

Injury reporting made easy!

Injured employee steps:

- 1** Immediately notify your employer of the injury.
- 2** Seek medical treatment from the nearest medical facility. A BWC-certified health-care provider must provide medical services after the initial treatment.
- 3** Show the MinuteMen OhioComp card to all medical providers treating your injury.
- 4** Complete the *BWC First Report of Injury* (FROI) form and any accident report that may be required by your employer.

Employer steps:

- 1** Complete the employer portion of BWC's *First Report of Injury* (FROI) form.
- 2** Fax the completed form to MinuteMen OhioComp at 1-888-644-7339.
- 3** Report the injury by phone to MinuteMen OhioComp at 1-888-644-6266 or 216-426-0646.

In an emergency, immediately notify your employer and seek treatment at the nearest medical facility. A BWC-certified healthcare provider must provide medical services after the initial treatment. Call MinuteMen OhioComp if you need help locating a BWC-certified medical provider.



INJURED WORKER IDENTIFICATION CARD

Please present to your medical provider when seeking initial medical treatment.



MINUTEMEN
OHIOCOMP
MANAGED CARE ORGANIZATION

**WORKERS'
COMPENSATION
IDENTIFICATION
CARD**

MANDATORY POST ACCIDENT DRUG TESTING

Employer Name: PLYMOUTH-SHILOH SCHOOLS

Employer Risk/Policy No: 37050651000

**First Report of Injury • Case Management
Billing Questions** **1-888-644-6266**

MEDICAL PROVIDER:

- Please Notify MinuteMen OhioComp For Pre-Authorization
- All Care Is To Be Based On Ohio Workers' Compensation Treatment Guidelines
- Treatment Should Be Rendered By An Ohio BWC - Certified / Enrolled Provider

Remit Bills To: 3740 Carnegie Ave., Ste. B200 • Cleveland, Ohio 44115
Claim Approval is Not Guaranteed

For Prescription-related matters, call 1-800-644-6292
www.bwc.ohio.gov

Injured at work?

WHAT TO DO IF YOU ARE INJURED ON THE JOB

- In case of medical emergency seek immediate treatment at the nearest medical facility.
- Notify your Supervisor immediately and assist in filing a First Report of Injury report.
- Obtain your Plymouth-Shiloh Schools injury packet from your supervisor.
- When seeking treatment, please let the medical provider know that MinuteMen OhioComp is your MCO and present your MinuteMen OhioComp card.

ALERT!

- With the exception of emergency medical care, you must receive treatment from a BWC certified medical provider or your medical treatment may not be covered.



Plymouth-Shiloh Local School District
Go Big Red!

Contact your supervisor
with any questions



**MINUTEMEN
OHIOCOMP**
MANAGED CARE ORGANIZATION

For information about medical treatment contact:
MinuteMen OhioComp
Managed Care Organization
1-888-644-6266
www.minutemenmco.com

PLYMOUTH-SHILOH SCHOOLS PREFERRED PROVIDERS

Mercy Health - Williard Hospital LLC	1100 Neal Zick Rd Willard OH 44890	(419) 964-5000	24 hours, daily
Fisher-Titus Willard Health Center	230 Walton St E Willard OH 44890	(419) 935-0196	Mon-Tue 7:20am-8pm Wed 7:20am-5pm Thu 8am-5pm Fri 7:20am-5pm
For severe injuries and after hours			
Mercy Health - Williard Hospital LLC	1100 Neal Zick Rd Willard OH 44890	(419) 964-5000	24 hours, daily



Bureau of Workers' Compensation

First Report of Injury, Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** bwc.ohio.gov **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215

Note: If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

Injured worker information									
First name, middle initial, last name				Date of injury/disease		Social Security number		Date of birth	
Mailing address; add apartment number or P.O. Box, if applicable						City		State	ZIP code
Sex ☐ Male ☐ Female		Email address				Home phone number		Cell phone number	
Employer name PLYMOUTH-SHILOH SCHOOLS		Employer address				City		State	ZIP code
Was the injured worker hired through a temp agency? ☐ Yes ☐ No If yes, name of temp agency				Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat			Regular work hours (include a.m. p.m.) From To		
Date hired	Job title		State where hired	State where supervised	Wage rate; \$ per hour		Number of hours scheduled to work the week of this injury		
Work number for call-offs (Number injured worker calls to reach supervisor)				Part(s) of body affected (For example: Left knee, right index finger)					
Accident description (Describe the sequence of events that directly caused the injury or death.)								Will the incident cause the injured worker to miss 8 or more days from work? ☐ Yes ☐ No	
Injured worker start time ____ ☐ am ☐ pm	Time of injury ____ ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ Yes ☐ No		Date last worked	If the injured worker has returned to work, provide the date.			
Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.							Was injured worker hospitalized overnight? ☐ Yes ☐ No		
Initial treatment date	Health-care office/Facility name		Treating physician/Provider name			Telephone number		Fax number	
Health-care office/Facility street address						City		State	ZIP code
If the injury resulted in death, answer the following.									
Date of death		Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed				Decedent's number of dependents			
To be completed by the injured worker									
By signing this form, I:									
- Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws. - Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim. - Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim. - Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.									
Furthermore, I understand that:									
- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation. - Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims. - Information or records maintained in my previous or future claims may affect decisions made in this claim. - Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).									
I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.									
Injured worker signature								Date	
To be completed by the treating provider									
Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). Important: If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".									
Initial treatment date		Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ No							
Treating physician/Provider's name (Print)			Treating physician/Provider's signature			BWC provider number		Date	
To be completed by the employer									
Employer name PLYMOUTH-SHILOH SCHOOLS		Employer county	Phone number		Fax number		Email address		
Employer policy number 37050651000		Federal ID number		Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation					
For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below. For self-insuring employers only: ☐ Medical only ☐ Lost time Clarification – I clarify and allow the claim for the condition(s) below.									
Employer signature and title								Date	
To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer									
Signature of person completing this form								Date	

PLYMOUTH-SHILOH SCHOOLS
EMPLOYEE'S STATEMENT

I, _____ certify that on _____, 20____ at _____ (a.m. or p.m.), I
(Name) (Date) (Time)

sustained an injury to my _____ that occurred as follows:
(Part of Body)

(Describe the incident in detail, stating part of body injured) _____

Has this body part been previously injured? ☐ Yes ☐ No If yes, when? _____

Place incident occurred _____

Did the incident occur while you were working (on the clock)? ☐ Yes ☐ No

Did the incident occur while you were performing your regularly assigned job/duty? ☐ Yes ☐ No

Did the incident occur on employer's property? ☐ Yes ☐ No

Name(s) of Witness(s) _____

Date/Time and to whom the accident was reported to _____

Name of Medical Provider and Treating Physician _____

Provider Address _____ Provider Phone # _____

Employee address _____

Phone Number _____ Date of Hire _____

Building/Occupation _____ Supervisor _____

Signature of Employee _____ Date _____

PLYMOUTH-SHILOH SCHOOLS

ANATOMY FORM

Instructions for Employee:

Please circle the injured body part(s) then sign and date this form.

Signature of Claimant

Date



PLYMOUTH-SHILOH SCHOOLS
SUPERVISOR'S REPORT

Employee Name _____

Nature of Injury (State employee's complaints and body part injured) _____

How did the incident occur? _____

In view of a camera? _____

Cause of the incident? _____

Was the incident preventable? ☐ Yes ☐ No

If yes, explain _____

What actions have been taken to prevent a reoccurrence of incident? _____

Employee sent to _____

Did employee report back to work? ☐ Yes ☐ No

Does Employee have work restrictions? (List) _____

Date returned to work: _____ In what capacity? ☐ Full Duty ☐ Light Duty

Employer's Address _____

Supervisor's Name: _____ Supervisor's Phone: _____

Signature of Supervisor: _____ Date: _____

PLYMOUTH-SHILOH SCHOOLS
WITNESS STATEMENT

Name of injured worker: _____

Date of injury _____ Time of injury: _____ (a.m. or p.m.)

Place of injury: _____

Description of injury: _____

Description of how injury occurred: _____

Did you see the accident? ☐ Yes ☐ No

Describe how you became aware of the incident _____

How did the injured person describe the accident to you? _____

Who else was aware of the accident? _____

Was the injured employee on the clock or on duty when the incident occurred? _____

Describe any known previous injuries or problems this person has with the same part of the body:

Any other information you wish to provide? _____

Witness's Name _____ Witness's Address _____

Witness's Phone: _____

Signature of Witness: _____ Date: _____



Instructions

- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

You can obtain this form online at www.bwc.ohio.gov

C-101 - Authorization to Release Medical Information: Injured workers should use this form to authorize the release of medical records relative to their work-related injury(s). By signing this form, the injured worker authorizes medical providers who have rendered services relative to the injury to release information to BWC, the Industrial Commission, the employer, the managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives. The form is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), although BWC is exempt from HIPAA requirements.

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name PLYMOUTH-SHILOH SCHOOLS		Employer MCO or QHP MINUTEMEN OHIOCOMP	

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (_____)

_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date
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If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____



Instructions

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
 - Have been awarded permanent and total disability.
 - Have returned to work without restrictions within seven days of the injury.
 - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

Note: Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- **Important:** Failure to provide complete information may delay compensation payments to the injured worker.

Injured worker name		Claim number	Date of injury	
Date of last appointment/examination		Date of this appointment/examination	Date of next appointment/examination	
1	Submission type (Select one of the options below.)			
	☐ Initial MEDCO-14. Proceed to Section 2. ☐ Subsequent MEDCO-14, no changes Proceed to Section 6. ☐ Subsequent MEDCO-14, with changes. Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.			
2	Job description and work status		☐ Reporting changes from last evaluation ☐ No changes	
	• Have you reviewed the injured worker's job description? ☐ Yes ☐ No ◦ If yes, who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC • Does the injured worker have any physical or health restrictions related to the allowed conditions in the claim on the date of this exam? ☐ Yes ☐ No ◦ If yes, are the restrictions: ☐ Permanent? ☐ Temporary? ◦ If no, check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ • If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No ◦ If yes, Proceed to Section 6. ◦ If no, provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. Proceed to Section 3.			
3	Disability information		☐ Reporting changes from last evaluation ☐ No changes	
	Complete the chart below for all work-related allowed conditions being treated.			
	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 ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
List all other conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).				



If you're injured at work, we're here for you!

CLAIMS REPORTING

Notify your employer immediately and complete any required accident report.

Please report your injury to **MinuteMen OhioComp** within 24 hours.

Report an injury by phone:
1-888-644-6266 or
216-426-0646

Fax First Report of Injury to:
1-888-644-7339 or
216-426-0651

MEDICAL MANAGEMENT

Give this information to your doctor along with your **MinuteMen OhioComp** ID card.

Fax treatment requests (C-9) or medical reports to:
1-888-644-7339 or 216-426-0651

Mail medical information to:
MinuteMen OhioComp
3740 Carnegie Ave., Ste. B200
Cleveland, OH 44115

Medical Management questions:
Call 1-888-644-6266

MEDICAL BILL PAYMENT

MinuteMen OhioComp will pay injury related medical bills in approved claims.

Mail medical bills to:
MinuteMen OhioComp
3740 Carnegie Ave., Ste. B200
Cleveland, OH 44115

Billing questions:
Call 1-888-644-6266
ext. 1398

Prescription-related matters:
Call 1-800-644-6292

MINUTEMEN OHIOCOMP IS YOUR MCO! Visit minutemenmco.com to learn more about our services and support.