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Table of Contents (Cont.)

B.W.C. Forms

Ohio | Bureau of Workers' Compensation

Compensation Rates 2010 to 2019 TT, LM, PT, WL, %PP, SL and Death Benefits

2019 weekly
Disabled Workers' Relief Fund (DWRF) entry level $390.04

2019 monthly
DWRF entry level $1,694.81

2019 statewide
Average weekly wage (AWW) $950

Here is a list of definitions for benefit types for the chart below.

- o Average weekly wage (AWW)
- o Disabled workers' relief fund (DWRF)
- o Full weekly wage (FWW)
- o Living maintenance (LM)
- o Percentage permanent partial (%PP)
- o Permanent total (PT)
- o Scheduled loss (SL)
- o Social Security disability (SSD)
- o Social Security retirement (SSR)
- o Temporary total (TT)
- o Wage loss (WL)

Dates covered	TT and LM without SSR maximum	TT and LM with SSR maximum	TT minimum (1)	LM minimum	PT maximum without SSD	PT maximum with SSD	PT minimum (2)	WL maximum	%PP maximum	SL weekly rate	Death benefit maximum	Death benefit minimum (3)
2019	$950	$633.33	$316.67	$475	$950	$633.33	$475	$950	$316.67	$950	$950	$475
2018	$932	$621.33	$310.67	$466	$932	$621.33	$466	$932	$310.67	$932	$932	$466
2017	$902	$601.33	$300.67	$451	$902	$601.33	$451	$902	$300.67	$902	$902	$451
2016	$885	$590	$295	$442.50	$885	$590	$442.50	$885	$295	$885	$885	$442.50
2015	$862	$574.67	$287.33	$431	$862	$574.67	$431	$862	$287.33	$862	$862	$431
2014	$849	$566	$283	$424.50	$849	$566	$424.50	$849	$283	$849	$849	$424.50
2013	$838	$558.67	$279.33	$419	$838	$558.67	$419	$838	$279.33	$838	$838	$419
2012	$809	$539.33	$269.67	$404.50	$809	$539.33	$404.50	$809	$269.67	$809	$809	$404.50
2011	$783	$522	$261	$391.50	$783	$522	$391.50	$783	$261	$783	$783	$391.50
2010	$775	$516.67	$258.33	$387.50	$775	$516.67	$387.50	$775	$258.33	$775	$775	$387.50

Scheduled loss - Schedule B

Location	Weeks	Effective 1-1-2019	Location	Weeks	Effective 1-1-2019	Location	Weeks	Effective 1-1-2019
Thumb	60	$57,000	Loss of metacarpal	10	$9,500	Foot	150	$142,500
Index finger	35	$33,250	Hand	175	$166,250	Leg	200	$190,000
Third finger	30	$28,500	Arm	225	$213,750	Eye	125	$118,750
Fourth finger	20	$19,000	Great toe	30	$28,500	Hearing (one ear)	25	$23,750
Little finger	15	$14,250	Other toe	10	$9,500	Hearing (total)	125	$118,750

1. If FWW and/or AWW are less than minimum shown, BWC pays TT at full FWW and/or AWW.
2. If AWW is less than minimum shown, BWC pays PT at full AWW.
3. Minimum for wholly dependents

Injured Worker Forms

OhioBWC - Worker - Form: (BWC Forms) - Injured Worker Forms Home

Injured worker Forms

Details

Industrial Commission Forms

Adobe Reader is required to view/print forms, click here.

BWC #	Form Title	Description	View/ Print	Online	Order
A-12	A.C.T. Enrollment and Direct Deposit Authorization				
A-12-ES EFT	Formulario de inscripción y autorización de depósito directo de la ACT				
A-21	EBT - Electronic Benefit Card Enrollment Application				
A-21-ES EBT	Solicitud de inscripción a la tarjeta electrónica de beneficios				
A-35	Direct Deposit ACT Bank Change				
A-35-ES	Cambio de banco de depósito directo de ACT				
C-5	Application for Death Benefits and/or Funeral Expenses				☐
C-5-ES	Solicitud para los beneficios por fallecimiento y/o gastos funerarios				
C-6	Application for Accrued Compensation				
C-11	ADR Appeal to the MCO Medical Treatment/Service Decision				☐
C-11-ES	Apelación a la decisión por servicio/tratamiento médico de la MCO de ADR				
C-17	Request for Injured Worker Outpatient Medication Reimbursement				☐
C-18	Notice to BWC of the Injured Worker and Employer Agreement and Authorization to Send Injured Worker's Check (s) to the Employer				☐
C-23	Notice to Change Physician of Record				☐
C-30	Request for Medical Information				
C-32	Application for Payment of Lump Sum Advancement				☐
C-60	Completing the Injured Worker Statement for Reimbursement of Travel Expense				☐
C-60-A	Injured Worker Reimbursement Rates for Travel Expense				
C-72	Consent to Release Information				
C-72-ES	Autorización para divulgar información				
C-77	Injured Worker's Change of Address Notification				☐
C-84	Request for Temporary Total Compensation				☐
C-84-ES	Petición de compensación total temporal				
C-86	Motion				☐
C-86-ES	Moción				
C-92	Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability				☐
C-92-ES	para determinar el porcentaje de incapacidad parcial permanente o aumento de la incapacidad permanente parcial				
Wages-IW	Injured Worker Earnings Statement				
WAGES-IW-ES	Declaración de los ingresos del trabajador lesionado				
Wages-EMP	Employer Report of Employee Earnings				
Wages-EMP-ES	Informe del empleador de ingresos del empleado				
C-101	Authorization to Release Medical Information				☐
C-101-ES	Autorización para divulger información médica				
C-108	Waiver of Appeal				
C-108-ES	Renuncia al período de apelación				
C-140	Initial Application for Wage Loss Compensation				☐
C-141	Wage Loss Statement for Job Search				☐

C-142	Employer Report of Employee Earnings for Wage Loss Compensation				
C-159	Waiver Of Workers' Compensation Benefits For Recreational Or Fitness Activities				
C-159-ES	Renuncia a los beneficios por indemnización de los trabajadores para actividades recreativas o de ejercicios físicos				
C-230	Authorization to Receive Workers' Compensation Check				
C-230-ES	Autorización para recibir Cheques de compensación por accidentes en el trabajo				
C-240	Settlement Agreement and Application for Approval of Settlement Agreement				
C-255	Affidavit for Attorney Fees				
C-261	Workers' Compensation Claim Log				
C-265	Presumption of Causation for Firefighter Cancer				
C-512	Notice of intent to Settle				
FROI	First Report of an Injury, Occupational Disease or Death				
FROI-ES	Informe inicial de lesión, enfermedad ocupacional o fallecimiento				
	Reporting fraud				
IC-167-T	Objection to Tentative Order Awarding Permanent Partial Disability Compensation				
MEDCO-31	Request for Prior Authorization of Medication Form				
OD-58-22	Application for Adjustment of Claim in Case of Death Due to Occupational Disease				
R-2	Claimant Authorized Representative				
R-2-ES	Autorización de un representante del trabajador lesionado				
R-4	Application for Representative Identification Number				
RH-1	Rehabilitation Agreement				
RH-6	On-the-job Training Agreement				
RH-7	Loan/Release Agreement for Tool and Equipment				
RH-10	Vocational Rehabilitation Plan Job Search Contacts				
RH-18	Authorization for Living Maintenance Wage Loss				
RH-24	Gradual Return to Work Agreement				
RH-94A	Report of Earnings for Living Maintenance Wage Loss Compensation				
SH-6	PERRP Complaint Form				
SI-28	Filing of Allegation Against a Self-Insured Employer				
SI-42	Self Insured Joint Settlement Agreement and Release				
SI-43	Acknowledgement of the Self-Insured Joint Settlement Agreement and Release				
	Subrogation Referral Form				

Next

Claim Application and Continuing Claim Forms

Ohio | Bureau of Workers' Compensation

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

Instructions

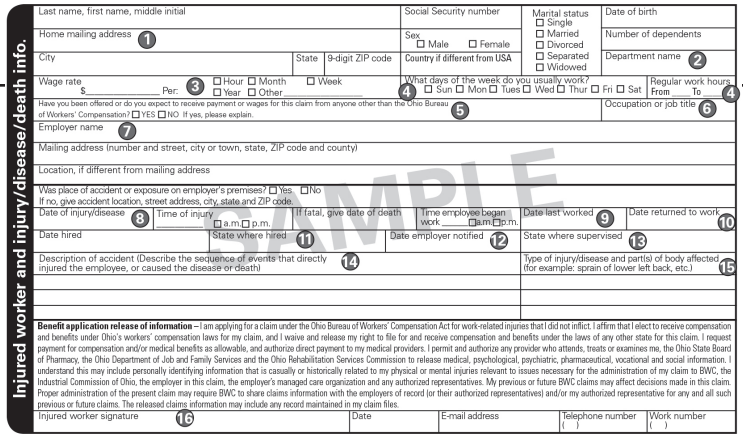
To expedite your claim, you can complete and submit this form online at **www.bwc.ohio.gov.**

- 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.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address (1) | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name (2)

Wage rate $_____ Per: (3) ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____ | What days of the week do you usually work? (4) ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours From ____ To ____ (4)

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ YES ☐ NO If yes, please explain. (5) | Occupation or job title (6)

Employer name (7)

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was place of accident or exposure on employer's premises? ☐ Yes ☐ No
If no, give accident location, street address, city, state and ZIP code.

Date of injury/disease (8) | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked (9) | Date returned to work (10)

Date hired | State where hired (11) | Date employer notified (12) | State where supervised (13)

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death) (14) | Type of injury/disease and part(s) of body affected (for example: sprain of lower left back, etc.) (15)

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 (16) | Date | E-mail address | Telephone number ( ) | Work number ( )

SAMPLE

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.

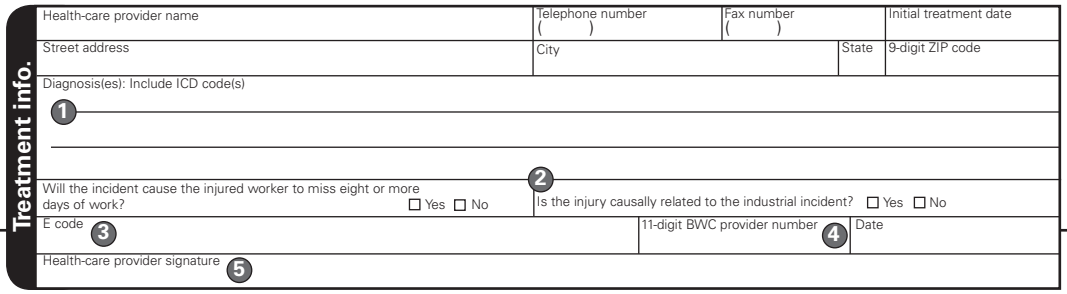
(15) Type of injury/disease and part of body affected: Describe the nature of the injury, occupational disease or death. Indicate the part(s) of body injured, affected or that caused the death.

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.

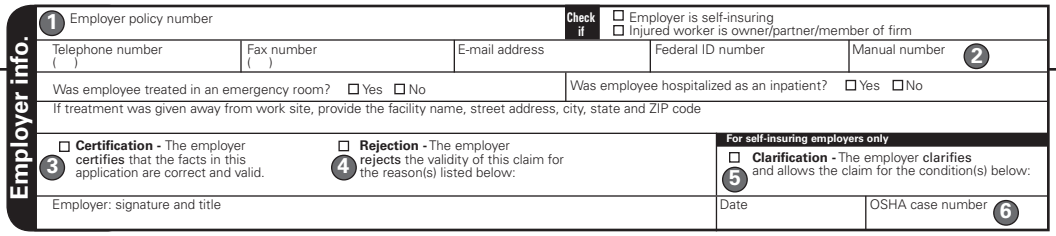
Completion instructions

(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

Ohio | Bureau of Workers' Compensation

Request for Medical Information

Claim number	Injured worker name	Date of injury/disability

We have received notice of a work-related injury for the claim mentioned above. For us to process this claim, it is necessary for us to have a copy of your treatment records. _____

Per BWC Rule (4123-6-20.1) providers cannot charge to complete this form

Please provide the following items checked below.

☐ 1. Date first seen: _____

☐ 2. Complaints: _____

_____

☐ 3. History of injury: _____

_____

☐ 4. Objective physical findings: _____

_____

☐ 5. Diagnosis: _____

_____

☐ 6. What diagnostics, if any, did you use in determining the diagnosis? _____

☐ 7. If occupational disease, first date injured worker sought treatment for this condition: _____
and date the medical diagnosis was determined to be work related: _____

☐ 8. Treatment: _____

☐ 9. Date last seen: _____

☐ 10. Prognosis: _____

☐ 11. Was injured worker disabled from employment? ☐ Yes ☐ No
If yes, indicate dates: from _____ to _____ inclusive.

☐ 12. Opinion as to causal relationship between history of injury and diagnosis: _____

_____

_____

☐ 13. Did injured worker have any known pre-existing condition which may have contributed to diagnosis and disability?
☐ Yes ☐ No
If yes, please explain and state whether you believe this pre-existing condition was aggravated by this injury:

_____

_____

☐ 14. Specifically requesting the following documents: _____

_____

I certify the information on this form is true and correct. 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 or imprisonment or both.

_____ _____

Signature of physician Date signed

_____

Type/print physician name

Ohio | Bureau of Workers' Compensation

Instructions for Completing the Physician's Report of Work Ability

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

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

Instructions

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

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

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

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

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

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

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

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

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

Instructions continued on page two

Ohio | Bureau of Workers' Compensation

Instructions for Completing the Physician's Report of Work Ability

Instructions continued

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

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

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

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

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

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

For more information or assistance

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

Print or Fax

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

MEDCO-14 submission (Select one of the options below.)

1

☐ I have never completed a MEDCO-14. ***Proceed to section 2.***
☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
☐ I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

Employment/Occupation (Complete this section and proceed to section 3.) (Updates Yes ☐ No ☐)

2

Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

Work status/Injured worker's capabilities (Updates Yes ☐ No ☐)

3A

Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, are the restrictions: ☐ Permanent ☐ Temporary ***Proceed to section 3B.***
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***

3B

If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***
If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
Date:_____.

Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.
Date:_____. **Proceed to section 3C.**

3C

Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date:_____.
The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker's dominant hand is: ☐ Left ☐ Right
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both
If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:
*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously										Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.	☐	☐	☐	☐	0 to 25 lbs.	☐	☐	☐	☐
Bend	☐	☐	☐	☐	Reach above shoulder	☐	☐	☐	☐	11 - 20 lbs.	☐	☐	☐	☐	26 to 40 lbs.	☐	☐	☐	☐
Squat/kneel	☐	☐	☐	☐	Type/keyboard	☐	☐	☐	☐	21 - 40 lbs.	☐	☐	☐	☐	41 to 60 lbs.	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐	Work with cold substances	☐	☐	☐	☐	41 - 60 lbs.	☐	☐	☐	☐	61 to 100 lbs.	☐	☐	☐	☐
Climb	☐	☐	☐	☐	Work with hot substances	☐	☐	☐	☐	61 - 100 lbs.	☐	☐	☐	☐	100 + lbs.	☐	☐	☐	☐

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

Proceed to section 4.

Injured worker name	Claim number	Date of injury

Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) (Updates Yes ☐ No ☐)

4A Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

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 ☐

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? Yes ☐ No ☐
If yes, give MMI date: _____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

Vocational rehabilitation (Updates Yes ☐ No ☐)

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?
Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

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

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

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 BWC customer service representative.

For all other injured workers: Please call 1-800-644-6292, or contact your BWC customer 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 BWC customer service representative, or at your BWC customer 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

Ohio | Bureau of Workers' Compensation

Injured Worker Earnings Statement

Failure to file earnings statements may delay or adversely affect rates of compensation.
Please note: If you are reporting income to BWC to set your wages but have not reported the income to the Internal Revenue Service (IRS) as wages, BWC may notify the IRS of the discrepancy (e.g., rental income, S-Corporation profits and partnership profits).

Employment history
If you were employed by more than one employer during the 52 weeks prior to your date of injury or date of disability in an occupational disease claim:

- List the name, address and phone number of each employer on the ***Injured Worker Earnings Statement*** (Wages-IW). If you were self-employed during this period, you must list yourself as an employer;
- List the dates of employment for every employer listed. You must also report if you are working for any employer(s) other than the employer for this claim.

If anyone other than the employer of record in this claim employed you during the 52 weeks prior to the date of injury or occupational disease, you must provide earnings information related to that employment. You may submit earnings by providing copies of paystubs, a report from the employer that includes the required information as described below or by having the employer complete an ***Employer Report of Employee Earnings*** (Wages-EMP).

Information submitted must include:

- Earnings beginning with the full-pay period that ended prior to the date of injury or date of disability in an occupational disease;
- Only earnings prior to the date of injury or date of disability in an occupational disease;
- The frequency of payment, (i.e., weekly, biweekly, bimonthly, monthly, quarterly, yearly, other);
- The pay period begin and end dates, not the date the payment was issued;
- Any **allowance** for meals, lodging, uniforms, tips, etc. that you received in addition to your regular wages, including the amount received and the type of payment. Do not report **reimbursements** made to you for meals, lodging, uniforms, travel, etc. BWC does not consider reimbursements earnings for the purpose of calculating wages;
- Any bonus or other lump sum payment received during the reporting period. Include the amount of the payment, the type of payment and the period of time over which you earned it.

If detailed earnings such as copies of paystubs or wage statements are not available, you can provide other documentation such as W-2s, 1099s or Social Security reports. If you submit a 1099, you must also submit accompanying evidence of expenses related to the earnings or submit the Wages-IW or an equivalent statement that indicates there were no expenses related to the earnings. BWC will assume earnings submitted on a W-2, Social Security report or 1099 were earned over the entire year unless specifically noted.

Self-employment
If you were self-employed during the 52 weeks prior to the date of injury or date of disability in an occupational disease claim, you must submit:

- Completed and signed income tax forms (1040 with the Schedule C) for the year prior to the date of injury and, if available, the year in which the injury occurred. The 1040 must include the page with your signature. You can only use a joint income tax return as proof of earnings when you can distinguish your earnings from your spouse's income. If submitting a joint return, please redact the Social Security number of anyone other than you; or,
- Completed quarterly reports that you have submitted to the IRS or profit and loss statements from an accountant for the year of the injury; or,
- A signed Wages-EMP.

Periods without earnings
If you were not employed over periods of time during the 52 weeks prior to the date of injury or date of disability in an occupational disease claim, complete and sign the Wages-IW.

Ohio | Bureau of Workers' Compensation

Injured Worker Earnings Statement

Injured worker name	Date of injury	Claim number
Address	City/State	ZIP code
Email address	Preferred contact number	☐ Cell ☐ Home

List below the name, address, and dates of employment **for all employers that employed you during the 52 weeks prior to the date of injury or date of disability in an occupational disease claim**. If applicable, include self employment information. Attach an additional sheet or use multiple copies of this form, if necessary. **You must submit evidence of actual earnings from these periods of employment to BWC. See the instructions for more details.**

Employer name	Address (including City, State and ZIP code)	Phone number (including area code)	Dates of employment Beginning date	End date

With your permission, BWC may **clarify earnings information you submit from employers other than the employer of record** in this claim (check one of the options below).

☐ BWC may contact the employers listed above to obtain clarification of earnings information I have submitted. I am also granting permission to the employers named above to release earnings information relevant to my workers' compensation claim.
I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC) or the Industrial Commission of Ohio. I understand this information is being released to the above-referenced entities for use in administering my workers' compensation claim.

☐ BWC may not contact the employers listed above to obtain clarification of earnings information I have submitted.

If you are submitting a 1099 (select one)

☐ I have attached accompanying evidence of expenses with this form related to the earnings.

☐ I acknowledge there were no expenses related to the 1099 earnings.

If applicable, list period(s) of time during the 52 weeks prior to your injury or date of disability in an occupational disease when you did not work. For each period listed, you must include the reason you were not employed and indicate whether or not you sought employment during that time. BWC may require you to provide evidence to support the reason for the unemployment or job search efforts**.**

Dates of unemployment		Reason for unemployment	Did you seek employment during this period? (circle one)
Beginning date	End date		
			Yes No
			Yes No
			Yes No

Comments or other information

- I understand 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 self-insuring employers, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.
- I, the above-named injured worker, also understand I am requesting BWC calculate or recalculate my full and/or average weekly wage and adjust previously paid compensation pursuant to RC 4123.52.

Signature of applicant	Date

Fax the completed form to 1-866-336-8352, or send it to the BWC customer service office where your claim is assigned.

Ohio | Bureau of Workers' Compensation

Employer Report of Employee Earnings

Instructions for the employer

Please note that if you report income to BWC to set wages but have not reported the income to the Internal Revenue Service (IRS) as wages, BWC may notify the IRS of the discrepancy.

You must complete the *Seven-day worksheet section* below. Then either complete and sign the ***Earnings statement worksheet*** (page two of this form), or submit a payroll report that includes the required information as described below.

- Report earnings for the employee beginning with the full-pay-period that ended prior to the date of injury or date of disability in an occupational disease claim using the actual end date of the pay period (not the date the payment was issued). Do not report wages earned on or after the date of injury or date of disability in an occupational disease claim.
- BWC includes the information below in the calculation of wages. Include the following information in your report or worksheet:
  - All **gross** earnings prior to any deductions such as for taxes, insurance, deferred compensation, garnishment or employee contributions to retirement programs;
  - Paid holidays, vacation, personal or sick leave (this is payment for time off work, not cash out of unused leave);
  - Bonuses and commissions (you must indicate the **period of time** over which the bonus or commission was earned);
  - Allowance for meals, lodging, uniforms, tips, etc., paid in addition to wages, (report as other earnings with a description of the earnings).
- Reimbursements made to the injured worker for meals, lodging, uniforms, travel, etc. (BWC does not consider these as earnings and so it does not include them in the calculation of wages.) DO not include them in your report or worksheet.
- If you attach a payroll report that includes earnings that BWC does not consider gross earnings as defined above, please note on the payroll report or on a separate attached document.
- Report any periods the injured worker did not work. If payment was made during those periods, report the amount and description of payment the injured worker received.

Seven-day worksheet

You must provide this information even if you are providing weekly earnings on a payroll report.
Provide the information based on pay period begin and end dates, <u>not payment dates</u>.

Injured worker name	Claim number
Date of injury	Date of hire
Employer name	Employer phone number
Employer address	Employer email address

If employed less than one full-pay period prior to the date of injury, provide the information below.

Number of hours scheduled the week of the injury: _____ Hourly rate: _____

If employed one full-pay period or longer prior to the date of injury or date of disability in an occupational disease claim, provide the information below using the actual end date of the pay period (not the date the payment was issued).

What was the BEGINNING date of the last pay period prior to the date of injury/disability? (DD/MM/YYYY) _____/_____/_____

What was the END date of the last pay period prior to the date of injury/disability? (DD/MM/YYYY) _____/_____/_____

Payment is (check one): ☐ Weekly ☐ Biweekly ☐ Bimonthly ☐ Monthly ☐ Other _____ (please explain)

- If the pay period **was weekly,** what was the amount of overtime earned? $_____
- If this pay period **was not weekly**, during the last seven calendar days of the pay period listed above, please provide the following:

Regular earnings the last seven calendar days of that pay period: $_____

Overtime earnings the last seven calendar days of that pay period: $_____

Signature Section

I certify the information provided 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 the 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.

I am requesting BWC calculate or recalculate the full and/or average weekly wage in this claim and adjust previously paid compensation pursuant to RC 4123.52.

Name of the person completing this form (printed)	Date
Signature	Title

Fax the completed form to 1-866-336-8352, or send it to the BWC customer service office where the claim is assigned.

Earnings statement worksheet

Injured worker name	Claim number
Date of injury	Date of hire
Employer name	Employer phone number
Employer address	Employer email address

Please see the Instructions for the employer for additional information before completing the worksheet.

Pay period end date: The actual end date of the pay period, not the date the payment was issued. For example, the check was issued on Jan. 25, 2014, for the pay period Jan. 12, 2014, to Jan. 18, 2014. In this example, the pay period end date is Jan. 18, 2014. In addition, to determine the 52 weeks needed for this report, start with the end date of the last pay period prior to the date of injury then count back 52 weeks. For example, the date of injury is Jan. 2, 2014. The last pay period end date prior to the date of injury is Dec. 21, 2013. The injured worker was paid weekly. Therefore, the 52 weeks needed for the worksheet are the pay periods with end dates from Dec. 29, 2012, to Dec. 21, 2013. This range may vary depending on the frequency of payment.

Gross regular earnings: This is the hourly rate multiplied by the hours worked, or the regular salary.

Other earnings: Earnings NOT included in the gross regular earnings such as bonuses or allowances. You must include an explanation of the other earnings in the Description of exceptions and earnings column.

Description of exceptions and earnings: You may also provide other information for BWC to consider in the calculation of earnings such as periods the injured worker was laid off, on disability, etc.

Payment is (check one): ☐ Weekly ☐ Biweekly ☐ Bimonthly ☐ Monthly ☐ Other _____ (please explain)

	Pay period end date	Gross regular earnings	Other earnings	Description of exceptions and earnings
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
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16				
17				
18				
19				
20				
21				
22				
23				

Injured worker name	Claim number

	Pay period end date	Gross regular earnings	Other earnings	Description of exceptions and earnings
24				
25				
26				
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52				

Comments or other information

I certify the information provided 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 the 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.

I am requesting BWC calculate or recalculate the full and/or average weekly wage in this claim and adjust previously paid compensation pursuant to RC 4123.52.

Name of the person completing this form (printed)	Date

Signature **X**	Title

Fax the completed form to 1-866-336-8352, or send it to the BWC customer service office where the claim is assigned.

Ohio | Bureau of Workers' Compensation

Application for Determination or Increase of Percentage of Permanent Partial Disability (C-92)

Claim number

Instructions
Complete this form and fax it to 1-866-336-8352, or send it to your local BWC claims office.

Injured worker information

Name		Date of injury
Address		Preferred method of contact ☐ Home phone ☐ Cell phone ☐ Email ☐ Mail
City	State	ZIP code
Home phone number	Cell phone number	Primary email address

Application designation

I am applying for one of the options listed below.

☐ The initial percentage of permanent partial disability (%PPD) — I understand I must attend a BWC exam, and that BWC will evaluate all the conditions allowed in my claim unless noted below.

Note exclusions, if applicable, here:

☐ A %PPD for a newly allowed condition in this claim — I understand if an exam is scheduled, I am required to attend.

Please list newly allowed condition(s) here:

☐ Increase in the %PPD — I believe my medical condition has worsened, and my %PPD for this claim has increased. I understand I am required to submit with this application a medical report from my doctor showing evidence of an increase. I understand BWC will only consider an increase for those conditions supported by evidence of new and changed circumstances. I understand if an exam is scheduled, I am required to attend.

Exam availability: Mornings (7 a.m. to 12 p.m.), afternoons (12 p.m. to 5 p.m.)
We will attempt to accommodate your requested exam availability. **WARNING! —** BWC may dismiss this application if the injured worker fails to respond to an attempt to schedule an exam or fails to attend the exam.

Please check all days of the week and times of the day that you can attend an examination.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐ Morning	☐ Morning	☐ Morning	☐ Morning	☐ Morning	☐ Anytime
☐ Afternoon	☐ Afternoon	☐ Afternoon	☐ Afternoon	☐ Afternoon	Note - Appointments on this day
☐ Anytime	☐ Anytime	☐ Anytime	☐ Anytime	☐ Anytime	are available on a limited basis.

- If there are specific dates you cannot attend an examination in the next six weeks, please list them below.

- If you are only available before/after a specific time of day (morning or afternoon), please note that time (e.g., only after 3 p.m.).

☐ Check here if you need an interpreter to attend the exam.

Injured worker signature

- I certify the information on this form is true and correct. I understand that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain benefits/compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.
- I certify all the information listed above is current as of the time of the filing of this application.

Signature of injured worker/injured worker representative	Date

Ohio | Bureau of Workers' Compensation

Application for Determination or Increase of Percentage of Permanent Partial Disability (C-92)

Authorized to receive workers' compensation check	
Injured worker representative name	Representative ID number

- I hereby authorize and direct BWC to mail directly to my attorney the compensation payment in the above numbered claim any accrued monetary award generated by this application.
- This authorization does not give my attorney the authority to cash or endorse a check on my behalf.
- This authorization shall not continue in effect after BWC has paid said award(s) on the original application noted above unless there is a subsequent hearing, appeal or reconsideration after payment was made.
- This authorization is not valid if it is filed beyond 18 months from the date of my signature.

Signature of injured worker	Date

Ohio | Bureau of Workers' Compensation

Instructions for Completing the Motion

Instructions

Below is an explanation of how to complete the form.

Section I – Injured worker

- Complete name, street address, city, state, ZIP code and claim number.

Section II – This *Motion* is a request to consider the following

- Additional condition – 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.

      I am aware I am filing this motion to request BWC recognize my psychiatric or psychological condition as being a result of the injury for which this claim is allowed.
      Signature _____ Date _____
- Wage adjustment – Please state the current wage amount and the amount you want adjusted.
- Self-insured claim dispute – Please state the issue you dispute, such as payment of medical bills compensation, authorization of treatment, allowance of medical condition, allowance of claim.
- Other – Please state any other issue or request that you wish BWC or the IC to consider. Please be specific in your request by outlining in detail the action you want BWC or the IC to take.

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 – In support of this *Motion* the following evidence is included

- Additional condition – 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 industrial injury; diagnostic test results, radiology exam results, operative reports, etc.
- Wage adjustment – Please indicate documentation on file that supports your request, or attach earning statements, pay stubs, C-94A wage statement form, payroll report, W2, other tax forms, etc.
- Self-insured claim dispute – Please indicate documentation on file that supports your request, or attach copies of authorization requests, medical bills or other evidence.
- Other – Please indicate documentation on file that supports your request, or attach specific evidence that supports the action you wish taken.
- Certificate of Service: By signing and dating this form you certify you have sent copies of it and supporting documentation to all parties in the claim and their representatives.
- Please indicate the party filing the form by checking the appropriate box.

Ohio | **Bureau of Workers' Compensation**

Motion

Instructions

- Parties to the claim requesting a decision by BWC or the Industrial Commission of Ohio must use this form if any other form or application does not apply. Parties to the claim include the injured worker, employer and/or their authorized representatives and BWC. For a complete list of injured worker and employer forms visit **www.bwc.ohio.gov,** or call BWC at **1-800-644-6292.**
- **Health-care providers or managed care organizations (MCOs) do not use this form**. Health-care providers or MCOs must use the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9).
- You must submit proof with this form to support the requested action. When requesting an additional condition, please include medical documentation, such as medical reports that include a physician statement addressing causal relationship between the requested condition and the industrial injury, diagnostic test results, radiology exam results, operative reports, etc. When requesting full or average weekly wage adjustments, include earning statements, such as pay stubs, C-94A wage statement form, payroll report, W2, tax forms, etc.
- The applicant must mail a copy of the *Motion* to all parties and/or their authorized representatives to the claim and will indicate a copy has been mailed by signing Certificate of Service below.

Section I

Injured worker name		Claim number	
Street address	City	State	Nine-digit ZIP code

This *Motion* is a request to consider the following:

Section II

In support of this *Motion,* the following evidence is included: (Please indicate the evidence included to support the request, such as medical reports that include a physician statement addressing causal relationship between the requested condition and the industrial injury, earning statements or any other evidence to support the requested action as outlined in the instructions.)

Section III

Certificate of Service: I certify I have served a copy of this *Motion* on all parties and representatives to the claim.

Signed _____ Date signed _____

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

Ohio | Bureau of Workers' Compensation

Settlement Agreement and Application for Approval of Settlement Agreement

for state-fund claims only

Instructions

- You must file this form when requesting a settlement. In addition:
  - o If you are an injured worker receiving permanent total disability (PTD) benefits, an injured worker who is requesting consideration of PTD benefits or a claimant currently receiving death benefits, you also must complete and submit:

    – *Medical History and Disclosure* (C-242) with supporting medical documentation;

    – *PTD-Death Settlement Acknowledgment and Waiver* (C-243) if applying for full settlement or;

    – *Indemnity Only Settlement Acknowledgment and Waiver* (C-245) if applying for an indemnity only settlement.
- **You must submit required information listed above to avoid delays in processing and/or disapproval of the application.**
- BWC may request that an injured worker submit the C-242 with supporting medical documentation for claims other than those listed above.
- By filing this application, the injured worker and the employer understand BWC will suspend all unresolved claim issues, except issues related to temporary total benefits, PTD benefits and alternative dispute resolutions, which BWC will continue to process.
- This application can only be used to settle a claim(s) with a single employer. If you wish to settle claims that are assigned to a different employer, you must file a separate application.
- Use a *Self-insured Joint Settlement Agreement and Release* (SI-42) to pursue a settlement with a self-insuring employer.
- Submit this form, via fax to 1-866-336-8352, or send it to your local BWC customer service office.

Print or Fax

Ohio | Bureau of Workers' Compensation

Settlement Agreement and Application for Approval of Settlement Agreement

for state-fund claims only

Claimant information			
Claimant name			Date of birth
Address	City	State	ZIP code
Email address			Phone number ☐ Home ☐ Cell

Claimant representative information		
Claimant representative name	Fax number	Phone number
Email address	Representative ID number	

Employer of record information			
Employer name	Risk number	Fax number	Phone number
Email address			

Employer representative information		
Employer representative name	Fax number	Phone number
Email address	Representative ID number	

All claims for which the claimant and above named employer make application to BWC for approval of settlement.

Claim number	**Please select type of settlement being requested** (select only full or partial).	**Requested settlement amount**
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	

Clearly set forth the circumstances by reason of which the proposed settlement is deemed desirable, describe briefly why you want to settle your claim(s). This information is **REQUIRED** pursuant to Ohio Revised Code (ORC) 4123.65.

Medical Information

If you are an injured worker, are you receiving medical treatment at this time for any of the claims listed above?
☐ Yes ☐ No

Special notice to medicare beneficiaries

Are you receiving, or have you applied for Medicare benefits or filed an appeal on a denied application?
☐ Yes ☐ No

If yes, Medicare does not pay medical bills for conditions covered by your workers' compensation claim. If a settlement of your workers' compensation claim is reached, and the settlement allocates certain amounts for future medical expenses, Medicare does not pay for those services until medical expenses related to your workers' compensation claim equal the amount of the lump sum settlement allocated to future medical expenses. For additional information, please call the Medicare coordination of benefits contractor at 800-999-1118.

Employment status information

If you are the injured worker, you are required to answer the following questions:

Are you still an employee of the employer listed above (the injury employer)? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No

If yes, what is your present occupation: _____

Name of the employer: _____

What are your present wages? Per hour: _____ Per week _____

If no, are you retired? ☐ Yes ☐ No

Employer/Attorney signature or claimant acknowledgment of exception

Instructions to the claimant:
Pursuant to Section 4123.65(A) of the Ohio Revised Code (ORC), the employer's signature is not required on this settlement application if the employer is no longer doing business in Ohio, or the employer is still doing business in Ohio, however:

- The claim(s) involved in the settlement application is out of the employer's experience and the claimant is no longer employed with the employer;
- The employer has failed to pay premiums as required by Section 4123.35 of the ORC.

☐ **Check here if the employer's signature has not been provided due to one of these exceptions.**

Instructions to the employer:
Please check one of the following boxes and sign below. Your signature does not waive your right as the employer to withdraw consent to the settlement by providing written notice to the employee and the BWC administrator within 30 days after the administrator issues the approval of the settlement agreement.

☐ A. The employer is supportive of and agreeable to a settlement up to the amount listed on the front of this application.
☐ B. The employer does not agree with the requested settlement terms but will participate with the BWC in the negotiation process.
☐ C. The employer is supportive of and agreeable to settlement of the claims listed on the front of this application. However, the employer will not participate in the settlement negotiations and requests the BWC to negotiate the settlement on behalf of the employer.
☐ D. The employer is not agreeable to settlement of the claim(s) listed on the front of this application.

Settlement of a state-fund claim(s) when the employer is now self-insuring:
If the claim to be settled is a state-fund claim(s), and the employer is now self-insuring, BWC charges the self-insuring employer dollar for dollar for any portion of the settlement attributed to past, present or future Disabled Workers' Relief Fund (DWRF) liability. By signing this agreement, the self-insuring employer acknowledges its obligation to reimburse BWC for the portion of the settlement amount allocated to DWRF costs of the above-referenced claim(s). BWC will bill the DWRF portion of the settlement to the self-insuring employer, even if the claimant has not yet been determined to be permanently and totally disabled or currently eligible for DWRF benefits.

Employer signature		Title	Date

Employer attorney signature		Attorney rep ID number	Date

Settlement agreement and release

As set forth in this agreement, the claimant, for and in consideration of the receipt of the settlement amount stated herein, approved by the administrator of the Bureau of Workers' Compensation (BWC) and to be paid from the appropriate fund on behalf of the employer, does hereby for him/herself and for anyone claiming by, through, or under him/her, forever release and discharge the above referenced employer, its officers, employees, agents, representatives, successors and assigns, the Industrial Commission of Ohio (IC), the BWC, the appropriate fund, and all persons, firms or corporations from any and all claims, demands, actions, or causes of action incurred on or prior to the date of the approval of this agreement, arising out of Ohio Revised Code Chapter 4121. or 4123., which he/she now has, or which he/she hereafter claims to have, whether known or unknown by reason of or in any manner growing out of the claims or parts thereof set forth above. The afore stated settlement agreement and release shall not be effective if, within thirty days of approval of the settlement agreement by the BWC administrator, any party submits written notification to the other parties of withdrawal from the settlement agreement or the IC disapproves the settlement agreement.

The claimant further understands and agrees that any amount paid pursuant to this agreement is subject to any valid court-ordered child support. The persons involved with filing this settlement agree that if any claim(s) or part of any claim(s) being settled has been recognized or allowed, the cost of all medical services, hospital bills, drugs and medicines with date(s) of service or filling of related prescriptions (not to exceed a 30-day supply) provided to the claimant before the effective settlement date, shall be the responsibility of the state insurance fund, provided such costs result from the allowed conditions of the claims and are properly payable under current medical payment guidelines. Unless this agreement settles indemnity benefits only, the costs of medical services, hospital bills, drugs and medicines provided to the claimant on or after the effective date of the settlement is the responsibility of the claimant.

Additionally, the claimant understands that Medicare does not pay medical bills for conditions covered by claimant's workers' compensation claim and that, if a settlement of a workers' compensation claim is reached, and the settlement allocates certain amounts for future medical expenses, Medicare does not pay for those services until medical expenses related to claimant's workers' compensation claim equal the amount of the settlement agreement allocated to future medical expenses.

Settlement of the claim(s) included in this agreement in no way impairs BWC's statutory rights to subrogation recovery. Further, upon a finding of fraud, the BWC administrator retains the right to rescind this settlement agreement and re-open the included claim(s) for an administrative overpayment hearing and referral for criminal prosecution.

☐ By initialing this box, the claimant acknowledges he/she has read, understands, and agrees to the above statements.

Claimant/Claimant representative signature

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.

Claimant signature		Date
Claimant attorney signature		Date

Authorization to receive payment

I hereby authorize and direct BWC to mail directly to my attorney the settlement compensation payment.
This authorization does not give my attorney the authority to cash or endorse a check on my behalf.
This authorization shall not continue in effect after BWC has paid said award(s) on the original application noted above unless there is a subsequent hearing, appeal or reconsideration after payment was made.
This authorization is not valid if it is filed beyond 18 months from the date of my signature.

Claimant signature		Date

Ministerial Forms

Ohio | Bureau of Workers' Compensation

Claimant Authorized Representative

Complete this form in its entirety and fax it to 1-866-336-8352, or send it to the BWC customer service office where your claim is assigned.

The form is available online at www.bwc.ohio.gov.

Claimant information

Claimant name	Date of injury	Claim number

Claimant address		

City	State	ZIP code

Email address, if available	Phone number

Representative information

*You may have only one legal representative (one attorney or one law firm) and one union representative.
Your representative **must have a BWC representative identification number prior to being designated as an authorized representative.

Representative/Firm name*	

Representative BWC ID number**	Phone number

Representative street address		

City	State	ZIP code

Authorization

I authorize the above to be my authorized representative. The authorization entitles the representative access to my complete claim file, including medical and/or other information contained therein, and to receive correspondence generated in the above claim.

I further understand that:

- If I designate an attorney or law firm, BWC will remove any previously designated attorney or law firm as legal authorized representative, and it is my responsibility to notify the former legal representatives of the change;
- If I have previously authorized an individual in this claim to receive my workers' compensation check, **I understand that, if desired, I must cancel the previous authorization separately in writing.**

The authorization above is being given to a:

Attorney ☐ Law firm ☐ Union representative ☐ Other (Please explain.) ☐

Signature of claimant	Printed name
	Date of authorization

Ohio | Bureau of Workers' Compensation

Application for Representative Identification Number (RIN)

Fax this completed form to BWC at 614-621-3437.

After receiving a RIN number an employer or injured worker may assign you as a representative to an individual claim using the *Employer Authorized Representative* (R-1) or *Injured Worker Authorized Representative* (R-2).

Applicant's name

- The listed name must match the name reported to the Social Security Administration or, if using an employer identification number, the associated name reported to the Internal Revenue Service.
- Complete the appropriate option below.
- You must complete one of the three options.

Option 1

Individual attorney applying for RIN

Name

Ohio attorney registration number; or

Certificate of Pro Hac Vice registration number

If you are an out-of-state attorney, you must attach a *Certificate of Pro Hac Vice* to this application.

Option 2

Individual non-attorney applying for RIN

Name

Check if you are: ☐ Union representative Other (Identify)

Option 3

Company, firm or union applying for RIN; individual employees/attorneys may share one RIN.

Name	Contact name

Check if you are: ☐ Law firm ☐ Local union ☐ Third-party administrator ☐ Other (Identify)

Taxpayer identification number (Social Security (SSN) or employer identification number (EIN)

If you anticipate payment for services, you must also attach a W-9 to this application.

Taxpayer identification number (SSN or EIN)

Applicant contact information

Street address

City	State	ZIP code

Email address

Phone number	Fax number

Signature of applicant (if applying as company or firm, signature of contact person)	Date

BWC use only

Representative number issued	Date

Signature of assigning BWC employee	Date

Ohio | Bureau of Workers' Compensation

Notice to Change Physician of Record

The physician selected must be BWC certified or the injured worker will be responsible for payment.

Instructions for the injured worker
- Please complete all of Part I of the form.
- Sign in the space provided, and submit all copies to your managed care organization (MCO) to record your change of physician.

Part I

Injured worker's name	Date of injury	Claim number

Address	Phone number ( )

City	State	Nine-digit ZIP code

Please change my physician of record for the above listed claim as follows:

From physician	Provider number

Address	Phone number ( )

City	State	Nine-digit ZIP code

To physician	Provider number

Address	Phone number ( )

City	State	Nine-digit ZIP code

Reason for change

☐ Physician moved ☐ Physician no longer practicing ☐ I moved ☐ Physician is not a BWC-certified provider

☐ Physician terminated patient-provider relationship
Please explain: _____

☐ Dissatisfied with physician's treatment
Please explain: _____

☐ Other, please explain: _____

Have you been treated by the new physician for the condition(s) allowed in your claim? Yes☐ No☐ If yes give date of first treatment _____

Injured worker's signature	Date

Instructions for the MCO
- MCO to complete PART II.
- MCO must notify BWC via EDI (148) of change of physician within 24 hours of notification by the injured worker.
- Return signed copies per distribution listed below.

Part II

We have received and recorded your request for change of physician. You may bill only medical services and items related to the treatment of the allowed conditions and in accordance with the MCO medical-management guidelines to the MCO or the self-insured employer. The allowed conditions for this workers' compensation claim with corresponding ICD-9-CM codes are as follows: _____

MCO name	Phone number ( )

MCO case manager	Date

Distribution: White–MCO Claim file • Yellow–Injured worker • Pink–Requested physician • Goldenrod–Former physician

Ohio | Bureau of Workers' Compensation

Injured Worker's Change of Contact Information (C-77)

Claim number(s)

Instructions

- Complete the appropriate sections below to document your contact information change(s).
- Submit this form via fax to 1-866-336-8352, or send it to your local BWC office.

I am reporting the following changes (check all that apply). Change of:

- ☐ **Name;**
- ☐ **Address (mailing and/or home);**
- ☐ **Phone number (cell and/or home);**
- ☐ **Email address.**

Effective date of change _____

Injured worker name	
Old name	Date of birth
New name	Date of birth

Mailing address		
Old mailing address		
City	State	ZIP code
New mailing address		
City	State	ZIP code

Home address		
Old home address		
City	State	ZIP code
New home address		
City	State	ZIP code

Phone number	
Old phone number ☐ Home ☐ Cell	New phone number ☐ Home ☐ Cell

Email address	
Old email	New email

Injured worker signature	
I have provided accurate and complete information. 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

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

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

- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

Injured worker name (first, M.I., last)		Date of injury		Claim number
Address	City		State	Nine-digit ZIP code
Employer name	Employer MCO or QHP			

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (_____

_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

_____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____

_____.

Ohio | Bureau of Workers' Compensation

Authorization to Receive Workers' Compensation Payment

Injured worker's name	Claim number
Attorney's name	Representative ID number

Instructions for completion

- You must complete this form in its entirety, including the correct claim number.
- You must file a separate authorization for each claim and for each application, motion or order.

BWC will not honor an authorization that is not completed in its entirety, is altered but not initialed by the party altering the form or is not timely filed.

Time limits for filing are as follows:

On all types of compensation, other than an application for the percentage of permanent partial compensation (C-92), you must file the authorization to receive workers' compensation payment:

- Prior to or at the hearing;
- Prior to the date of the payment of compensation (before the award is issued) whether the award of compensation was made at a hearing or made without a hearing.

On any compensation paid pursuant to a C-92 application or an agreement of the parties to a percent permanent partial award, you must file the authorization:

- With the application or the agreement for permanent partial disability;
- With the application for the election of permanent partial from temporary partial;
- With the Industrial Commission of Ohio at the hearing;
- After the hearing but prior to the date of mailing of the hearing officer order.

I hereby authorize and direct BWC to mail directly to my attorney the compensation payment in the above numbered claim for the accrued portion of my award as specified below. You must specify the date of the application, request, motion or order.

Application, request, motion or order dated _____/_____/_____ for the type(s) of compensation listed below.

Check all that apply.

- ☐ Temporary total
- ☐ Wage loss
- ☐ Change of occupation
- ☐ Scheduled loss
- ☐ Permanent total disability
- ☐ Death benefits
- ☐ Impairment of earning capacity
- ☐ Violation of specific safety
- ☐ Facial disfigurement
- ☐ Lump sum settlement
- ☐ Percentage permanent partial
- ☐ Lump sum advancement

This authorization does not give my attorney the authority to cash or endorse a check on my behalf.

This authorization shall not continue in effect after BWC has paid said award(s) on the original application noted above unless there is a subsequent hearing, appeal or reconsideration after payment was made.

This authorization is not valid if it is filed beyond 18 months from the date of my signature.

Injured worker's/claimant's signature	Date

BWC Subrogation Referral Form

Claimant _____

Claim No._____ Date of Injury_____

Claimant's PI Attorney and Address

_____

_____

_____

Telephone No._____

Third Party Name and Address

_____

_____

_____

Telephone No._____

Third Party's Insurance Company

Address, Claim No. and Claims Rep

_____

_____

_____

Third Party's Attorney (If known)

Name and Address

_____

_____

_____

Description of Accident

_____

_____

_____

_____

Refer to:

Subrogation Department
P.O. Box 15487
Columbus, OH 43215
Phone: (614) 466-6600
Fax: (614) 621-2549

Referred By:_____
Telephone:_____
Affiliation:_____
Date:_____

Attached:

MVA Report__

Other__ Specify_____

Employer Forms

Ohio | Bureau of Workers' Compensation

Employer Authorized Representative

Instructions
- The employer and representative must complete this form and file it with BWC.
- You must possess a valid BWC representative ID number.
- To obtain a valid representative ID number, contact the Central Office, customer assistance desk at 614-466-1958 or 614-466-1563, or inquire at any BWC customer service office information desk.

Injured worker name	Claim number
Date of injury	Employer policy number
Employer name	
Employer address	City, State, ZIP code

Representative

Representative name	Representative ID number
Address	Telephone number
City, State, ZIP code	
Representative e-mail address	Fax number

Authorization

I hereby authorize the above representative to represent me in the above claim before the Ohio Bureau of Workers' Compensation and the Industrial Commission of Ohio. This authorization also entitles this representative to automatically receive correspondence generated in the above claim file.

X	
Signature of employer official granting this authorization	Date of authorization

Ohio | Bureau of Workers' Compensation

Application for Representative Identification Number (RIN)

Fax this completed form to BWC at 614-621-3437.

After receiving a RIN number an employer or injured worker may assign you as a representative to an individual claim using the *Employer Authorized Representative* (R-1) or *Injured Worker Authorized Representative* (R-2).

Applicant's name

- The listed name must match the name reported to the Social Security Administration or, if using an employer identification number, the associated name reported to the Internal Revenue Service.
- Complete the appropriate option below.
- You must complete one of the three options.

Option 1

Individual attorney applying for RIN

Name

Ohio attorney registration number; or

Certificate of Pro Hac Vice registration number

If you are an out-of-state attorney, you must attach a *Certificate of Pro Hac Vice* to this application.

Option 2

Individual non-attorney applying for RIN

Name

Check if you are: ☐ Union representative Other (Identify)

Option 3

Company, firm or union applying for RIN; individual employees/attorneys may share one RIN.

Name	Contact name

Check if you are: ☐ Law firm ☐ Local union ☐ Third-party administrator ☐ Other (Identify)

Taxpayer identification number (Social Security (SSN) or employer identification number (EIN)

If you anticipate payment for services, you must also attach a W-9 to this application.

Taxpayer identification number (SSN or EIN)

Applicant contact information

Street address

City	State	ZIP code

Email address

Phone number	Fax number

Signature of applicant (if applying as company or firm, signature of contact person)	Date

BWC use only

Representative number issued	Date

Signature of assigning BWC employee	Date

Ohio | **Bureau of Workers' Compensation**

Temporary Authorization to Review Information

To: Ohio Bureau of Workers' Compensation

☐ Employer Services Department, 22nd Floor
☐ Self-Insured Department, 22nd Floor

Please mark a box and return to:
30 W. Spring St.
Columbus, Ohio 43215-2256

From: Policy number
Entity
DBA
Address

Note: For this to be a **valid** letter, the self-insured department for self-insured employers, or the employer services department for all other employers, must stamp it. Being temporary in nature, BWC will not record via computer or retain this authorization. Representative must possess a copy when requesting service relative to the authority granted therein.

This is to certify that _____, including its agents or representatives identified to you by them, has been retained to review and perform studies on certain workers' compensation matters on our behalf.

The limited letter of authority provides access to the following types of information relating to our account:

1. Risk files;
2. Claim files;
3. Merit-rated or non-merit-rated experiences;
4. Other associated data.

This authorization does not include the authority to:

1. Review protest letters;
2. File protest letters;
3. File form *Application for Handicap Reimbursement (CHP-4);*
4. *Notice of Appeal* (IC-12) or *Application for Permanent Partial Reconsideration (IC-88);*
5. File self-insurance applications;
6. Represent the employer at hearings;
7. Pursue other similar actions on behalf of the employer.

I understand this authorization is limited and temporary in nature and will expire on _____ or automatically nine months from the date received by the employer services or self-insured departments, whichever is appropriate. In either case, the length of authorization will not exceed nine months.

Telephone number	Fax number	Email address	
Print name	Title	Signature	Date

Completion of the temporary authorization provides a third-party administrator (TPA) limited authority to view an employer's payroll and loss experience. By signing the AC-3, the employer grants permission to the BWC to release information to the employer's authorized representative(s). The form allows a TPA to view an employer's information regarding payroll, claims and experience modification.

Attention group rating prospects

- Employers may complete the AC-3 for as many TPAs or group-rating sponsors they feel are necessary to obtain quotes for a group-rating program.
- Group sponsors must notify all current group members if they will not accept them for the next group-rating year. The deadline for this notification is prior to the last business day in October for private employers and prior to the last business day in April for public employers.
- All potential group-rating prospects must have:
  Active BWC coverage status as of the application deadline;
  Active coverage from the application deadline through the group rating year;
  No outstanding balances;
  Operations similar in nature to the other members of their group.
- Any changes to a group member's policy will affect the group policy. Changes can result in either debits or credits to each of the members.

Note: For complete information on rules for group rating, see Rules 4123-17-61 through 4123-17-68 of the Ohio Administrative Code or your TPA. All group-rating applicants are subject to review by the BWC employer programs unit.

Ohio | Bureau of Workers' Compensation

Request to Add/Change or Terminate Permanent Authorization

To: Ohio Bureau of Workers' Compensation

☐ Employer Services Department, 22nd floor

☐ Self-Insured Department, 22nd floor

Please mark a box and return to:
30 W. Spring St.
Columbus, OH 43215-2256

Fax: 614-621-1405

Policy number
Entity
DBA
Address

Note: For this to be a **valid** letter, the employer services department, or the self-insured department for self-insuring employers, must stamp it.

This is to certify that effective _____
(Date)

_____,
(Representative name and rep ID number)

Including its agents or representatives identified to you by them, has been terminated or retained to represent us before the Ohio Bureau of Workers' Compensation and the Ohio Industrial Commission in matters pertaining to our participation in the workers' compensation fund according to the type of representation checked below.

Please check only one type of representation. See description of representatives at the bottom of this form.

✔ **Type of authorized representation addition/change or termination** ☐ Add ☐ Terminate	
☐ Employer-risk claim representative (ERC)	☐ Risk-management representative (RISK)
☐ Claim-management representative (CLM)	☐ Payroll service vendor (PSV)

This authorization supersedes all permanent authorizations on file for the type of representation indicated above.

I understand and agree BWC will process any letters, requests and actions initiated by a superseded authority.

I understand this authorization, now being granted, is of a continuous nature from the effective date indicated herein. However, I possess the right to terminate this authorization at any time through written notification to the employer services or self-insured departments as appropriate.

Telephone number	Fax number	Email address
Print name and title	Employer signature	Date

BWC authorized representative service/roles

Employer-risk claim representative (ERC) – The ERC is designated as the employer's authorized representative for both risk- and claims-management-related issues. He or she is also the employer's authorized representative on each claim under the employer's policy number. The ERC receives copies of all risk and claim correspondence. The ERC has full access to the employer's risk information and information pertaining to the workers' compensation claims filed against the employer. He or she will also have the authority to access such information on www.bwc.ohio.gov.

BWC will consider the ERC as the authorized representative in handling risk-related issues for an employer if there is no designated group-risk claim representative (GRC). BWC also will consider the ERC as the authorized representative in handling claim-related issues for an employer if there is no designated CLM or GRC.

Risk-management representative (RISK) – The RISK is the employer's designated authorized representative for risk-related issues. He or she represents an employer on risk-related issues only. The RISK receives copies of all risk correspondence. A RISK will have access to only the employer's risk-related information and authority to access that information on www.bwc.ohio.gov.

BWC will consider the RISK as the authorized representative in handling risk-related issues for an employer if there is no designated GRC or ERC. The RISK will have no authority to represent the employer on any matters if either a GRC or ERC is appointed. In addition, the RISK will have access only to the employer's risk-related information and authority to access that information on www.bwc.ohio.gov.

Claims-management representative (CLM) – The CLM is the employer's designated authorized representative on each claim associated with the employer. He or she will receive copies of all claim correspondence. The CLM represents an employer on claim-related issues only. A CLM will have access only to information pertaining to the workers' compensation claims filed against the employer and authority to access that information on www.bwc.ohio.gov.

BWC will consider the CLM the authorized representative in handling claims-related issues for an employer.

Payroll service vendor (PSV) – A payroll service vendor provides payroll services, including reporting and/or withholding and remittance services for workers' compensation premium payments.

Note: Based on the designation made by the group's sponsor, only the employer services group-rating unit can update a GRC.

You cannot use the AC-2 to select a GRC authorization. This representative type only applies to private employers and public employer taxing districts. BWC will consider the GRC the authorized representative in handling risk-related issues for an employer. In addition, BWC will consider the GRC the authorized representative in handling claim-related issues for an employer if there is no designated claims-management representative (CLM).

Ohio | Bureau of Workers' Compensation

Salary Continuation Agreement

This form can be obtained online at: **www.bwc.ohio.gov**

Instructions

- This form is used to acknowledge an agreement to pay salary/wage continuation in lieu of temporary total or living maintenance compensation.
- Regular (full) salary/wages includes any benefits which the employee would normally be entitled to if the employee was working.
- This form must be signed by the employee and the employer.
- Fax or mail this completed agreement to your local BWC service office.

Employee name		Claim number
Employer name	Policy number	Employer telephone number

On the _____ day of _____ , _____ , _____ , the employer and
Employer name
the employee named above executed the following terms and conditions pertaining to the payment of salary continuation.

The employer, **since the inception of the employee's disability** resulting from an accident/occupational disease suffered by the employee on ____ / ____ / ____ , while in course of their employment, has been or is paying regular (full) salary/wages in lieu of temporary total or living maintenance compensation, to the employee during the period of disability as indicated below:

Continuation of regular (full) salary/wages and any benefits the injured worker would otherwise have been entitled to has been/will be paid. Salary continuation will be paid at the rate of $_____ per _____(week, two weeks, etc.) for the period of time from ____/____/____ to ____/____/____, (a period of time not to exceed 45 days per C-55 submission).

Does the amount paid include salary/wages from other employment? ☐ Yes ☐ No

Should salary continuation payment continue a new C-55 must be submitted within five days of the end date of this agreement. The employer must notify BWC immediately if salary continuation will be discontinued and/or if the injured worker returns to work.

Employee signature	Date
Employer signature and title	Date

Ohio | Bureau of Workers' Compensation

Waiver of Workers' Compensation Benefits for Recreational or Fitness Activities

Instructions

- Complete this form to waive workers' compensation coverage for voluntary participation in employer-sponsored recreational activities or fitness programs.
- In the space provided, list all employer-sponsored recreational activities and fitness programs for which the employee wishes to waive workers' compensation coverage. Make a line through any blank spaces.
- The employee **must** sign and date this form to acknowledge agreement.
- The employer shall retain the original for his or her files and provide a copy to the employee.
- The employer should submit a copy to BWC **only when an employee files a claim** for an injury or occupational disease sustained in the employer- sponsored recreational activity or fitness program. For further information call 1-800-644-6292.

Employee name (please print or type)	Date
Employer name	Risk number

Pursuant to Section 4123.01(C)(3) of the Ohio Revised Code (ORC), the employer and employee shall list those employer-sponsored recreational activities and fitness programs for which the employee wishes to waive all rights to compensation and benefits under Chapter 4123 of the ORC. The waiver must be signed and dated prior to the date of injury or, in an occupational disease claim, the date of disability. Should an employee sustain an injury or occupational disease in an employer-sponsored recreational activity or fitness program **which is not listed**, the employee may be eligible for workers' compensation benefits.

Recreational activities/Fitness programs

_____

_____

_____

_____

_____

_____

The undersigned declares that he or she is a voluntary participant in the employer-sponsored recreational activities or fitness programs listed above. He or she hereby waives and relinquishes all rights to workers' compensation benefits under Chapter 4123 of the ORC for any injury or disability incurred while participating in the above activities or programs. This waiver is valid for two calendar years. The waiver may not bar any workers' compensation claim filed for death benefits by the employee's dependents.

_____ _____

Employee signature Date signed

BWC-1286 (12/29/1997)
C-159 (previously OIC-0161)

Ohio | Bureau of Workers' Compensation

Application for Handicap Reimbursement

Under the Ohio Revised Code Section 4123.343, BWC uses this application to determine the percentage of compensation to properly charge to, or to refund from, the Statutory Surplus Fund due to an aggravation of one or more of the pre-existing conditions below:

01 Epilepsy
02 Diabetes
03 Cardiac disease
04 Arthritis
05 Amputated foot, leg, arm or hand
06 Loss of sight of one or both eyes or partial loss of uncorrected vision of more than 75 percent bilaterally
07 Residual disability from poliomyelitis
08 Cerebral palsy
09 Multiple sclerosis
10 Parkinson's disease
11 Cerebral vascular accident
12 Tuberculosis
13 Silicosis
14 Psycho-neurotic disability following treatment in a recognized medical or mental institution
15 Hemophilia
16 Chronic osteomyelitis
17 Ankylosis of joints
18 Hyper Insulinism
19 Muscular dystrophies
20 Arterio-sclerosis
21 Thrombo-phlebitis
22 Varicose veins
23 Cardiovascular and pulmonary diseases of a firefighter employed by municipal corporation or township as a regular member of a lawfully constituted fire department
24 Coal miners pneumoconiosis
25 Disability with respect to which an individual has completed a rehabilitation program for a previous injury or claim (ORC 4121.61-69)
26 Service connected injury (see ORC 4123.63)

Attachments

1. Medical evidence (in the form of doctor's reports, diagnostic tests such as an MRI, X-RAY, or CTScan, laboratory records) that the employee suffered from one or more of the conditions listed above.
2. Evidence that the condition constituted a handicap within the meaning of the law, including but not limited to evidence that **prior** to the injury, disease or death, the handicap condition caused the employee to be hospitalized or to obtain extensive medical treatment.
3. Evidence that the injury, disease, death, or the handicap condition caused the employee to be absent from work for at least eight or more consecutive days or resulted in a scheduled loss under R.C. 4123.57(B).
4. Evidence in the form of affidavits or medical reports to support the contention that the injury, disease or death would not have occurred but for the pre-existing handicap condition of the employee or that the resulting disability or death was caused, in part, through aggravation of the handicapped condition.
5. Under BWC rules, if the application is not accompanied by all relevant medical evidence and substantial proof, the Administrator may dismiss the application.

Filing instructions

- You may hand deliver this application to:
  BWC, Customer Service, 30 W. Spring St., Columbus, OH, Second Floor.
- You may mail this application to: **BWC, Attn: Handicap Reimbursement Unit, 30 W. Spring St., 26th Floor, Columbus, OH 43215-2256.** If you provide a copy of the application and a self-addressed stamped envelope, BWC will mail a date-stamped copy to the employer representative. Note: You may send an e-mail with any questions concerning the Handicap Reimbursement Program by using: HandreimbQuest@bwc.state.oh.us

To be completed by employer or employer representative

Injured worker name	Social Security number	Claim number
Nature of handicap	**Date of injury**	**Date of death**

History of injury	Allowed condition(s) in this claim

State how the pre-existing handicap increased the cost of this claim (Staple attach all forms) ***Note: The administrator will not consider applications lacking a sufficient description concerning the handicapped condition's impact on the occupational injury, disease or death. The administrator will make a determination based on the information contained in this application.***

Type of compensation	☐ Temporary Total	☐ Wages in lieu of TT *(attach proof)*	☐ R.C. 4123.57 (B) *(scheduled loss)*	☐ Permanent Total	☐ Death
Do you request an informal conference	☐ In person	☐ By phone	Contact name		

Fill out information below completely

Employer name		Risk number	Manual number
Address			**Telephone number** ( )
City	**State**	**Nine-digit ZIP code**	**E-mail address**
Employer representative name		**Docketing (contact name)**	
Address			**Telephone number** ( )
City	**State**	**Nine-digit ZIP code**	**E-mail address**

Ohio | Bureau of Workers' Compensation

Amended True-Up Payroll Report

Instructions

- You must complete this form in its entirety along with a reason for the change. If supplemental coverage applies (sole proprietor, partnership, limited liability company acting as a sole proprietor/partnership, family farm corporate officer or ministers), you must report the payroll under the correct National Council on Compensation Insurance (NCCI) classification and manual type code (SN).
- Submit this report by fax to 614-719-5313.

Policy number

Legal business name	Trading name or doing business as name	
Mailing address	Email address	Telephone number ( )
City	State	ZIP code

Payroll period
from through

NCCI manual classification

Manual	Type code	Description	Number of employees	Original reported payroll	Actual payroll
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

Reason for change

_____

_____

_____

Certification

I hereby certify the amended payroll reported herein is correct as to the classification and amount for the period stated. I understand that misrepresentation of payroll for premium purposes could lead to a penalty of 10 times the amount of the premium underreported, as provided by Section 4123.25 of the Ohio Revised Code.

By my signature, I certify I have the authority to execute this document, and that the facts set forth on this document are true and correct to the best of my knowledge and belief. I am aware that any person who does not secure or maintain workers' compensation coverage and pay all appropriate premiums in accordance with Ohio laws, or misrepresents, conceals facts or makes false statements to obtain coverage may be subject to civil, criminal and/or administrative penalties.

Signature and title (must be signed by owner, partner or officer)	Date

Ohio | Bureau of Workers' Compensation

Application for Ohio Workers' Compensation Coverage

Have question? Need assistance? BWC is here to help!
Call 1-800-644-6292, and listen to the options to reach a customer service representative.
You can dial the number nationwide, and in Canada and Mexico from 7:30 a.m. to 5:30 p.m. EST.
Remember, you can access information and request services by visiting BWC's website at www.bwc.ohio.gov.

Workers' compensation coverage protects you and your employees in the event of a work-related injury, disease or death. In Ohio, all employers with one or more employees must carry workers' compensation coverage. It's the law. Coverage becomes effective when BWC receives this completed application and the $120 non-refundable application fee and shall be contingent on the timely receipt of the first installment payment. Independent contractors and subcontractors also must obtain coverage for their employees.

BWC considers officers of a corporation employees for the purposes of workers' compensation; except for an individual incorporated as a corporation with no employees.

However, if you are self-employed, a partner in a business, an officer of a family farm corporation or an individual incorporated as a corporation, you are not automatically covered. You may elect coverage for yourself by selecting Yes in the elective coverage section and the owners/officers/ministers information section of this application.

Note: Even if you do not elect coverage for yourself you must have coverage for any employees you hire.

It's easy to obtain coverage by following these steps.

1. Apply for coverage online at www.bwc.ohio.gov, or complete all fields on this application for coverage.
2. Provide as many details as possible. When describing the nature of the business, include the type of work performed and the equipment used.
3. Sign and date the application. It's not valid without a signature.
4. Mail the completed application with the $120 non-refundable application fee to: **Ohio Bureau of Workers' Compensation**
   P.O. Box 15698
   Columbus, OH 43215-0698

Please make check or money order payable to the **Ohio Bureau of Workers' Compensation.**

What happens next?

Once BWC processes your application, you will receive:

- A policy invoice for your first installment. BWC determined your estimated annual premium from the 12-month estimated payroll you submitted. BWC uses this figure to calculate installments;
- A Notice of Estimated Annual Premium, which provides you with pertinent information about your policy. The notice also directs you to the new employer kit, which explains your rights and responsibilities. It also provides cost savings tips for your business. In addition, the kit includes an MCO Selection Guide that contains instructions on how to select a managed care organization (MCO). MCOs manage the medical portion of your company's workers' compensation claims;
- Certificate of Ohio Workers' Compensation Coverage, which includes the effective date of coverage. Coverage is contingent upon timely receipt of your first installment payment. You must post the Certificate of Ohio Workers' Compensation Coverage as proof of coverage.

General information

Ohio law requires employers to obtain workers' compensation coverage for their employees from the first date of hire. Indicate the date your employees first earned wages in Ohio or the date you estimate your employees will first earn wages in Ohio. If you do not provide this information, you may be assessed a penalty for non-covered periods where coverage should have been obtained.

Be sure to supply your federal employer identification number (FEIN). You can obtain a FEIN number by calling the Internal Revenue Service. If you have applied for a FEIN, but have not received one, write "applied for" in the appropriate box, and you may supply it at a later date. Domestic household employers, sole proprietors and partnerships who do not need a FEIN should supply a Social Security number of the sole proprietor, one of the home owners or partners.

Address information

BWC uses your primary physical Ohio location to assign one customer service office for all your policy services. Please provide the address for your primary Ohio location best capable of handling and resolving your policy issues or an out of state location if you have no physical Ohio location. BWC will send all employer related correspondence including your policy invoice to the mailing address. If no mailing address is provided, BWC will use the primary physical Ohio location for all employer notifications.

Coverage is not in effect until BWC receives the completed application and the $120 non-refundable application fee. In addition, coverage should be contingent on the timely receipt of the first installment payment. BWC cannot process incomplete applications.

Additional Ohio locations

This section is used for additional Ohio locations that may be covered under this policy. Please provide a brief description of operation for each location.

Business information

Please provide general business information for your primary location.

Business contact information

Provide specific individual(s) information that will allow BWC to make direct contact with those handling your workers' compensation matters.

Domestic household coverage

Coverage applies to full or part-time domestic workers employed inside or outside your private residence and includes private chauffeurs. Domestic household employers who pay workers $160 or more in a calendar quarter must have workers' compensation insurance. Normally these workers provide domestic services such as gardening, housekeeping, babysitting, etc. However, you should include workers you hire as employees to provide home improvement for construction type activities to your residence if the worker does not have his or her own business or their own workers' compensation insurance. Please check the appropriate box under Domestic household employer that applies to the type of worker you will hire, and supply a 12-month estimate so BWC may calculate your future installment payments due. If you are hiring a contractor to perform these services, you may want to verify he or she has active workers' compensation coverage.

Business entity information

Select the one business entity type that applies to your company. For workers' compensation purposes, there are four possible business entity types that apply to a corporation (i.e., limited liability company acting as a corporation, corporation, individual incorporated as a corporation with no employees and family farm corporation). Select the business entity type that best describes your corporate structure. Be sure to include the corporation date, charter number and state where incorporated. If incorporated in a state other than Ohio, the charter number may be referred to as some other identifier name.

Sole proprietor and partners (including limited liability companies acting as a sole proprietor or partnership): Sole proprietor and partners are exempt from workers' compensation coverage. However, you must cover your employees. If you qualify for elective coverage, you can elect coverage by selecting Yes in the elective coverage section and the owners/officers/minister information section of this application.

Limited liability companies: These companies can elect to be treated as a corporation, sole proprietorship or partnership for income tax purposes. Because of this, owners of a limited liability company can be treated differently depending upon the form of entity they elect for income tax purposes. Therefore, if you file your income taxes as a sole proprietorship or partnership, coverage is elective for the owners. If you file your income taxes as a corporation, coverage for the owners is not elective except for an individual incorporated as a corporation (with no employees).

Corporations: Corporate officer reportable wages are subject to a minimum and maximum amount based on the statewide average weekly wage and the effective date of the policy period. The minimum reportable payroll applies only to active executive officers of the corporation (i.e., officers engaged in the decision making and the day to day operation of the corporation). Officers of a corporation who earn between the minimum and maximum will report their actual W-2 wages. For S-corporations, officers must report wages for services they perform. This may include W-2 wages as well as all or part of ordinary income from Schedule K-1 up to the maximum. Officers of a nonprofit corporation, as defined in section 1701.02 of the Ohio revised code, who volunteers the person's services as an officer are excluded from workers' compensation coverage.

Note: Log on to www.bwc.ohio.gov and click on the Employers section. From the left-side menu go to Payroll/Premium, then select Payroll true-up reports, then select Details, then select Minimum and maximum payroll reporting requirements to obtain the minimum and maximum payroll reporting requirement amounts applicable for the policy year.

Individuals incorporated as a corporation (with no employees): To qualify for this business entity type you must have a single/sole owner with no employees. The single/sole owner with no employees can elect coverage by selecting "Yes" in the elective coverage section and the ownership/officers/ministers information section of this application. By law, corporations having more than one owner or a single/sole owner with employees must have workers' compensation coverage for all personnel associated with the corporation, including all corporate officers.

Family farm corporation: These officers are exempt from workers' compensation coverage. However, they must cover their employees. These family farm corporate officers can elect coverage by selecting "Yes" in the elective coverage section and in the owners/officers/minister information section of this application. To qualify as a family farm corporation, you must meet the following criteria:

- The family farm must be founded for the purpose of farming animal or plant products intended for consumption by human beings or animals (excluding nurseries and flower production enterprises);
- A majority of the shareholders must be related within the fourth degree of kinship (siblings, parents, grandparents, aunts, uncles, great aunts, great uncles, or first cousins) or be the spouse of such persons;
- No shareholder may be a corporation;
- At least one of the related persons within the corporation must reside on or actively operate the farm.

Association: In general, an association is a group of persons banded together for a specific purpose. To qualify under section 501(a) of the Code, the association must have a written document such as articles of association showing its creation. At least two persons must sign and date the document.

Elective coverage

Coverage on certain owners or ministers is elective. The categories of individuals that qualify for elective coverage are listed below.

- Sole Proprietor
- Partnership
- Limited liability company acting as a sole proprietor
- Limited liability company acting as partnership
- Family farm corporate officers
- Ordained or associate ministers of a religious organization in the exercise of their ministries
- Individual incorporated as a corporation (with no employees)

If you qualify for elective coverage, you can elect coverage by selecting Yes in the Elective coverage section and the owners/officers/ministers information section of this application. If you choose not to cover yourself at this time, you may elect coverage at a later date time and/or to add additional qualifying owners or ministers by completing the *Application for Elective Coverage* (U3S). Remember, if you choose not to cover yourself and you are injured at work, BWC will not provide coverage and other insurance may not cover your work-related disability or medical bills.

Specific payroll reporting requirements associated with elective coverage are listed below.

Sole proprietors and partners (including limited liability companies acting as a sole proprietor or partnership): For all individuals electing coverage, the reportable wages are subject to a minimum and maximum amount based on the statewide average weekly wage. The minimum and maximum reporting requirements are determined by the effective date of the policy period. To determine the current minimum and maximum reporting requirements refer to the note below. Individuals who earn between the minimum and maximum must report their actual net incomes based on their federal tax form Schedule C for sole proprietors or Schedule K-1 for partnerships, inclusive of any draws.

Officers of a family farm corporation: For corporate officers of a family farm electing coverage, the reportable wages are subject to a minimum and maximum amount based on the statewide average weekly wage. The minimum and maximum reporting requirements are determined by the effective date of the policy period. To determine the current minimum and maximum reporting requirements refer to the note below. Corporate officers of a family farm who earn between the minimum and maximum must report their actual W-2 wages for corporations or S-corporations. Officers must report a reasonable wage for services they perform, including W-2 wages. Wages include all or part of the ordinary income from Schedule K-1.

Religious organizations: Ohio law requires religious organizations to cover their paid employees. However, ordained ministers and associate ministers are not considered employees for the purpose of workers' compensation. When a minister is covered under the religious organization's policy they must report actual earnings, which are not subject to the minimum and maximum. However, a minister who elects coverage as a sole proprietor is subject to the minimum and maximum amount based on the statewide average weekly wage and the effective date of the policy period.

Individuals incorporated as a corporation (with no employees): Individuals electing coverage must report actual wages subject to a minimum and maximum amount based on the statewide average weekly wage and the effective date of the policy period. To determine the current minimum and maximum reporting requirements refer to the note below. ICORP owners who earn between the minimum and maximum must report their actual wages. ICORP owners must report a reasonable wage for services they perform, including W-2 wages. Wages include all or part of the ordinary income from Schedule K-1.

Note: Log on to www.bwc.ohio.gov and click on the Employers section. From the left-side menu go to Payroll/Premium, then select Payroll true-up reports, then select Details, then select Minimum and maximum payroll reporting requirements to obtain the minimum and maximum payroll reporting requirement amounts applicable for the policy year.

Owners/officers/ministers information (does not apply to domestic household employers)

You must provide name, home address, Social Security number, date of birth, title/relationship and percentage of ownership interest, if any. If contact information is different than that provided in the business or business contact information section, you may provide that information here. Provide a brief description of your duties as an owner/officer/minister. (Attach additional sheets, if necessary). Additionally, individuals that qualify for elective coverage must indicate whether or not they wish to elect coverage for themselves in this section.

Operations description (does not apply to domestic household employers)

A complete description of your business is necessary to classify your operations. If you supply inadequate information, BWC could misclassify your policy. To prevent this from occurring, BWC asks that you supply in-depth information regarding your processes, the equipment used and any final product you may produce.

Out-of-state considerations

Ohio employers: You must disclose payroll information for employees who are from Ohio but work within and outside of Ohio. However, you may segregate your payroll by state if you elect to obtain non-BWC coverage for work done outside of Ohio. Please refer to BWC's *Notice of Election to Obtain Coverage from Other States for Employees Working Outside of Ohio* (U-131) and instructions to determine if this election is available to your business.

If you elect coverage from another state, you:

- Should NOT include work done outside of Ohio when reporting payroll or calculating premium payments to BWC for work done in Ohio;
- Must report payroll for work done outside of Ohio to BWC on a separate form. (This is for recordkeeping purposes only. You do NOT have to pay an Ohio premium for out-of-state work.)

Out-of-state employers: BWC will recognize out-of-state coverage for employees who are residents of another state but work in Ohio for no more than 90 days. You must obtain coverage and report payroll to BWC only if a temporary period exceeds 90 days. Multiple temporary periods with each exposure less than 91 days in duration is a distinct temporary period.

If you specifically hire employees to work in Ohio, you must obtain coverage from BWC regardless of where you hired the workers.

Premium payment installment plan

Ohio law allows for employers who pay a premium greater than the minimum $120 to select a payment plan installment schedule. Employers who report the minimum premium will automatically be set up on a one pay. The option you select may not be available for your first policy period. If you meet the qualifications for the payment plan option you selected, the payment plan schedule will be available for your first full policy year.

Estimated annual payroll by operation type (does not apply to domestic household employers)

Provide the estimated 12-month Ohio payroll for each operation conducted by your employees as well as the number of employees you have under each operation. For individuals who qualify for elective coverage, list only those who have elected coverage in the owner/officer/minister information section. The estimated annual payroll is used to calculate your estimated annual premium which will determine your installment billings. If the estimated payroll increases or decreases significantly through the course of the policy year, please contact BWC.

Business acquisition/merger or purchase/sale and associated policy information

For all successions on or after Sept. 1, 2006, in situations where a successor takes over the entire operation, any and all existing and future liabilities will transfer to the successor in addition to the experience. Pursuant to Ohio Administrative Code 4123-17-02 you may be considered a successor if you continue the previous employer's operations, even if there is no purchase. In such cases, it will be the successor's responsibility to notify BWC of the succession. When you acquire or purchase a business, you must apply for Ohio workers' compensation coverage if you have one or more employees. An exception to this would be when the operations are continued by a family member. In such case you may complete *Notification of Policy Update to Make Changes to the Existing Policy* (U-117).

If an employer purchases or acquires only a portion of the business, BWC transfers only that portion of the former employer's experience to the succeeding employer. BWC will inspect the former employer's payroll and claims records to determine what should transfer to the successor for rate calculation purposes.

Certification - Signature required

All applications require a signature. Please be sure to complete this area.

Coverage is not in effect until BWC receives the completed application and the $120 non-refundable application fee. In addition, coverage should be contingent on the timely receipt of the first installment payment. BWC cannot process incomplete applications.

Ohio | Bureau of Workers' Compensation

Application for Ohio Workers' Compensation Coverage

Have questions? Need assistance? BWC is here to help!
Call 1-800-644-6292, and listen to the options to reach a customer service representative.
You can dial the number nationwide, and in Canada and Mexico from 7:30 a.m. to 5:30 p.m. EST.
Remember, you can access information and request services by visiting www.bwc.ohio.gov.

BWC will not process incomplete applications. You must complete all required fields (*).
BWC will also not process applications without a $120 non-refundable application fee.

General information – completed by all employer types

*Legal business name or homeowner name	*Federal employer identification number or Social Security number
Trade name or doing business as name	*Date employees first earned wages in Ohio. If no employees, enter today's date.

Address information

*Primary physical (Ohio) location: If no Ohio location, provide your out-of-state location

Street (Do not use P.O. box) | City | State | ZIP code

*Mailing address: If different from primary (Ohio) location

Street | City | State | ZIP code

Additional Ohio locations (attach additional sheets if necessary)

Street, City, State, ZIP code	Brief description of operation

Business information (for your primary Ohio location)

*Business phone: Is this a cell ☐ Yes or ☐ No	Business fax
Business email	Business website

Business contact information (primary contact(s) for the business)

*Contact #1 (First, Middle initial, Last and Suffix)	*Title/Contact type
*Phone: ☐ Direct Dial or ☐ Cell	Email
Contact #2 (First, Middle Initial, Last and Suffix)	Title/Contact type
Phone: ☐ Direct Dial or ☐ Cell	Email

Domestic household coverage

☐ Domestic household: Applies to full/part-time domestic workers employed inside or outside your private residence.
Check the type of services your domestic household employees will perform within your residence.

☐ Domestic inside and/or outside yard/ground maintenance ☐ Home improvement/Maintenance ☐ Construction (new/addition/roofing) on or in your home.

12-month payroll estimate _____

Business entity information

*Please check the one business entity type below that applies to you.

☐ Sole proprietor
☐ Partnership
☐ Limited partnership
☐ Corporation
☐ Limited liability company acting as a sole proprietor
☐ Limited liability company acting as a partnership
☐ Limited liability company acting as a corporation
☐ Individual incorporated as a corporation
☐ Family farm corporation
☐ Association
☐ State/local government

Incorporation date	Charter number	State where incorporated

Elective coverage

See additional details in the business entity information and elective coverage sections for completing the application, which describe the reporting requirements for elective coverage.

Coverage on the owners or officers of a corporation and a limited liability company acting as a corporation (except for individuals incorporated as a corporation with no employees) are automatically covered (i.e., coverage is not voluntary).

Coverage on certain owners or ministers is voluntary. Listed below are the categories of individuals that qualify for elective coverage.

- Sole proprietor
- Partnership
- Limited liability company acting as a sole proprietor
- Limited liability company acting as a partnership
- Family farm corporate officers
- Ordained or associate minister of a religious organization
- Individual incorporated as a corporation (with no employees)

If individuals at your company meet the qualifications for elective coverage, please enter all of their names in the owner/officers/minister information section. If you select yes to request elective coverage, please understand that by electing coverage that you are acknowledging your agreement to the minimum payroll reporting requirements outlined in the U-3 instructions. Remember, if you choose not to cover yourself and you are injured at work, BWC will not provide coverage, and other insurance may not cover your work-related disability or medical bills.

☐ Please initial to acknowledge you have read and understand the elective coverage guidelines.

Owners/officers/ministers: Include the names of all owners and officers. If you are a religious organization you only need to provide the names of the ministers who you wish to elect coverage.

*Name #1 (First, Middle Initial, Last and Suffix)	*Social Security number	Date of birth	*Title/Relationship

*Home mailing address (street, city, state, ZIP code)	*% Ownership

*Phone: ☐ Home or ☐ Cell	Email

*Duties

*For individuals that qualify, do you wish to elect coverage? (see elective coverage section)
☐ YES I do wish to elect coverage for myself.
☐ NO I understand that BWC will not pay benefits for my work-related injury if I do not elect coverage

*Name #2 (First, Middle Initial, Last and Suffix)	*Social Security number	Date of birth	*Title/Relationship

*Home mailing address (street, city, state, ZIP code)	*% Ownership

*Phone: ☐ Home or ☐ Cell	Email

*Duties

*For individuals that qualify, do you wish to elect coverage? (see elective coverage section)
☐ YES I do wish to elect coverage for myself.
☐ NO I understand that BWC will not pay benefits for my work-related injury if I do not elect coverage

*Name #3 (First, Middle Initial, Last and Suffix)	*Social Security number	Date of birth	*Title/Relationship

*Home mailing address (street, city, state, ZIP code)	*% Ownership

*Phone: ☐ Home or ☐ Cell	Email

*Duties

*For individuals that qualify, do you wish to elect coverage? (see elective coverage section)
☐ YES I do wish to elect coverage for myself.
☐ NO I understand that BWC will not pay benefits for my work-related injury if I do not elect coverage

Total ownership %	

Operations description

*Check all types that apply to your Ohio operations.

Agriculture	☐ Crop	☐ Livestock	☐ Dairy	☐ Vegetable	☐ Poultry	☐ Orchard	☐ Berry/vineyard
Extraction	☐ Mining	☐ Oil or gas	☐ Quarry				
Manufacturing	☐ Yes If yes, please complete the section of the application where you are to describe your service or products.						
Construction	☐ Permanent yard operations	☐ Residential three stories and under	☐ Interior trim/cabinets				
	☐ Commercial, industrial and dwellings more than three stories						
	☐ Other (describe) _____						
Transportation	☐ Owned goods	☐ Non-owned goods	☐ Ground	☐ Air carrier	☐ Water transport	☐ Interstate carrier	
	☐ Gen. freight	☐ Parcel	☐ People	☐ Appliance	☐ Furniture	☐ Oil	☐ Gas
	Distance	☐ Local 200 miles or less		☐ More than 200 miles			
Utility	☐ Yes If yes, please complete the section of the application where you are to describe your service or products.						
Commercial	☐ Wholesale: Sales_____%	☐ Retail: Sales _____%		☐ Packaging		☐ Drivers/delivery	
(merchandising)	☐ Repair	☐ Principal products sold _____					
	☐ Coffee or tea house (no cooking)	☐ Beverages _____% of total sales		☐ Food _____% of total sales			
Service	☐ Restaurant – fast food	☐ Restaurant – wait service (not counter)		☐ Delivery			
	☐ Alcohol _____% of receipts compared to total sales						
	☐ Warehousing for others	☐ Religious organization	☐ Residential house cleaning	☐ Commercial cleaning			
	☐ Vacant residential cleaning	☐ Domestic employees working in your home	☐ Elevated cleaning from stool, ladder etc.				
High risk Commercial/Service	☐ Yes If yes, please complete the section of the application where you are to describe your service or products.						
Office work/ Miscellaneous	☐ Clerical	☐ Outside sales	☐ Medical office	☐ Attorney	☐ Real estate agent		
	☐ Property management (not property preservation)	☐ Professional employee organization	☐ Temp. agency				

*Describe your services or products, including your methods of operations. Include raw and semi-finished materials used (attach additional documentation, if necessary). Note: It is important for you to provide as much information as possible for BWC to properly determine your correct classification.

_____

_____

_____

_____

*Describe machinery, equipment and tools (attach additional documentation, if necessary).

_____

_____

_____

*If you do not have a primary physical Ohio location, provide an explanation for not having an Ohio location and/or reason you are applying for Ohio coverage.

_____

_____

_____

Out-of-state considerations

Ohio employers: Do you have employees who are supervised from Ohio but work within and outside of Ohio, or work temporarily outside Ohio? ☐ Yes ☐ No If yes, are the employees covered under another workers' compensation policy issued for a state other than Ohio? ☐ Yes ☐ No
*If yes, provide the insurance information below.

Insurer name: _____ Policy number: _____

Out-of-state employers: Do you have regular employees who are residents of a state other than Ohio that will perform work in Ohio for a temporary period not to exceed 90 days? ☐ Yes ☐ No *If yes, provide the insurance information below.

Insurer name: _____ Policy number: _____

Premium payment installment plan

Select the installment option that you will use for the next full policy year. For partial policy years, not starting on July 1, BWC will match as closely as possible to your selection.

☐ Annual (1) ☐ Semiannual (2) ☐ Quarterly (4) ☐ Bimonthly (6) ☐ Monthly (12)

Estimated annual payroll by operation type

*Operation type (List all types - attach additional sheets if necessary). Provide estimated information for all employees including officers of a corporation or LLC corporation	*Estimate number of employees.	*Estimate total payroll for next twelve months.
Clerical office personnel (No duties outside the office, in sales or service, no counter service or exposure to factory operations);		
Clerical telecommuter (clerical employees working from residence);		
Traveling salespeople (no handling, service or delivery);		
Drivers (truck or delivery).		
Provide estimated information for each sole proprietor, partner, individual incorporated as a corporation, family farm corporate officer or minister that has elected coverage on themselves.		
Name #1:		
Name #2:		
Name #3:		

Business acquisition/merger or purchase/sale and associated policy information

Have there been other Ohio workers' compensation policies associated with this operation or any other affiliated operation? ☐ Yes ☐ No

List policy(s) number _____

*Do any of the principals have workers' compensation coverage in this or any other operation; or have they had workers' compensation coverage in any operation in the past? ☐ Yes ☐ No

Name _____

*Did you acquire/purchase this business? ☐ Yes ☐ No	*Previous business name and BWC policy number	*Date you acquired/purchased business	*Did you acquire/purchase ☐ all or ☐ part of an existing business

Did you acquire/purchase this business from a family member? ☐ Yes ☐ No If yes, indicate relationship _____	Was this a stock acquisition? ☐ Yes ☐ No If yes, did you retain the previous employer's federal identification number? ☐ Yes ☐ No	How many employees of the former employer did you hire?

Previous employer contact name	Previous employer phone number	Do you have a purchase agreement associated with the transaction? ☐ Yes ☐ No If yes, BWC may request a copy of the agreement.

Was the business purchased out of bankruptcy or receivership? ☐ Yes ☐ No
Explain

Has the business been in continuous operation? ☐ Yes ☐ No
Explain

Did you acquire/purchase the previous employer's contracts or customers? ☐ Yes ☐ No
Explain

Are you operating in the former employer's location? ☐ Yes ☐ No
Explain

Will you conduct business in the same/similar manner as the former employer? ☐ Yes ☐ No
Explain

Did you acquire or purchase any machinery or equipment from the former employer? ☐ Yes ☐ No
Explain

Certifications – signature required

Name (please print) _____

By my signature, I certify I have the authority to execute this application, and that the facts set forth on this application are true and correct to the best of my knowledge and belief. I am aware that any person who does not secure or maintain workers' compensation coverage and pay all appropriate premiums in accordance with Ohio laws, or misrepresents, conceals facts, or makes false statements to obtain coverage may be subject to civil, criminal and/or administrative penalties.

*Employer signature _____ Title: _____ *Date: _____

WARNING: Insurance is not in effect until BWC receives the application and the $120 non-refundable application fee. In addition, coverage should be contingent on the timely receipt of the first installment payment.

BWC will bill the balance of the yearly premium. BWC cannot process incomplete applications or applications submitted without payment.

BWC USE ONLY

Policy number	Quote number	Effective date	Payment type ☐ Money order ☐ Check	Payment amount	Date received	Initials

Ohio | Bureau of Workers' Compensation

Application for Elective Coverage

Have questions? Need assistance? BWC is here to help!
Call 1-800-644-6292, and listen to the options to reach a customer service representative.
You can dial the number nationwide, and in Canada and Mexico from 7:30 a.m. to 5:30 p.m. EST.
Remember, you can access information and request services by visiting BWC's Web site at www.bwc.ohio.gov

STOP!
If you do not have an existing policy with BWC, please complete the *Application for Ohio Workers' Compensation Coverage (U-3)* instead of this form.

All employers with one or more employees must carry workers' compensation coverage. It's the law. However, Ohio law makes coverage elective for owners or ministers in one of the following categories: Sole proprietor; partnership; limited liability company acting as a sole proprietor; limited liability company acting as a partnership; family farm corporate officers; individual incorporated as a corporation; and ordained or associate ministers of a religious organization. These individuals may cover themselves by submitting this form. Elective coverage is effective the date BWC receives the application. You must complete an additional application for elective coverage to cover owners or ministers you wish to add at a later date. Remember, if you choose not to cover yourself and you are injured at work, BWC will not provide coverage, and other insurance may not cover your work-related disability or medical bills. Contact your insurance carrier if you have questions.

Payroll reporting requirements

Specific payroll reporting requirements associated with elective coverage are listed below.

Sole proprietors and partners (including limited liability companies acting as a sole proprietor or partnership): For all individuals electing coverage, the reportable wages are subject to a minimum and maximum, which is based on the statewide average weekly wage (SAWW) calculated annually by the Ohio Department of Job and Family Services (ODJFS.) The minimum payroll reporting limit will be 50 percent of the SAWW and the maximum payroll reporting limit will be 150 percent of the SAWW. Individuals who earn between the minimum and maximum will report their actual net incomes based on their form 1040, Schedule C for sole proprietors, or form 1065 Schedule K-1 for partnerships, inclusive of any draws.

Officers of a family farm corporation: For corporate officers of a family farm electing coverage, the reportable wages are subject to a minimum and maximum, which BWC bases on the SAWW calculated annually by the ODJFS. The minimum payroll reporting limit will be 50 percent of the SAWW and the maximum payroll reporting limit will be 150 percent of the SAWW. Officers of a corporation who earn between the minimum and maximum will report their actual W-2 wages. For S-corporations, officers must report wages for services they perform. This may include W-2 wages as well as all or part of ordinary income from Schedule K-1 up to the maximum.

Religious Organizations: Ohio law requires religious organizations to cover their paid employees. However, BWC does not consider ordained ministers and associate ministers employees for the purpose of workers' compensation. When a minister is covered under the religious organization's policy, actual earnings are reportable and are not subject to the minimum and maximum. Ministers not covered under the religious organization's policy can complete an application for coverage and elect coverage on themselves as a sole proprietor. Ministers electing coverage as a sole proprietor are subject to the minimum and maximum reporting requirements as described above.

Individuals incorporated as a corporation (with no employees): For individual corporate officers electing coverage, the reportable wages are subject to a minimum and maximum, which BWC bases on the SAWW calculated annually by the ODJFS. The minimum payroll reporting limit will be 50 percent of the SAWW and the maximum payroll reporting limit will be 150 percent of the SAWW. Officers of a corporation who earn between the minimum and maximum will report their actual W-2 wages. For S-corporations, officers must report wages for services they perform. This may include W-2 wages as well as all or part of ordinary income from Schedule K-1 up to the maximum.

Note: Visit BWC's Web site, www.bwc.ohio.gov, or call BWC to obtain the minimum and maximum payroll reporting requirement amounts applicable for each payroll reporting period.

Elective coverage type

☐ Sole proprietor ☐ Partnership ☐ Limited liability company acting as a sole proprietor ☐ Limited liability company acting as a partnership
☐ Family farm corporate officers ☐ Ordained or associate minister of a religious organization ☐ Individual incorporated as a corporation

Legal business name			Policy number
Trade name or doing business as name		Federal employer identification number or Social Security number	
Mailing address Street		City	State ZIP code
E-mail address			Telephone number

Owners/ministers information – list owners/ministers electing coverage.
(Attached additional sheets if necessary.)

Name #1		
Residential address		
City	State	ZIP code
Social Security number	Title	
Duties		

Name #2		
Residential address		
City	State	ZIP code
Social Security number	Title	
Duties		

Name #3		
Residential address		
City	State	ZIP code
Social Security number	Title	
Duties		

Name #4		
Residential address		
City	State	ZIP code
Social Security number	Title	
Duties		

Certification – signature required

By my signature, I certify I have the authority to execute this application, and the facts set forth on this application are true and correct to the best of my knowledge and belief. I am aware that any person who does not secure or maintain workers' compensation coverage and pay all appropriate premiums in accordance with Ohio laws or misrepresents, conceals facts, or makes false statements to obtain coverage may be subject to civil, criminal and/or administrative penalties.

Print name _____ Signature and title _____ Date _____

WARNING: Insurance is not in effect until BWC receives the completed application.

Mail completed form to:
Ohio Bureau of Workers' Compensation
Policy Processing Department, 22nd Floor
30 W. Spring St.
Columbus, OH 43215-2256

Apply for or cancel supplemental coverage online at:
www.bwc.ohio.gov

BWC use only

Policy number	Effective date	Date received	Initials	Manual class number(s)

Industrial Commission
Claims Benefit Forms

Industrial Commission Forms

Industrial Commission Forms

Quick Links to Forms

IC-12 Notice of Appeal

IC-13 Request for Corrected Order

IC-50 Request for Cancellation

IC-51 Request for Continuance

IC-52 Request for .522/52 Relief

IC-2 App. for PTD

IC-22 PTD Award Agreement

IC-88 App. for Reconsideration

IC-EMP2 Representative or Employer
Change of Address/Contact

IC 8/9 App. for VSSR

IC-10 Settlement VSSR

IC-32A Lump Sum of Attorney Fees

IC-INT Request for Interpretive Services

IC-PW Outside Access Form

IC-GC1 Agreement as to Compensation for PPD

IC-167-T Objection to BWC Tentative Order

Representative Photo ID Form

Employer Photo ID Form

Quick Links

Office Locations

IC Fact Sheets

Frequently Asked Questions

Commissioner Bios

Reports & Newsletters

Medical Specialist Resources

Adjudications Before the Ohio Industrial Commission (PDF)

Ombuds Office

Visit the BWC Website

Supreme Court of Ohio Website

Commission Member Orders

Industrial Commission Meeting Minutes

Ohio | Industrial Commission

Claim Number:

(Use the claim #with the most recent date of injury or diagnosis)

APPLICATION FOR COMPENSATION FOR PERMANENT TOTAL DISABILITY

1. Each application for permanent total disability shall identify, if already on file, or be accompanied by medical evidence supporting the application. If documents are already on file, there is no need to resubmit them.
   a. The medical examination upon which the report is based must have been **performed within twenty-four months prior to the date of filing of the application for permanent total disability compensation (document information below).**
   b. If an application for permanent total disability compensation is filed that does not meet the filing requirements of Ohio Adm.Code **4121-3-34**, or if proper medical evidence is not filed or identified within the claim file, the application **shall be dismissed** without hearing.

2. The completed application should be filed at an Industrial Commission office.

3. **If permanent total disability is granted, the injured worker is not permitted to return to work in any capacity.**

Injured Worker's Information	
Name	Date of Birth
Address	
City, State, Zip	
Telephone	Fax

Injured Worker's Representative Information	
Rep ID#	
Name	
Telephone	Fax

☐ Consider All Claims

☐ Consider only the injured worker's claim numbers listed below when processing this application (claims with similar body parts will be considered):

Claims not listed here will not be considered and cannot be added at the time of your hearing.

By not listing a claim, you cannot then argue that the allowed conditions in that claim prevent you from working. This does not preclude future benefits and/or medical treatment for the named conditions in the claim.

If you have not checked the "Consider All Claims" box, the Industrial Commission will include all claims containing similar body parts to those conditions in the claims that have been identified.

☐ I have attached the required medical documentation to support this application for permanent total disability.

Date of Exam _____ (mm/dd/yyyy) Physician Name _____

Date of Exam _____ (mm/dd/yyyy) Physician Name _____

☐ Medical documentation listed below has been previously filed and supports this application for permanent total disability.

Claim _____ Date of Exam _____ (mm/dd/yyyy) Physician Name _____

Claim _____ Date of Exam _____ (mm/dd/yyyy) Physician Name _____

Claim _____ Date of Exam _____ (mm/dd/yyyy) Physician Name _____

Medical documentation listed above must opine only on the allowed conditions in the claims you have identified above or the application for permanent total disability will be dismissed. If necessary, please attach additional information.

Claim Number:

MEDICAL HISTORY

List all of the physicians you have seen in the last five years, their addresses, and for what condition(s) you have seen them:

Physician's Name	Physician's Address	Condition(s)

List all of the surgeries and procedures you have had, beginning with the most recent:

Surgery/Procedure	Physician's Name	Date (mm/dd/yyyy)

Do you use any medical equipment such as a cane, brace, walker, wheelchair, oxygen or TENS unit? ☐ Yes ☐ No

If yes, please specify: _____

_____

Do you have any other medical conditions that impact your ability to work? _____

_____

_____

DAILY ACTIVITIES

Has your treating doctor told you to restrict or limit your activities due to your injuries? ☐ Yes ☐ No

If yes, please specify: _____

_____

Do you drive a vehicle? ☐ Yes ☐ No How far can you drive at one time? _____

How far can you walk at one time? _____ How long can you stand at one time? _____

How long can you sit at one time? _____ How long do you sleep each night? _____

Claim Number:

DAILY ACTIVITIES CONTINUED

Are you involved in any organizations, clubs, charities or associations of any kind, either as a volunteer or member? ☐ Yes ☐ No

If yes, please provide name of organization and nature of association: _____

_____

Do you have hobbies or engage in recreational or social activities? ☐ Yes ☐ No

If yes, please specify: _____

_____

Do you dress yourself? ☐ Yes ☐ No ☐ Need Assistance

Do you shower or bathe yourself? ☐ Yes ☐ No ☐ Need Assistance

Do you prepare any meals? ☐ Yes ☐ No

Do you do any housework/yardwork (laundry, repairs, grocery shopping, grass cutting etc.)? ☐ Yes ☐ No

If yes, please specify: _____

_____

_____

_____

_____

What is the most weight you lift on a daily basis? _____

Describe any other limitations or changes in your lifestyle, if any, resulting from the allowed condition(s) in your claim(s): _____

_____

_____

_____

_____

OTHER DISABILITY BENEFITS

Have you ever filed for Social Security Disability benefits? ☐ Yes ☐ No

If you are now, or have ever, received Social Security Disability payments, complete the following section. This **does not** apply to Social Security Retirement.

Starting Date _____ (mm/dd/yyyy) Termination Date _____ (mm/dd/yyyy)

What was the reason for termination? _____

Do you receive disability benefits other than Social Security? (i.e.: VA, Fireman & Police Officer Disability, etc.)? ☐ Yes ☐ No

Claim Number:

VOCATIONAL REHABILITATION HISTORY

Have you sought or been offered vocational rehabilitation services? ☐ Yes ☐ No

If yes, please explain: _____

EDUCATION

What is the highest grade of school you completed? _____ When? _____ (mm/dd/yyyy)

Where? _____ (School, City)

Did you graduate from high school? ☐ Yes ☐ No

If yes, which curriculum? ☐ Special Education ☐ Standard ☐ College Preparatory

If no, did you receive a certificate for passing the General Educational Development test (GED)? ☐ Yes ☐ No

Why did you end your schooling? _____

Have you gone to trade or vocational school or had any type of training? ☐ Yes ☐ No

If yes, what type of trade school, vocational schooling or special training have you received and when?

How has this schooling or training been used in any of the work you have done? _____

Can you read? ☐ Yes ☐ No If yes, what language(s)? _____

Can you write? ☐ Yes ☐ No If yes, what language(s)? _____

What languages can you speak? _____

Can you do basic math? ☐ Yes ☐ Not Well ☐ No

Do you have basic computer skills (keyboarding; business office software applications such as Microsoft Office; using and creating spreadsheets)? List all software with which you are proficient. _____

WORK HISTORY

What is the last date you worked in any capacity, including contractor work or self-employment: _____ (mm/dd/yyyy)

Do you have military experience? ☐ Yes ☐ No

If yes, provide your last date of service: _____ (mm/dd/yyyy)

Include your military service information in the work history list starting on the next page.

Claim Number:

When completing the following sections of the application, please be specific and as detailed as possible. **A thorough work history is very important when processing an application for permanent total disability.** Attach additional pages as needed providing the same information as listed below for past positions held. Include all military service and past positions.

Title of Most Recent Job

Name of Employer

Dates Worked From: (mm/dd/yyyy) To: (mm/dd/yyyy) Hours per Week

Describe your basic duties:

List machines, tools, and equipment, including computer equipment, you used:

Describe technical knowledge and skills you used:

Describe reading and writing you did:

Did you supervise people? ☐ Yes ☐ No If yes, how many?

Describe the kind and amount of physical activity this job involved during a typical day:

Walking (circle the number of hours a day spent walking) 0 1 2 3 4 5 6 7 8

Standing (circle the number of hours a day spent standing) 0 1 2 3 4 5 6 7 8

Sitting (circle the number of hours a day spent sitting) 0 1 2 3 4 5 6 7 8

Bending (circle how often a day you had to bend) Never Occasionally Frequently Constantly

Check the heaviest weight lifted occasionally: ☐ Up to 10 lbs. ☐ Up to 20 lbs. ☐ Up to 50 lbs. ☐ Up to 100 lbs. ☐ Over 100 lbs.

Check the weight frequently lifted/carried: ☐ Up to 10 lbs. ☐ Up to 20 lbs. ☐ Up to 50 lbs. ☐ Up to 100 lbs. ☐ Over 100 lbs.

Claim Number:

SPECIAL FACTORS

Please use this space for comments, explanations or special factors (social, economic, psychological) you wish to add to support your application.

ATTENTION

This application will be dismissed if not signed by the injured worker or if the medical evidence supporting the request for Permanent Total Disability is not attached or identified as previously filed.

I, _____ , certify that the information on this page
Injured Worker's Name
and the preceding pages is true to the best of my knowledge. By signing this application, I expressly waive all provisions of law which forbid any person, persons or medical facility who has medically attended, treated, or examined me, or who may have medical information of any kind which may be used to render a decision in my claim, from disclosing such knowledge or information to the Industrial Commission or employer(s) in my claim(s).

Help Us, Help You!

Please take a minute to give us your correct address in the space provided on the first page of this application.

Injured Worker's Name: Date:	Person Completing this Form: Date:
Signature	Signature

IC-8/9 Ohio Industrial Commission

Application for Additional Award for Violation of Specific Safety Requirement in a Workers' Compensation Claim

(☐ For Fatal or ☐ Non-Fatal Injuries)

Mail this form to:
Industrial Commission of Ohio
VSSR Claims Examiner
30 W. Spring St. 7th floor
Columbus, Ohio 43215 Fax: (614) 995-0696

☐ **APPLICANT'S ADDRESS IS NEW**

CLAIM NUMBER _____

SOCIAL SECURITY # _____

DATE OF INJURY _____

Applicant's Address		Employer's Address	
Name		Name	
Address		Address	
City, State, Zip Code		City, State, Zip Code	
County	Phone ( )	County	Phone ( )
Applicant's Representative		**Employer's Representative**	
Name		Name	

The applicant hereby makes application for an additional award because of failure of the employer to comply with a specific requirement for the protection of the lives, health, and safety of employees.

1. **The injured worker was injured on** _____ **at** _____ **M.**
(Month) (Day) (Year)

2. **While employed by:** _____

of _____
(Street Address) (City) (State) (Zip Code) (County)

3. **If the injured worker was employed by a temporary service agency, professional employer organization or staff leasing company at the time of the injury, list the name and address of the employer where the work was being performed.**

_____
(Name)

_____
(Street Address) (City) (State) (Zip Code) (County)

4. **Describe, in detail, how the injury occured (attach extra sheet if necessary).**

_____

_____

_____

5. **Please state the specific Ohio Administrative Code Section (s) which were violated and which caused the injured worker to sustain an injury:(Attach extra sheet if necessary).**

_____

_____

_____

6. **IMPORTANT: Please provide the complete names, addresses, and phone numbers (if available) of persons who witnessed the accident. The Safety Violations Investigation Unit may be unable to contact your witnesses if this information is not given.**

_____

_____

(Please attach any additional informaton)

_____
(Applicant will sign here)

Industrial Commission

Ministerial Forms

Ohio | Bureau of Workers' Compensation

ADR Appeal to the MCO Medical Treatment/Service Decision

Instructions

- Please print or type.
- Complete this form to the best of your knowledge.
- This form may also be used to withdraw this appeal by completing the **withdraw appeal section** in the instructions.
- The injured worker, employer, authorized representatives or provider must file this appeal with the injured worker's managed care organization (MCO).
- Use this form to appeal the MCO's medical treatment/service decision and to start the alternative dispute resolution (ADR) process.
- You must file your appeal with the MCO within 14 days of receipt of the written notice of the MCO's initial medical treatment/service decision.

The injured worker name and BWC claim number are mandatory.

Injured worker name	BWC claim number

Appealed by: (check appropriate box)

☐ Injured worker name		Telephone number ( )
☐ Injured worker representative name	Representative ID number	Telephone number ( )
☐ Employer name	Contact person	Telephone number ( )
☐ Employer representative name	Representative ID number	Telephone number ( )
☐ Provider name	Specialty	Telephone number ( )

Date of MCO initial decision letter:

Date of receipt of MCO initial decision:

Was this treatment/service decision ☐ Denied ☐ Approved ☐ Amended

Specify medical treatment/service you wish to appeal. _____

Enter start date of requested treatment: _____	Enter total number of treatments: _____ ☐ per week for _____ weeks OR ☐ per month for _____ months

Give reason for the appeal. Please be specific, include any relevant information, any new evidence that will assist in approval of your appeal. (Attach additional documentation if necessary.)

Signature of party filing appeal	Date

Withdraw appeal

I withdraw the above referenced appeal

(Signature of party withdrawing appeal) (Date)

Ohio | Industrial Commission

Claim Number:

NOTICE OF APPEAL

Injured Worker Information		Employer Information	
Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
Telephone	Fax	Telephone	Fax
Injured Worker's Representative Information		**Employer's Representative Information**	
Rep ID#		Rep ID#	
Name		Name	
Telephone	Fax	Telephone	Fax

Appealed by:

- ☐ Injured Worker
- ☐ Employer
- ☐ BWC Administrator

Appealing Order of:

- ☐ BWC Administrator
- ☐ District Hearing Officer
- ☐ Staff Hearing Officer

Hearing Location _____ (city)

Heard on _____ (mm/dd/yyyy)

Date Order Received _____ (mm/dd/yyyy)

NOTE: If you are filing an appeal of a staff hearing officer order, failure to identify the necessary documents may result in a determination not to hear an appeal at the Commission level.

REASON FOR APPEAL: _____

Have you filed, or do you intend to file, new evidence not available at the last hearing? ☐ Yes ☐ No

To be completed by Self-Insuring Employer.

- ☐ Compensation / benefits HAVE or WILL be timely paid as mandated by R.C. 4123.511
- ☐ Compensation / benefits WILL NOT be timely paid as mandated by R.C. 4123.511

- ☐ I will be requesting an interpreter for the upcoming hearing. Language Needed: _____
- ☐ I will be requesting a court reporter.

By checking either or both boxes, I am asking for extra time for the hearing.

I hereby certify that I have mailed copies of this notice to the ☐ injured worker's representative and/or ☐ employer's representative (check one or both), on _____ mm/dd/yyyy

If there is no representative, I have mailed a copy to the injured worker and/or employer.

☐ By checking this box, I certify that I am a non-attorney representative who has been authorized and directed to file this notice of appeal by the ☐ Injured Worker ☐ Employer.

_____ (Appellant's Signature)

IC-88 Ohio Industrial Commission

Application For Permanent Partial Reconsideration

☐ **Address on reconsideration is new**

This form should be delivered to the office where this decision took place.	**CLAIM NUMBER** _____ **SOCIAL SECURITY #**_____ **DATE OF INJURY**_____

This form is to be used by an injured worker or employer in making application for reconsideration of decisions of District Hearing Officers regarding extent of permanent partial disability as provided in O.R.C. 4123.57 (A).

Injured Worker's Address		**Employer's Address**	
Name	Phone ( )	Name	Phone ( )
Address		Address	
City, State, Zip Code	County	City, State, Zip Code	County
Injured Worker's Representative		**Employer's Representative**	
Name		Name	

Appealed by

☐ **BWC Administrator**

☐ **Injured Worker**

☐ **Employer**

Heard at (City)_____

Date of Hearing _____

Date Order Received _____

Applicant states that above numbered claim was heard and the following finding made:

Applicant requests that such finding be reviewed and reconsidered by the Staff Hearing Officer and that the finding be modified in the following respects:

I hereby certify that I have mailed copies of this notice to the ☐ injured worker's representative and / or ☐ employer's representative (check one or both), on _____,20____. If there is no representative, I have mailed a copy to the injured worker and /or employer.

☐ By checking this box, I certify that I am a non-attorney representative who has been authorized and directed to file this application for reconsideration by the ☐ injured Worker ☐ Employer

_____

(APPELLANT'S SIGNATURE)

Ohio | Industrial Commission

Objection to Tentative Order

Determining the Percentage of Permanent Partial Disability Compensation

Instructions
* Print or type all information.
* This form is to be used by the injured worker and employer and/or their authorized representatives to object to the tentative order determining a percentage of permanant partial disability compensation.
* This objection should be sent to the local Industrial Commission office.

INJURED WORKER INFORMATION

Injured worker name	Claim number
Social Security Number	Date of injury

NAME AND ADDRESS OF PERSON FILING OBJECTION

Name		
Address		
City	State	9-digit ZIP Code

Please indicate your status
☐ Injured worker ☐ Injured worker representative ☐ Employer ☐ Employer representative

INFORMATION FROM TENTATIVE ORDER

Date of order	Date received

ADDITIONAL INFORMATION

Choose one: ☐ I intend to file additional medical evidence. ☐ I do not intend to file additional medical evidence.

STATEMENT OF OBJECTION

I hereby OBJECT to the TENTATIVE ORDER that determined the percentage of permanent partial disability compensation in the above numbered claim, and request the matter to be set for a hearing before an Industrial Commission district hearing officer.

*I understand that if this OBJECTION is not received **within twenty days** of the date I received the TENTATIVE ORDER, that order shall become effective and compensation shall be paid as provided in that order.*

CERTIFICATE OF SERVICE: I certify that I have served a copy of this objection to the tentative order determining a percentage of permanent partial disability compensation to the ☐ injured worker's representative and / or ☐ employer's representative (check one or both), on _____, 20____. If there is no representative, I have mailed a copy to the injured worker and / or employer.

By checking this box, I certify that I am a non-attorney representative who has been authorized and directed to file this objection by the ☐ injured worker ☐ employer.

Signature	Date

Ohio | Industrial Commission

Claim Number:

Interpretive Services Request Form

The Industrial Commission provides interpretive services to Injured Workers or Employers who are hearing impaired or require a foreign language interpreter at hearings and medical examinations at no charge. **The representative is responsible for requesting an interpreter for each hearing.**

To request interpretive services, please contact the Interpreter Coordinator in one of the following ways:

- Print form and mail to: Ohio Industrial Commission, Attn: Interpreter Services Coordinator, 30 W. Spring St. 1st floor, Columbus, Ohio 43215-2233
- Call and request by telephone: (614) 466-6136 or 1-800-521-2691
- Call and request by TDD: 1-800-686-1589
- Print form and fax: (614) 728-7004
- Email the information on this form: AskIC@ic.ohio.gov

Should the need for this service change, please contact the Industrial Commission 24 hours prior to the hearing.

Please complete the information below to aid in processing this request.

Injured Worker's Information	**Employer Information**
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Telephone Fax	Telephone Fax
Injured Worker's Representative's Information	**Employer's Representative Information**
Rep ID#	Rep ID#
Name	Name
Telephone Fax	Telephone Fax

Date of hearing/medical examination where services are requested _____ (mm/dd/yyyy)

Location/office where service is to be performed _____ (city)

Type of service needed (select one):

☐ Albanian	☐ Fulani	☐ Serbian
☐ American Sign Language	☐ Greek	☐ Shanghaniese
☐ Amharic	☐ Haitian Creole	☐ Somali
☐ Arabic	☐ Hindi	☐ Soninke
☐ Asanti Twi	☐ Italian	☐ Spanish
☐ Ashanti	☐ Korean	☐ Tagalog
☐ Bosnian	☐ Laotian	☐ Thai
☐ Bulgarian	☐ Macedonian	☐ Tigrinia
☐ Burmese	☐ Mai-mei	☐ Turkish
☐ Chinese Mandarin	☐ Nepali	☐ Ukranian
☐ Creole	☐ Polish	☐ Urdu
☐ Croatian	☐ Portuguese	☐ Vietnamese
☐ Egyptian	☐ Puerto Rican	☐ Other: _____
☐ Farsi	☐ Punjabi	
☐ French	☐ Russian	

Applicant Name Date

Signature

Medical Forms

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 / /