

— Injury reporting packet

Geauga County

Employee



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Employee instructions for work place injury

1. Immediately report the injury to your Supervisor
2. Complete the Employee's Report of Incident and Injury If needed, seek medical attention at an Occupational Health Clinic
3. Take MCO ID Card Information and Medco 14 to Doctor
4. Return Medco 14 to your Supervisor immediately

Phone: 888-627-7586

sedgwickmco.com

Fax: 888-711-9284

Detach ID card below and present at all medical appointments



sedgwick | managed care ohio

Workers' compensation Identification card



24-hour customer service: 888.627.7586



Employer name: **Geauga County**

Policy number: **32800001-0**

INJURY ON THE JOB CLAIM PROCEDURES

<u>EMPLOYER AND BWC POLICY #</u>		<u>YOUR Worker's Comp Contact:</u>	
Name:	Geauga County	Name:	Kelly Bidlack
Address:	12611 Ravenwood Dr., Suite 350	Title:	Human Resources Specialist
City, State, Zip:	Chardon, OH 44024	Phone:	440-279-1671 Fax: 440-279-1309
BWC Policy Number:	32800001-0	Email:	kbidlack@co.geauga.oh.us

IF YOU EXPERIENCE AN ON-THE-JOB INJURY:

- Report the injury/incident to your supervisor IMMEDIATELY.
- Complete the Geauga County Employee's Incident/Accident Report and return to your supervisor immediately, if possible, or within 24 hours of the injury/accident. *If you were involved in a vehicle accident involving a county vehicle, complete the Vehicle Incident/Accident Report also and send that report to Kathy Hostutler: Fax: 440-279-1317.*
- If medical treatment is necessary please use a BWC-certified medical provider (see enclosed).
- Give your MCO Identification Card and MEDCO-14 Form (in this packet) to the medical provider to ensure all bills and necessary document are sent to the correct address.
- *Make sure you have your completed MEDCO-14 Form when you leave your doctor/urgent care.*
- Return the MEDCO-14 form to your Supervisor immediately as notification of your medical condition.

See enclosed insert for Medical Providers

YOUR MANAGED CARE ORGANIZATION IS:

Sedgwick – Managed Care Ohio

P.O. Box 1040

Email: injury.incident@sedgwickmco.com

Dublin, Ohio 43017

Customer Service: 1-888-627-7586

Fax: 1-888-711-9284

Online Reporting: www.sedgwickmco.com

**Bureau of Workers Compensation Certified Medical Providers for
Geauga County Employees BWC Policy # 32800001-0**

UH Concord Health Center Urgent Care

7500 Auburn Road Suite 1200

Concord, Ohio

440-358-5400

UH Geauga Medical Center Emergency

13207 Ravenna Road

Chardon, Ohio

440-285-6000





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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of birth	
Home mailing address			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				Number of dependents	
City		State	9-digit ZIP code		Country if different from USA		Department name	
Wage rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other _____			What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.							Occupation or job title	
Employer name Geauga County								
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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, give accident location, street address, city, state and ZIP code)								
Date of injury/disease		Time of injury _____ a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work _____ a.m. <input type="checkbox"/> p.m.		Date last worked
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? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
E code				11-digit BWC provider number		Date	
Health-care provider signature							

Employer info.

Employer policy number 32800001-0		Check if <input type="checkbox"/> Employer is self-insuring <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				Was employee hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code									
<input type="checkbox"/> Certification - The employer certifies that the facts in this application are correct and valid.				<input type="checkbox"/> Rejection - The employer rejects the validity of this claim for the reason(s) listed below: _____ _____				For self-insuring employers only <input type="checkbox"/> Clarification - The employer clarifies and allows the claim for the condition(s) below: <input type="checkbox"/> Medical only <input type="checkbox"/> Lost time	
Employer signature and title						Date		OSHA case number	



**Bureau of Workers'
Compensation**

Physician's Report of Work Ability

Geauga County
32800001-0

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 <input type="checkbox"/> I have never completed a MEDCO-14. Proceed to section 2. <input type="checkbox"/> I have previously completed a MEDCO-14, and all of the information remains the same. Proceed to and complete section 8. <input type="checkbox"/> 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 <input type="checkbox"/> No <input 8"="" type="checkbox/>)</td></tr><tr><td colspan="/> 2 Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - please indicate who (select all sources) provided the job description <input type="checkbox"/> Injured worker <input type="checkbox"/> Employer <input type="checkbox"/> MCO <input type="checkbox"/> BWC																																																																																																																										
Work status/Injured worker's capabilities						(Updates Yes <input type="checkbox"/> No <input 8"="" type="checkbox/>)</td></tr><tr><td colspan="/> 3A Does the injured worker have any work restrictions related to allowed conditions in the claim? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Both The injured worker can perform repetitive wrist motion with: <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Both The injured worker's dominant hand is: <input type="checkbox"/> Left <input type="checkbox"/> Right The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No *Drive: <input type="checkbox"/> Yes <input type="checkbox"/> No *Perform other critical job tasks as defined by any source listed above in section 2: <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																
<table border="1" style="width:100%"><tr><td colspan="5">Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously</td><td colspan="4">Lifting/carrying</td><td>N</td><td>O</td><td>F</td><td>C</td><td colspan="4">Pushing/pulling</td><td>N</td><td>O</td><td>F</td><td>C</td></tr><tr><td>Activity</td><td>N</td><td>O</td><td>F</td><td>C</td><td>Activity</td><td>N</td><td>O</td><td>F</td><td>C</td><td>0 - 10 lbs.</td><td></td><td></td><td></td><td></td><td>0 to 25 lbs.</td><td></td><td></td><td></td><td></td></tr><tr><td>Bend</td><td></td><td></td><td></td><td></td><td>Reach above shoulder</td><td></td><td></td><td></td><td></td><td>11 - 20 lbs.</td><td></td><td></td><td></td><td></td><td>26 to 40 lbs.</td><td></td><td></td><td></td><td></td></tr><tr><td>Squat/kneel</td><td></td><td></td><td></td><td></td><td>Type/keyboard</td><td></td><td></td><td></td><td></td><td>21 - 40 lbs.</td><td></td><td></td><td></td><td></td><td>41 to 60 lbs.</td><td></td><td></td><td></td><td></td></tr><tr><td>Twist/turn</td><td></td><td></td><td></td><td></td><td>Work with cold substances</td><td></td><td></td><td></td><td></td><td>41 - 60 lbs.</td><td></td><td></td><td></td><td></td><td>61 to 100 lbs.</td><td></td><td></td><td></td><td></td></tr><tr><td>Climb</td><td></td><td></td><td></td><td></td><td>Work with hot substances</td><td></td><td></td><td></td><td></td><td>61 - 100 lbs.</td><td></td><td></td><td></td><td></td><td>100 + lbs.</td><td></td><td></td><td></td><td></td></tr></table>								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.				
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3C In an eight-hour workday, how many total hours is the injured worker able to: Sit: ____ hours <input type="checkbox"/> Continuously <input type="checkbox"/> With break Walk: ____ hours <input type="checkbox"/> Continuously <input type="checkbox"/> With break Stand: ____ hours <input type="checkbox"/> Continuously <input type="checkbox"/> 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			
Disability period information (If 3B above is NO you must address all fields, including site/location if applicable)			(Updates Yes <input type="checkbox"/> No <input 6"="" style="text-align: center; vertical-align: middle;" type="checkbox/>)</td> </tr> <tr> <td rowspan="/> 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 <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).					
Clinical findings: Office notes can be referenced in lieu of writing clinical findings below.			(Updates Yes <input type="checkbox"/> No <input center;="" middle;"="" text-align:="" type="checkbox/>)</td> </tr> <tr> <td style=" vertical-align:=""/> 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.		
Maximum medical improvement (MMI)			(Updates Yes <input type="checkbox"/> No <input center;="" middle;"="" text-align:="" type="checkbox/>)</td> </tr> <tr> <td style=" vertical-align:=""/> 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.						
Vocational rehabilitation			(Updates Yes <input type="checkbox"/> No <input center;="" middle;"="" text-align:="" type="checkbox/>)</td> </tr> <tr> <td style=" vertical-align:=""/> 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.		
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, telephone and fax numbers			
	Treating physician's signature					
	BWC provider (Peach) number	Date				

EMPLOYEE'S REPORT OF INCIDENT AND INJURY
PLEASE PRINT IN INK To be completed by Employee

Geauga County

BWC Policy No: 32800001-0

Location of Injury/Incident: _____

Name _____	Social Sec. No. _____
Home Address _____	Birth Date _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City/State/Zip _____	Telephone: () _____

Date of injury or onset of symptoms _____ Time _____ ☐ am ☐ pm

Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:** _____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? _____

Did you report this incident to anyone? ☐ Yes ☐ No If not, why not? _____

If yes, to whom did you report it? _____ Title/Position _____ When? _____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull)

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: _____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when? _____

Where? _____ If treatment was not sought immediately, explain why: _____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury? _____

By whom or where? _____

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury: _____

Medical Release

Under current workers' compensation law, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print) _____

Employee Signature _____ Date (required) _____

Vehicle Incident/Accident Report
**REPORT THE ACCIDENT IMMEDIATELY AND PROVIDE ADDITIONAL DOCUMENTS AS SOON
AND POSSIBLE.**

County Vehicle Year, Make, Model _____

Location/Address of Accident _____ Date/Time _____

Weather Conditions _____

Road Conditions _____

Traffic Controls _____

Responding Police Agency _____

Officer _____ Phone _____

Damage Description _____

Owner's Vehicle, Name and Address _____

Insurance Carrier _____ Agent _____ Phone _____

Describe action taken _____

Estimated Cost of Repair _____

Who will do the repairs? _____

Vehicle	Driver's Name & Address	DOB	Driver's License #	Vehicle Description & License Plate #
#1				
#2				
#3				
Injured Party: Name/Address/Phone			Describe Injury: Reported/Observed	

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.



Phone:

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



Email:

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



Fax:

Send injury forms to 888.711.9284.

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

Detach ID card below and present at all medical appointments

 sedgwick | managed care ohio

Workers' compensation identification card



24-hour customer service: 888.627.7586



Employer name: Geauga County
Policy number: 32800001-0

Key contacts and additional information

Medical treatment questions, medical documentation and billing issues

Contact Sedgwick Managed Care Ohio:

Phone: 888.627.7586

Fax: 888.627.0074

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

Prescription questions

Call 800.644.6292 and follow the prompts.

Ohio Bureau of Workers' Compensation (BWC)

Call 800.644.6292 or visit bwc.ohio.gov.

Medical options and provider search

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

Transitional work benefits everyone

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

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

Please send all information within 24 hours of visit.

Injury report and FROI fax: 888.711.9284

Medical and authorization fax: 888.627.0074

Customer service: 888.627.7586

Prescription questions: 800.644.6292 (follow prompts)

Send all mail and medical bills to:

Sedgwick Managed Care Ohio

PO Box 1040

Dublin, OH 43017

*This card is not a
guarantee of coverage.*

Responsibilities

Sedgwick MCO

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

BWC

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

Medical providers

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

Important BWC forms

First report of injury (FROI)

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

MEDCO-14

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

C-9

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