# **Injury Reporting**

## — PACKET —

**Care**Works

1-888-627-7586 | www.careworksmco.com

# Workplace Injury. Take the Right Steps.

# INJURED EMPLOYEE 4-STEP PROCESS

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

## EMPLOYER 2-STEP PROCESS

- Complete the "Employer Info." section of the BWC First Report of Injury form.
- 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.careworksmco.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.



Helping
Simplify
the First
Report of
Injury
(FROI)
Process



#### 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;

#### 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

Ů	and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.									prosecution for fraud. (R.C. 2913.48)				
	Last name, first name, mid	Socia	al Security nu	Marital sta ☐ Single		Date of birth	of birth							
	Home mailing address	Sex	☐ Male ☐	] Female	☐ Married☐ Divorce	Divorced			i					
	City		Sta	te S	9-digit ZIP code	Cou	ntry if differe	nt from USA	☐ Separa		Departmen	t name		
	Wage rate	Dow	☐ Hour				•	week do you	•			Regular wo	_	
	\$Per:						un				or job title	To		
info	of Workers' Compensation Employer name	? ∐Yes ∐I	No If yes, p	lease ex	xplain.									
ath				710										
/de	Mailing address (number a	Mailing address (number and street, city or town, state, ZIP code and county)												
Injured worker and injury/disease/death info.	Location, if different from mailing address													
/diş	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)													
<u>inı</u>	Date of injury/disease	e of injury/disease Time of injury If fatal, give date of c				1				Date last worked Date returned to			urned to work	
d in	Date hired	a hired   a.m. p.m.   state where hired				began work a.r  Date employer notified			m. 🗆 p.m.	ISta	State where supervised			
an					I <del></del>	·								
rker	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)					
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	care organization and any authorized	inistration of my claim to BWC, the Industrial made in this claim. Proper administration of uch previous or future claims. The released o			al Commission of Ohio, the employer if the present claim may require BWC			in this claim, the employer's managed C to share claims information with the						
	Health-care provider name						phone numb	Fax number			Initial treatn	nent date		
	Street address					( City	)		( )		State	9-digit ZIP c	code	
	Diagnosis(es): Include ICD	code(s)												
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18	Will the incident cause the miss eight or more days of	Is th	e injury caus	the industrial incident?				]Yes □ No						
	E code							provider n	provider number Date					
	Health-care provider signature													
Ž	Employer policy number  Check if Employer is self-insuring Injured worker is owner/partner/member of firm													
	Telephone number Fax number E-mail address							umber	·					
fo.	Was employee treated in an emergency room? Yes No Was employee hospitalized overnight as an inpatient? Yes											]Yes □ No		
Employer info.	If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code													
old	Certification - The em	he er	mployer		For self-insuring employers only  Clarification - The employer clarifies									
Em	application are correct	lidity of this claim for listed below:			and all	and allows the claim for the condition(s) below:  Medical only Lost time								
	Employer signature and titl	e							Date			OSHA case	number	



Your employer has selected CareWorks to medically manage its workers' compensation medical benefits. If injured at work, please follow these important steps:

- 1. Immediately notify your employer and complete the BWC First Report of Injury (FROI) form and fax to CareWorks as quickly as possible, toll-free, at 1.888.711.9284.
- 2. If unable to notify your employer, please call CareWorks, toll-free, at 1.888.627.7586 to report your injury.
- **3.** Show this card to each and every medical provider that treats your workplace injury.

WORKERS' COMPENSATION MCO IDENTIFICATION CARD



**Care**Works

#### FOR WORKERS' COMPENSATION INJURY MANAGEMENT ONLY

BWC Policy # \_\_\_\_

#### **Attention Provider**

You are required by Rule 4123-6-028 to report work-related injuries within 24 hours.

#### **Attention Employee**

This card is for information purposes only. This card is not a guarantee of coverage.

Send Medical Bills to:

CareWorks

P.O. Box 182726

Columbus, Ohio 43218-2726

Customer Service: 1-888-627-7586

Injury Reporting Fax: 1-888-711-9284
Prior Authorization Fax: 1-888-627-0074

Email: CWmedical@careworks.com

Internet: www.careworksmco.com



For prescription drug information, contact 1-800-OHIOBWC or visit www.bwc.ohio.gov.

# Care\Vorks 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 182726
 Columbus, Ohio 43218-2726

#### **Billing Questions**

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



## Other Important Information

#### **Prescriptions**

 For questions regarding prescriptions, please contact BWC at 1-800-OHIOBWC or visit www.bwc.ohio.gov.

## Provider Search and Injury Reporting

 Visit www.careworksmco.com for online injury reporting and provider searches.