OPTUM® sedgwick Franklin County Board of Commissioners HUMAN RESOURCES

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Sedgwick	Franklin County Board of Commissioners
CARRIER/TPA	EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Employer:

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

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."

tmesys®

IMP14-1614-76_SEDGWCFFOP

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death (FROI)

Instructions

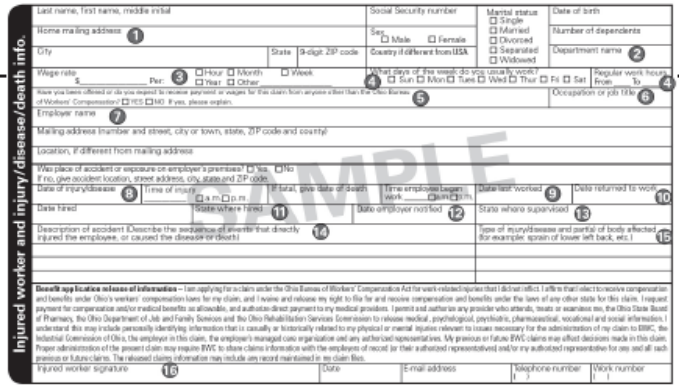
To expedite your claim, you can complete and submit this form online at **www.bwc.ohio.gov.**

- If submitting the hard copy form, complete as much of this form as possible to reduce the time necessary for BWC to determine the claim.
- If you complete this form at your first visit to a medical provider, the provider should complete the treatment information section. The provider can then submit the FROI to the managed care organization (MCO).
- You should also report this injury to your employer.

Where do I file the hard copy FROI?

For injured workers whose employer is self-insured: Send the form to your self-insuring employer. If you are not sure if your employer is self-insured, ask your employer.

For all other injured workers: Fax the form to 1-866-336-8352, or send it to your local BWC customer service office.



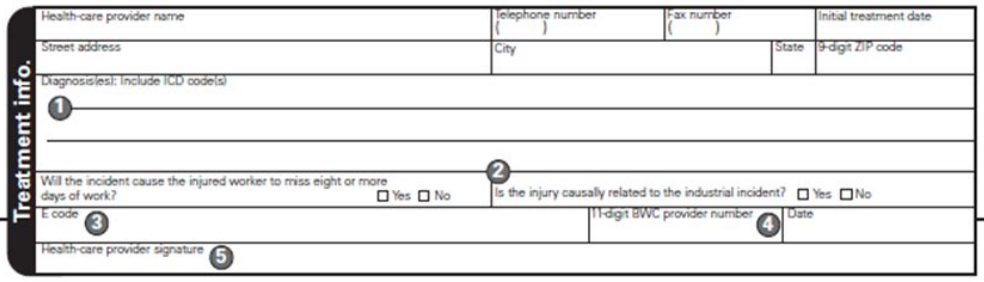
Injured worker and injury/disease/death info.

1. Home address: Address where you live, including the apartment number, if applicable.
   - If the post office does not deliver mail to the home address, list the mailing address.
2. Department name: Enter the department where you normally report for work.
3. Wage rate: Enter your rate of pay, then select how often you receive it. (If the pay rate reported is not hourly, report the gross amount.)
   - If you will miss eight or more days of work, BWC needs wage information for the 52 weeks prior to the date of injury.
4. What days of the week do you usually work? What are your regular work hours: Enter the days and hours you normally work.
   - 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 type of occupation or job title at the time of injury, occupational disease or death.
7. Employer name: Enter the name of your employer at the time of the injury, occupational disease or death.
8. Date of injury/disease: Enter the date you were injured, or if you 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.
   For death claims, enter the injured worker date of death.
9. Date last worked: Enter the last day worked as a result of this injury, occupational disease.
10. Date returned to work: Enter the date you returned to work after the injury or occupational disease.
11. State where hired: Enter the state where the employer listed on this application hired you.
12. Date employer notified: Enter the date that you notified the employer of the injury, occupational disease or death.
13. State where supervised: Enter the state where the employer listed on the application supervised you.
14. Description of accident: Describe in detail the events that caused the injury, occupational disease or death.
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.

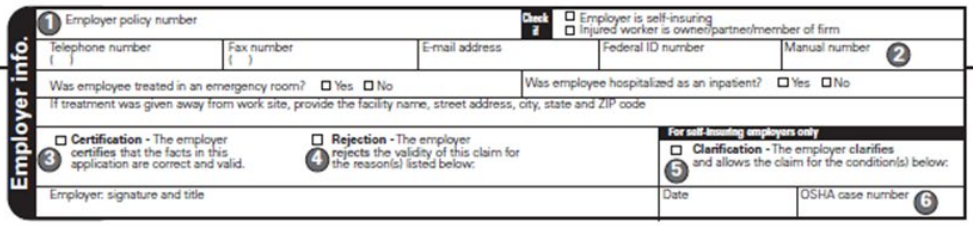
    Examples:
    - Laceration of first toe, left foot;
    - Sprain of lower right back; etc.
16. Injured worker signature (injured workers only): Please read the Benefit application/Medical release information before signing and dating this form.

Completion instructions
(continued)



Treatment info.

1. Indicate the diagnosis and ICD codes for conditions 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. 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.
   - If you do not know the injured worker's manual number, call **1-800-644-6292**, and follow the prompts.
3. If you select certification, and BWC allows the claim, BWC will promptly pay it. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.
4. If you select rejection, 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 sheets, if necessary.
6. If this is an Occupational Safety and Health Administration (OSHA)-reportable injury, include the case number assigned by the employer. This form meets OSHA 301 requirements.You may use it 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's Employer Report of Employee Earnings), W-2s, etc.

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

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

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial			Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address			Sex ☐ Male ☐ Female		Number of dependents
City	State	9-digit ZIP code	Country if different from USA		Department name
Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____			What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From _____ To _____
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.					Occupation or job title

Employer name					
Mailing address (number and street, city or town, state, ZIP code and county)					
Location, if different from mailing address					
Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No (If no, give accident location, street address, city, state and ZIP code)					
Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified	State where supervised	
Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)			Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)		

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

Injured worker signature	Date	E-mail address	Telephone number	Work number

Treatment info.

Health-care provider name		Telephone number	Fax number	Initial treatment date
Street address		City	State	9-digit ZIP code
Diagnosis(es): Include ICD code(s)				
Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No		Is the injury causally related to the industrial incident? ☐ Yes ☐ No		
E code		11-digit BWC provider number		Date
Health-care provider signature				

Employer info.

Employer policy number			Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm	
Telephone number	Fax number	E-mail address	Federal ID number	Manual number
Was employee treated in an emergency room? ☐ Yes ☐ No		Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No		
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code				

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

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

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

Employer signature and title	Date	OSHA case number

BWC-1101 (Rev. June 12, 2014)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets **OSHA 301** requirements

Ohio | Bureau of Workers' Compensation

Motion (C-86)

Instructions

Section I Injured worker information

Complete demographic information.

Section II Specific request to be considered

You must specifically state the requested action as noted below.

- For an additional condition(s), please state the diagnosis of the medical condition(s) you wish BWC or the Industrial Commission of Ohio (IC) to consider. If requesting a psychiatric or psychological condition, please include the statement below. This statement must be signed and dated by the injured worker.

  I am aware this motion is requesting that this claim be additionally recognized for a psychiatric or psychological condition that is a result of the injury for which the claim is allowed.

  Injured worker's signature _____ *Date* _____
- For temporary total (TT) compensation, please state the period for which you are requesting TT.
- For wage adjustment, please state the current wage amount and the amount you want adjusted.
- For a self-insured claim dispute, please state the issue you dispute, such as payment of medical bills compensation, authorization of treatment, allowance of medical condition, etc.
- For any other issue, please state in detail the specific action you wish BWC or the IC to consider.
- **Note: Do not use this form to file an appeal to a BWC or IC hearing order. Use Notice of Appeal (IC-12).**

Section III Supporting evidence

You must submit or reference evidence to support the requested action as noted below.

- For an additional condition(s), please indicate documentation on file that supports your request, or attach medical documentation such as medical reports, which includes a physician statement addressing the causal relationship between the requested diagnosis and the work-related injury, diagnostic test results, radiology exam results, operative reports, etc.
  - If you are requesting the addition of a pre-existing condition that has been aggravated by the work-related injury, you must clearly identify it as an aggravation or substantial aggravation (depending on the date of injury) of the specific pre-existing condition.
  - If the date of injury is on or after Aug. 25, 2006, (substantial aggravation), you must provide objective diagnostic findings, objective clinical findings, or objective test results that show the specific pre-existing condition has substantially worsened due to the work-related injury.
  - If the date of injury is before Aug. 25, 2006, you must provide objective or subjective evidence or both that show aggravation, i.e., some real adverse effect on the specific pre-existing condition.
- For TT, please include a completed and signed *Request for Temporary Total Compensation* (C-84), *Physician's Report of Work Ability* (MEDCO-14) or equivalent form, and any additional evidence to support your request.
- For a wage adjustment, please indicate documentation on file that supports your request, or attach earning statements, pay stubs, a wage statement form, a payroll report, a W-2 or other tax forms, etc.
- For a self-insured claim dispute, please indicate documentation on file that supports your request, or attach copies of authorization requests, medical bills, or other evidence.
- For any other request, please indicate documentation on file that supports your request or attach specific evidence that supports the action you wish taken.

BWC-1208 (Rev. Sept. 23, 2020)
C-86

Ohio | Bureau of Workers' Compensation

Motion

Instructions

- Parties to the claim requesting a decision by BWC or the Ohio Industrial Commission (IC) must use this form if any other form or application does not apply. For a complete list of forms visit www.bwc.ohio.gov, or call BWC at **1-800-644-6292.**
- **Attention health-care providers: Do not use this form.** Health-care providers must use the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9).

Section I Injured worker information

Injured worker name		Claim number	
Street address	City	State	ZIP code

Section II Specific request to be considered

This *Motion* is a request to consider the following: (You must specifically state the requested action as outlined on the instructions page.)

Section III Supporting evidence

In support of this *Motion,* the following evidence is included: (You must submit or reference evidence with this form to support the requested action as outlined on the instructions page.)

Signature

Certificate of Service: By signing below, I certify I have provided a copy of this *Motion* to all parties and representatives to the claim. Parties to the claim include the injured worker, employer and/or their authorized representatives, and BWC.

Signature of applicant	Date

Please indicate the party filing the form by checking the appropriate box.

☐ Injured worker ☐ Employer ☐ Authorized representative ☐ Administrator of the Ohio Bureau of Workers' Compensation

BWC-1208 (Rev. Sept. 23, 2020)

C-86

Ohio | Bureau of Workers' Compensation

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

Instructions

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

Section I – Injured worker

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

Section II – Requested services

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

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

Section III – Additional conditions

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

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

Section IV – Physician/provider information

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

Section V – MCO/Self-insuring employer decision

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

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

Ohio | Bureau of Workers' Compensation

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

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

Fax note

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

IW

❶ Injured worker name	Claim number	Date of injury

II. Requested services

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

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

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

III. Additional conditions

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

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

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

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

IV. Physician/provider information

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

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

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

V. MCO/Self-insuring employer decision

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

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

☐ Approved Date service begins _____ Date service ends _____

☐ Amended approval: _____

☐ Denied explanation: _____

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

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

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

☐ Withdrawn ☐ Dismissed _____

BWC claim status: ☐ Allowed ☐ Denied ☐ Pending

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

Self-insuring employer

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

Self-insuring employer signature	Date

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

Ohio | Bureau of Workers' Compensation

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

Instructions

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

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

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

Injured worker name	Claim number	Date of injury

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

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

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

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

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

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

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

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

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

BWC-3914 (Rev. July 5, 2022)
MEDCO-14

Injured worker name	Claim number	Date of injury

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

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

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

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

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

Comments:

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

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

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

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

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

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

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

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

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

BWC-3914 (Rev. July 5, 2022)
MEDCO-14

Ohio | Bureau of Workers' Compensation

Instructions for Completing the Request for Temporary Total Compensation

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

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

Instructions

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

Where do I file the C-84?

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

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

Where do I find more information or assistance?

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

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

You can obtain BWC forms at www.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.

Ohio | Bureau of Workers' Compensation

Request for Temporary Total Compensation

Injured worker demographics

1

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

Disability information

2

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

_____

Employment information

3

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

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

  If yes, what duties? _____

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

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

_____

Vocational rehabilitation information

4

Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job-seeking skills or necessary retraining.

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

_____

Benefits/earnings received or requested during the period of disability

5

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

Injured worker signature

6

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

Signature	Date

C-84 BWC-1205 (Rev. March 12, 2019)

OHIO BUREAU OF WORKERS' COMPENSATION CERTIFIED PROVIDERS

Franklin County BOARD OF COMMISSIONERS 1803 Service. Progress. Excellence.

ATTENTION: If you seek medical treatment, you must treat with a BWC certified provider. When you go for medical treatment, please ask the provider if he / she is BWC certified. Below is a listing of BWC certified occupational medicine providers in central Ohio counties. This list is broken down geographically for your convenience. For a complete list of all BWC certified providers, please go to *www.ohiobwc.com* and search for providers.

DOWNTOWN COLUMBUS	
WorkHealth Grandview 889 W Third Ave Columbus, Ohio 43212 (614) 566 - 9675 Monday – Friday: 7AM to 4PM	*Urgent Care Grandview* 895 W Third Ave Columbus, Ohio 43212 (614) 437 - 0278 Monday – Sunday: 9AM to 9PM
Bexley Urgent Care 2216 E Main St Bexley, OH 43209 (614) 826 - 9266 Monday – Friday: 8AM to 8PM, Saturday: 10AM to 6PM, Sunday: 10AM to 4PM	

NORTH	
WorkHealth Westerville 300 Polaris Pkwy Westerville, Ohio 43082 (614) 566 - 9675 Monday – Friday: 7AM to 4PM	*Clintonville Urgent Care* 4400 N High St Columbus, Ohio 43214 (614) 263 - 4400 Monday – Sunday: 8AM to 8PM
Urgent Care Dublin 6905 Hospital Dr. Suite 130 Dublin, Ohio 43016 (614) 923 - 0300 Monday – Sunday: 9AM to 9PM	*Arlington Urgent Care* 3062 Kingsdale Center Upper Arlington, OH 43221 (614) 484 - 1940 Monday – Friday: 8AM to 8PM, Saturday: 10AM to 6PM, Sunday: 10AM to 4PM

EAST	
Mount Carmel Urgent Care East Broad 6599 E Broad St Columbus, Ohio 43213 (614) 986 - 7752 Monday – Friday: 8AM to 8PM Saturday & Sunday: 8AM to 6PM	*Urgent Care Gahanna / New Albany* 5610 N Hamilton Rd Columbus, Ohio 43230 (614) 775 - 9870 Monday – Sunday: 9AM to 9PM
Urgent Care Reynoldsburg 2014 Baltimore - Reynoldsburg Rd Reynoldsburg, Ohio 43068 (614) 522 - 6900 Monday – Sunday: 9AM to 9PM	*Groveport Urgent Care* 3813 S. Hamilton Rd Groveport, Ohio 43215 (614) 835 - 0400 Monday – Sunday: 8AM to 8PM
Easton Urgent Care 2880 Stelzer Rd Columbus, Ohio 43219 (614) 472 - 2880 Monday – Sunday: 8AM to 8PM	*Columbus East - Urgent Care* 4849 E Main St Columbus, OH 43213 (614) 863 - 5188 Monday – Friday: 8AM to 5PM

OHIO BUREAU OF WORKERS' COMPENSATION CERTIFIED PROVIDERS

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WEST	
Clime Road Urgent Care 4300 Clime Rd Columbus, Ohio 43228 (614) 272 - 1100 Monday – Sunday: 8AM to 8PM	*ExpressMed Urgent Care - Hilliard* 5263 Nike Station Way Hilliard, OH 43026 (614) 293 - 0047 Monday – Friday: 9AM to 7PM Saturday & Sunday: 9AM to 3PM
Mount Carmel Occupational Health Center - Hilliard 4674 Britton Pkwy. Suite 1600 Hilliard, OH 43026 (614) 210 - 4400 Monday – Friday: 8AM to 4PM	*Columbus West - Urgent Care* 4821 Roberts Rd Columbus, OH 43228 (614) 850 - 1476 Monday – Friday: 8AM to 5PM
Scioto Urgent Care 4760 Sawmill Rd Columbus, OH 43235 (614) 789-9464 Monday – Friday: 10AM to 7.45PM, Saturday: 9AM to 5.45PM, Sunday: 11AM to 4.45PM	

SOUTH	
WorkHealth Grove City 4079 Gantz Rd Grove City, Ohio 43123 (614) 566 - 9675 Monday – Friday: 7AM to 4PM	*Urgent Care Grove City* 2030 Stringtown Rd Grove City, Ohio 43123 (614) 883 - 0160 Monday – Sunday: 9AM to 9PM
Groveport Urgent Care 3813 S. Hamilton Rd Groveport, Ohio 43215 (614) 835 - 0400 Monday – Sunday: 8AM to 8PM	

DELAWARE COUNTY	
Mount Carmel Occupational Health Center - Lewis Center 7100 Graphics Way Suite 1650 Lewis Center, OH 43035 (740) 953 - 4080 Monday – Friday: 8AM to 4.30PM	*Lewis Center Health Center* 7853 Pacer Dr Delaware, Ohio 43015 (614) 788 - 9000 Monday – Sunday: Open 24 Hours
Wedgewood Urgent Care 10330 Sawmill Pkwy. Suite 300 Powell, Ohio 43065 (614) 923 - 9200 Monday – Friday: 8.30AM to 8.30PM Saturday & Sunday: 9AM to 6PM	*Sunbury Urgent Care* 101 W Cherry St. Suite D Sunbury, Ohio 43074 (740) 965 - 8305 Monday – Friday: 8.30AM to 8.30PM Saturday & Sunday: 9AM to 6PM
FAIRFIELD COUNTY	
Lancaster Urgent Care 1612 N Memorial Dr Lancaster, OH 43130 (740) 994 - 4110 Monday – Sunday: 8AM to 8PM	

OHIO BUREAU OF WORKERS' COMPENSATION

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CERTIFIED PROVIDERS

PICKAWAY COUNTY

WorkHealth Circleville 1434 Circleville Plaza Dr Circleville, Ohio 43113 (740) 420 - 7975 Monday – Friday: 8AM to 4.30PM	*Berger Hospital* 600 N Pickaway St Circleville, OH 43113 (740) 474 - 2126 Monday – Sunday: Open 24 hours

Adena Health Center - Circleville
140 Morris Rd
Circleville, OH 43113
(740) 420 - 3000
Monday, Tuesday & Thursday: 7.30AM to 8PM
Wednesday: 7.30AM to 4.30PM, Friday: 7AM to 4PM
Office Closed for Lunch 12.30 -1.30 p.m. daily

UNION COUNTY

Memorial Urgent Care
120 Coleman's Crossing Blvd
Marysville, Ohio 43040
(937) 578 - 4310
Monday – Friday: 9AM to 9PM
Saturday & Sunday: 9AM to 6PM

LICKING COUNTY

Newark Valley Urgent Care 1906 Tamarack Rd Newark, Ohio 43055 (740) 522 - 0222 Monday – Friday: 8.30AM to 8.30PM Saturday & Sunday: 9AM to 6PM	*Licking Memorial Urgent Care - Granville* 14 Westgate Dr Newark, OH 43055 (220) 564 - 7500 Monday – Friday: 9AM to 8PM Saturday & Sunday: 9AM to 5PM

Licking Memorial Urgent Care - Pataskala
1 Healthy PL
Pataskala, OH 43055
(740) 964 - 7600 or (220) 564 - 7600
Monday – Saturday: 9AM to 6PM
Sunday: 12PM to 6PM

****ATTENTION: Most urgent care centers and walk - ins occupational medicine facilities are BWC certified, but, if possible, please check with the exact location prior to receiving medical treatment. ****