Sedgwick CMS

CompManagement Health Systems, Inc.

Key Contact Information

Medical Management Information

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

MAIL Medical Information to:
- CHS
  P.O. Box 1040
  Dublin, OH 43017

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

Medical Bill Payment Information

MAIL Medical Bills to:
- CHS
  P.O. 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 ACS State Healthcare, toll-free at 1-800-OHIOBWC, Option 5.

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

PO Box 1040, Dublin OH 43017 | 7731 E. Kemper Rd., Cincinnati OH 45249 | 9100 S. Hills Blvd., Cleveland OH 44147 | 3454 Oak Alley Court, Ste 500 Toledo, OH 43606
Toll-free phone: 1-888-247-7799 www.chsmco.com

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 workers 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.

Sedgwick CMS
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888-247-7799 www.chsmco.com

BWC
Better Workers' Compensation
Built with you in mind

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

Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or 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			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		

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 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 causally or historically related to physical or mental injuries relevant to issues necessary to the administration of 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. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.*

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. 8/2005)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets OSHA 301 requirements

Ohio Bureau of Workers' Compensation

Physician's Report of Work Ability

Instructions
- Physician must complete this form when the injured worker is under work restrictions or is temporarily totally disabled.
- You must send or fax a copy of the completed form to the managed care organization (MCO) and a copy given to the injured worker at time of exam.
- You may use any other physician-generated document provided that the substitute document contains, at a minimum, the data elements on the MEDCO-14.
- If injured worker is employed by a self-insuring employer complete this form and mail or fax it to the self-insuring employer.

Fax Note:

To	From
Toll-free phone number	Phone number
Toll-free fax number	Fax number

Injured worker name	Claim number	SSN if claim number unknown	Date of injury
			/ /

Injured worker occupation	Employer name

WORK ACTIVITY

☐ May return to work (RTW) with no restrictions on _____

☐ May RTW with restrictions due to work-related injury/disease from _____ to _____ (complete work/non-work capabilities on the right). Work restrictions apply to work and non-work activity. If restrictions cannot be met at work, then injured worker is recommended to be off work.

The restrictions are ☐ permanent ☐ temporary? If temporary, how long? _____

☐ Is totally disabled from work from _____ to _____.

Please explain in the space provided below why the injured worker is unable to work, due to work-related injury/disease. List ICD-9 codes for the allowed conditions being treated which prevent return to work. _____

Estimated RTW date _____

Work/Non-Work Capabilities

	None at all	Occasional	Frequent	Continuous
% of Workday (8 hr)	0%	1-33%	34-66%	67-100%
Repetitions per hr		4-6	6-12	>12
Lift/Carry				
Up to 10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs.	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐
Reach below knee	☐	☐	☐	☐
Push/pull	☐	☐	☐	☐
Squat/kneel	☐	☐	☐	☐
Stand/walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
No lifting above shoulders	☐	☐	☐	☐

Hand restrictions ☐ Left ☐ Right
- ☐ Must wear splint
- ☐ No lifting greater than _____ lbs
- ☐ No repetitive activities
- ☐ No work with hot or cold substances

No use of ☐ Left ☐ Right
- ☐ Arm
- ☐ Hand
- ☐ Finger _____
- ☐ Other

☐ Change positions every _____ ☐ Work activity as splint/bandage permits
☐ Avoid driving ☐ Keep wound clean/dry ☐ Limit working to _____ Hrs./Day

Physician's further explanation of work abilities or why the injured worker is unable to perform any work: _____

MMI

Has the work-related injury(s) or occupational disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement): ☐ Yes ☐ No

▶ ***Note: Periodic medical treatment may still be requested and provided.***

IF YES, give date _____ **IF NO, please explain (attach additional sheet if necessary)**

REHAB

☐ **Check if vocational rehabilitation return to work services are indicated.**

Physician name and address ***(please print, type or stamp)***

Date of this exam	Follow-up appointment Date	Time
/ /	/ /	

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.

Physician signature ***(mandatory)*** **Date** / /

Distribution: White-Physician Fax a copy to MCO Yellow-Injured worker