

# — Injury reporting packet

# Steps to take when a workplace injury occurs

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

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

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

### Employee instructions

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

### Employer instructions

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

## Reporting a work-related injury to Sedgwick MCO



### Online:

Submit an injury form (FROI) online at [sedgwickmco.com](https://sedgwickmco.com).



### Phone:

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



### Email:

Send encrypted injury/incident reports as soon as possible to: [injury.incident@sedgwickmco.com](mailto:injury.incident@sedgwickmco.com).



### Fax:

Send injury forms to 888.711.9284.

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

*Detach ID card below and present at all medical appointments*

### Workers' compensation identification card



24-hour customer service: 888.627.7586



Employer name:  
Policy number:

## Key contacts and additional information

### Medical treatment questions, medical documentation and billing issues

Contact Sedgwick Managed Care Ohio:

Phone: 888.627.7586

Fax: 888.627.0074

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

### Prescription questions

Call 800.644.6292 and follow the prompts.

### Ohio Bureau of Workers' Compensation (BWC)

Call 800.644.6292 or visit [bwc.ohio.gov](http://bwc.ohio.gov).

### Medical options and provider search

If medical treatment is required, see a BWC-certified medical provider. For more information, see the Sedgwick MCO website at [sedgwickmco.com](http://sedgwickmco.com).

## Transitional work benefits everyone

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

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

#### Please send all information within 24 hours of visit.

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

#### Send all mail and medical bills to:

Sedgwick Managed Care Ohio  
PO Box 1040  
Dublin, OH 43017

*This card is not a  
guarantee of coverage.*

## Responsibilities

### Sedgwick MCO

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

### BWC

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

### Medical providers

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

## Important BWC forms

### First report of injury (FROI)

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

### MEDCO-14

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

### C-9

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



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)

Form section for injured worker and injury/disease/death info. Includes fields for personal information, employment details, accident description, and signature.

Form section for treatment info. Includes fields for health-care provider name, address, diagnosis, and dates.

Form section for employer info. Includes fields for employer policy number, contact information, and certification/rejection options.



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 to each section checked.

**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 work restrictions related to allowed conditions in the claim? Yes  No   
**If yes**, proceed to section 3B.  
**If no** restrictions, please indicate release to work date \_\_\_\_/\_\_\_\_/\_\_\_\_. **Proceed to and complete sections 6 and 8.**

3B If there are work restrictions, can the injured worker return to his/her job held on the date of injury (former position of employment)? Yes  No   
**If yes**, please indicate release to work date: \_\_\_\_/\_\_\_\_/\_\_\_\_. **Proceed to sections 3C, 5, 6, and 8.**  
**If no**, please indicate when the injured worker initially could not do the job held on the date of injury. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.  
**Proceed to section 3C.**

**Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is "no").**  
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, is the injured worker able to safely:  
\*Operate heavy machinery:  Yes  No \*Drive:  Yes  No \*Perform other critical job tasks as defined by any source listed above in section 2:  Yes  No

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

3C In an eight-hour workday, how many total hours is the injured worker able to:  
Sit: \_\_\_\_ hours  Continuously  With break Walk: \_\_\_\_ hours  Continuously  With break Stand: \_\_\_\_ hours  Continuously  With break  
In the space below please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Injured worker name		Claim number	Date of injury
<b>Disability period information (If 3B above is NO you must address all fields, including site/location if applicable)</b>			(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.			
4A	Narrative description of the work-related allowed condition	Site/location if applicable	ICD code
			Is the condition preventing full duty release to the job injured worker held on the date of injury? Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
4B	List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).		
<b>Clinical findings: Office notes can be referenced in lieu of writing clinical findings below.</b>			(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
5	The injured worker is progressing: <input type="checkbox"/> As expected <input type="checkbox"/> Better than expected <input type="checkbox"/> Slower than expected Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.		
<b>Maximum medical improvement (MMI)</b>			
			(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
6	MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give MMI date: ____/____/____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).		
Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.			
<b>Vocational rehabilitation</b>			(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
7	Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain why and provide your recommendations to help the injured worker return to employment.		
<b>Treating physician signature - mandatory</b>			
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.		Address, city, state, nine-digit ZIP code, telephone and fax numbers
	Treating physician's name (please print legibly)		
	Treating physician's signature		
BWC provider (Peach) number		Date	