

— Injury reporting packet

North College Hill School

Steps to take when a workplace injury occurs

Call 911 immediately in case of serious or life-threatening emergencies

If an incident or injury occurs, we are here to help. Just follow these steps.

An injured employee, their employer or medical provider may report a work-related injury. Your company has chosen Sedgwick Managed Care Ohio to help you through this process.

Employee instructions

1. Immediately notify your supervisor.
2. Complete the first section of the BWC First Report of Injury (FROI) form as completely as possible.
3. Seek appropriate medical treatment if needed, and provide the attached ID card at all medical appointments.
4. Keep your supervisor informed of your medical status and return all completed claim documentation to your employer promptly.

Employer instructions

1. Assist in the completion of an injury/incident report, and/or the Employer Info section of the enclosed FROI.
2. If medical treatment is involved, ensure the incident is reported to Sedgwick MCO using one of the methods described under "Reporting a work-related injury to Sedgwick MCO."

Reporting a work-related injury to Sedgwick MCO



Online:

Submit an injury form (FROI) online at <https://resources.sedgwickmco.com>.



Phone:

Contact our customer service team at 888.627.7586 (available 24/7).



Email:

Send encrypted injury/incident reports as soon as possible to: injury.incident@sedgwickmco.com.



Fax:

Send injury forms to 888.711.9284.

Early documentation and reporting of injuries promotes the best results for everyone.

Detach ID card below and present at all medical appointments

Workers' compensation identification card



24-hour customer service: 888.627.7586



Employer name: North College Hill School
Policy number: 33105751-0

Key contacts and additional information

Medical treatment questions, medical documentation and billing issues

Contact Sedgwick Managed Care Ohio:

Phone: 888.627.7586

Fax: 888.627.0074

Mail: P.O. Box 1040, Dublin, OH 43017

Prescription questions

Call 800.644.6292 and follow the prompts.

Ohio Bureau of Workers' Compensation (BWC)

Call 800.644.6292 or visit bwc.ohio.gov.

Medical options and provider search

If medical treatment is required, see a BWC-certified medical provider. For more information, see the Sedgwick MCO website at sedgwickmco.com.

Transitional work benefits everyone

A safe and timely return to work is important! Together, we will explore opportunities for modified duty/transitional work that can accommodate any physical limitations in order to speed your recovery, ease your transition back to work and minimize any hardship as a result of a workplace injury. Employee safety and recovery are the highest priorities. It's essential – and required – to keep Sedgwick MCO and your employer updated on your recovery status and work restrictions at all times.

Please provide MEDCO-14 form with any physical restrictions, as employer may have modified duty available.

Please send all information within 24 hours of visit.

Injury report and FROI fax:	888.711.9284
Medical and authorization fax:	888.627.0074
Customer service:	888.627.7586
Prescription questions:	800.644.6292 (follow prompts)

Send all mail and medical bills to:

Sedgwick Managed Care Ohio
PO Box 1040
Dublin, OH 43017

*This card is not a
guarantee of coverage.*

Responsibilities

Sedgwick MCO

- Initiate new claims with the BWC, collect and submit required information
- Return to work and medical case management
- Review and approval of medical treatment
- Medical bill payment
- Medical management of workers' compensation claims
- All associated managed care organization responsibilities

BWC

- Claim allowance and compensability determination
- Claim number assignment
- Compensation award payment(s)
- Coordination of Industrial Commission hearings

Medical providers

- Treating physicians must be BWC certified
- Promptly submit all medical documentation to Sedgwick MCO
- Clearly indicate work readiness and periods of disability utilizing the MEDCO-14 form

Important BWC forms

First report of injury (FROI)

Initiates workers' compensation claim; complete and send to Sedgwick MCO

MEDCO-14

Physician's statement of workability, recovery status; send to Sedgwick MCO

C-9

Physician's request for treatment approval; addressed by Sedgwick MCO



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

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

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

Injured worker information									
First name, middle initial, last name				Date of injury/disease		Social Security number		Date of birth	
Mailing address; add apartment number or P.O. Box, if applicable						City		State	ZIP code
Sex ☐ Male ☐ Female		Email address				Home phone number		Cell phone number	
Employer name North College Hill School		Employer address				City		State	ZIP code
Was the injured worker hired through a temp agency? ☐ Yes ☐ No If yes, name of temp agency				Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat			Regular work hours (include a.m. p.m.) From To		
Date hired	Job title		State where hired	State where supervised	Wage rate; \$ per hour		Number of hours scheduled to work the week of this injury		
Work number for call-offs (Number injured worker calls to reach supervisor)				Part(s) of body affected (For example: Left knee, right index finger)					
Accident description (Describe the sequence of events that directly caused the injury or death.)								Will the incident cause the injured worker to miss 8 or more days from work? ☐ Yes ☐ No	
Injured worker start time ____ ☐ am ☐ pm	Time of injury ____ ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ Yes ☐ No		Date last worked	If the injured worker has returned to work, provide the date.			
Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.							Was injured worker hospitalized overnight? ☐ Yes ☐ No		
Initial treatment date	Health-care office/Facility name		Treating physician/Provider name			Telephone number		Fax number	
Health-care office/Facility street address					City		State	ZIP code	
If the injury resulted in death, answer the following.									
Date of death		Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed						Decedent's number of dependents	
To be completed by the injured worker									
By signing this form, I:									
• Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws. • Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim. • Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim. • Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.									
Furthermore, I understand that:									
• Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation. • Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims. • Information or records maintained in my previous or future claims may affect decisions made in this claim. • Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).									
I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.									
Injured worker signature								Date	
To be completed by the treating provider									
Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). Important: If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".									
Initial treatment date		Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ No							
Treating physician/Provider's name (Print)			Treating physician/Provider's signature			BWC provider number		Date	
To be completed by the employer									
Employer name North College Hill School		Employer county	Phone number		Fax number		Email address		
Employer policy number 33105751-0		Federal ID number		Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation					
For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below. For self-insuring employers only: ☐ Medical only ☐ Lost time Clarification – I clarify and allow the claim for the condition(s) below.									
Employer signature and title								Date	
To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer									
Signature of person completing this form								Date	



Employer Name: North College Hill School

Policy Number: 33105751-0

Instructions

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

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

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

Injured worker name		Claim number	Date of injury	
Date of last appointment/examination		Date of this appointment/examination	Date of next appointment/examination	
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
List all other conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).				

