Injury Reporting

PACKET

CareWorks®

1.888.627.7586 | www.careworks.com

Helping Simplify the First Report of Injury (FROI) Process

Workplace Injury. Take the Right Steps.

INJURED EMPLOYEE 4-STEP PROCESS

1. **Immediately notify your employer.**
2. **Complete the first two sections of the "BWC First Report of Injury" form as completely as possible.**
3. **This "Injury Reporting Packet" contains a CareWorks I.D. card. Show this card to each medical provider that treats your work-related injury.**
4. **Then, seek treatment from a CareWorks* network provider.**

EMPLOYER 2-STEP PROCESS

1. **Complete the "Employment" section of the BWC First Report of Injury form.**
2. **FAX completed form to CareWorks, toll-free, at 1-888-711-9284.**

   Call CareWorks to report the injury, toll-free, at 1-888-627-7586.

   Or, report your injury over the Internet by visiting CareWorks Internet Injury Reporting Center at www.careworks.com.

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.

CareWorks®

the **best managed care solution** for your business

First Report of an Injury, Occupational Disease or Death

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/she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Complete as much of all four sections of this form as possible. Type or print in black or blue ink.

Injured Worker 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 than U.S.A.
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 for this claim from anyone other than the Ohio Bureau of Workers Compensation or the employer? ☐ YES ☐ NO
Occupation or Job Title

Benefit Application/Medical Release

I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to treats or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization, and any authorized representatives.

Telephone Number
Work Number
Injured Worker Signature
Date

Injury/Disease/Death Info.

Date of Injury/Disease
Time of Injury ________ ☐ AM ☐ PM
If fatal, give date of death
Date Last Worked
Date Returned to Work
Accident Location (street address)
Date Hired
State Where Hired
Date Employer Notified
City
State
Was place of accident or exposure on employer s premises? ☐ YES ☐ NO
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, etc.)

Treatment Info.

Physician/Health–Care Provider Name
Telephone Number ( )
Fax Number ( )
Initial Treatment Date
Street Address
City
State
9-digit ZIP Code
Diagnosis(es): Include ICD-9 Code(s)
Will this incident cause the injured worker to miss eight or more days of work? ☐ YES ☐ NO
Is this injury causally related to the industrial incident? ☐ YES ☐ NO
Provider Signature
BWC Provider Number
Date

Employment Info.

Employer Name
Policy Number
CHECK IF: ☐ Employer is Self-Insuring ☐ Injured Worker is Owner/Partner/Member of Firm
Mailing Address (Number and Street, City or Town, State, and ZIP Code)
County
Location, if different from mailing address
Manual Number
Telephone Number ( )
Fax Number ( )
Federal ID number

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

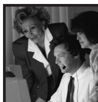
☐ **REJECTION** - The employer **rejects** the validity of this claim for the following reason(s) below:

FOR SELF-INSURING EMPLOYERS ONLY
☐ **CLARIFICATION** - The employer **clarifies and allows** the claim for the condition(s) below:

Employer Signature and Title
Date
OSHA Case Number

CareWorks®

KEY INFORMATION



Medical Management INFORMATION

FAX medical information to:
- 1-888-711-9284 (toll-free)

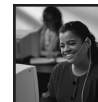
MAIL medical information to:
- CareWorks
  P.O. Box 182726
  Columbus, Ohio 43218-2726

PRIOR AUTHORIZATION
- Fax C9 form to
  1-888-627-0074 (toll-free)

Medical Bill Payment INFORMATION

MAIL medical bills to:
- CareWorks
  P.O. Box 94748
  Cleveland, Ohio 44101-4748

BILLING QUESTIONS
- Call CareWorks Customer Service, toll-free at 1-888-627-7586



Other Important INFORMATION

PRESCRIPTIONS
- For questions regarding prescriptions, contact RxNet, toll-free at 1-888-796-3864

PROVIDER SEARCH & INJURY REPORTING
- Visit www.careworks.com for online injury reporting and comprehensive provider searches.

5555 Glendon Court Dublin, Ohio 43016 | 1.888.627.7586 1.888.711.9284 FAX | **www.careworks.com**