Steps to take when a workplace injury occurs

Injured Employee

1. Immediately report the injury to your supervisor
2. Complete the BWC First Report of Injury form
3. Seek medical treatment
4. Take your ID card to all appointments
5. Let your supervisor know that you have received medical treatment for your work-related injury

Employer

1. Complete the Employment section of the BWC First Report of Injury form
2. Fax the completed form to CHS toll-free to 800-334-4229
3. Stay in touch with the injured worker while they are off work

In emergency cases, injured workers should immediately notify their employer and seek treatment at the nearest medical facility.

*According to Health Partnership Program (HPP) guidelines, injured workers may seek treatment from any BWC-certified medical provider.

CompManagement
Health Systems, Inc.

888-247-7799 www.chsmco.com

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/medical release – *I am applying for a claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I affirm that I elect to receive compensation and benefits under the Ohio 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, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social information that is causally 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 BWC MCO and any authorized representatives.*

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		
Health-care provider signature		11-digit BWC provider number		Date

Employer info.

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

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

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

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

Employer signature and title	Date	OSHA case number

BWC-1101 (Rev. 3/26/2009)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets OSHA 301 requirements

Please submit this completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

CompManagement
Health Systems, Inc.

Key Contact Information

Medical Management Information

FAX Medical Information:
- 1-800-334-4229

MAIL Medical Information:
- CHS
  PO Box 1040
  Dublin, OH 43017

Prior Authorization:
- Fax C-9 form to
  1-800-334-4229

Medical Bill Payment Information

MAIL Medical Bills:
- CHS
  PO Box 1040
  Dublin, OH 43017

Billing Questions:
- Call CHS
  Customer Service
  toll-free 1-888-247-7799

Other Important Information

Prescriptions:
- For questions regarding prescriptions, contact SXC Health Solutions, toll-free at 1-800-OHIOBWC, press zero (0), select option three (3)

Provider Search & Injury Reporting:
- Visit www.chsmco.com for online injury reporting and provider searches