Ohio Workers' Compensation Injury Packet

Employer:

Employer:

Address:

City, State, Zip:

Phone:

BWC Policy #:

Managed Care Organization (MCO):

Genex Care for Ohio
11590 Century Blvd., Suite 202
Cincinnati, Ohio 45246
Phone: 800.447.6250
Fax: 888.275.9719
Email: GenexCareforOhio@genexservices.com

Third Party Administrator (TPA):

genex
AN ENLYTE COMPANY

urac®
ACCREDITED
Case Management
Expires 08/01/2023

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Cincinnati, OH 45246
800.447.6250

Workers' Compensation Injury Packet Contents

By certifying a claim the employer is stating that they are in agreement that the facts reported are correct and valid to the best of their knowledge. Certification does not mean that BWC will grant the allowance of a claim, just as rejection does not mean that BWC will deny a claim. BWC will conduct an investigation and determine whether the claim should be allowed or denied, regardless of the employer certification.

If an employer does not agree with the allowance of a claim they should check off the box marked "rejection." Consult your third party administrator about certifying or rejecting claims.

Accident investigations determine how and why these failures occur. By using the information gained through an investigation, a similar or perhaps more disastrous accident may be prevented. Conduct accident investigations with accident prevention in mind.

Pharmacy Benefits Program
Unless a BWC Claim number has been issued the injured worker will need to pay out of pocket for their prescription and get reimbursement from the BWC. Once a claim number has been generated the pharmacy will bill the BWC for prescriptions. Inquiries for pharmacy benefits should be directed to 877-543-6446. To obtain a claim number immediately you can call the claim into Genex or file online at www.bwc.ohio.gov.

Job Description
Send a job description to the doctor with your injured worker. This allows the physician to better determine the job functions of the injured worker and assist them in returning to work with restrictions if needed.

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INJURY REPORTING PROCEDURES

- Work-related illness / injury occurs.
- Employee *IMMEDIATELY* notifies Employer of Injury.
- If an emergency, employee should seek immediate medical attention.
- If not an emergency, Employer refers employee to their Preferred Physician who is BWC Certified Provider.

  For additional assistance in finding a medical provider:
  Genex Care for Ohio 800.447.6250 or www.bwc.ohio.gov
- Employer and Employee should complete the **First Report of Injury (FROI)** as soon as possible. Three methods of reporting injuries:

  ✓ Fax completed FROI to Genex Care for Ohio at 888.275.9719
  ✓ Email completed FROI to genexcareforohio@genexservices.com
  ✓ Call Genex Care for Ohio at 800.447.6250
  ✓ File FROI online at www.bwc.ohio.gov
  Please contact Genex Care for Ohio within 24 hours of an injury*
- Employer and employee should complete accident analysis forms: injury incident report, injury fact sheet and witness statement.
- If the Employee is not going to seek treatment, do not notify Genex, keep the completed FROI and accident analysis forms in their personnel file.
- Employer provides Employee with a Genex Care for Ohio Identification Card and Job Description. Employee should present their identification card and job description to the medical provider upon arriving for treatment.
- **Employee is to provide Employer with medical documents and/or information (e.g.: physician ordered restrictions, physical therapy orders, appointment dates for therapy) in a timely manner.**
- A Genex Care for Ohio Claims Specialist and/or Nurse Case Manager will be assigned to each claim. Upon notification of the work-related illness/injury, immediate contact will be made with the employer, injured employee, and medical provider.

Transitional work may be available for employees to allow suitable alternate employment or reasonable productive accommodations for those employees who are unable to perform their normal job duties due to work related accident, injury, or illness.

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ATTENTION MANAGEMENT - What To Do After The Injury

Genex will Facilitate Return to Work and Coordination of Care

- Stay in close COMMUNICATION with parties involved in the claim: Genex, your TPA, the BWC and the injured worker.

- What is the work status of the Injured Worker:

  IW Released Full Duty: notify Genex of the return to work date.

  IW Released with Restrictions:
  - ✓ Genex will need to know if you are accommodating the restrictions outlined by the physician.
  - ✓ Contact the Injured Worker and let them know that you have transitional work until they can return full duty.
  - ✓ Instruct the Injured Worker to provide you with medical documents and/or information (e.g.: physician ordered restrictions, physical therapy orders, appointment dates for therapy) in a timely manner.
  - ✓ Complete and return the Transitional Work Participation Agreement to Genex.
  - ✓ Contact Genex if you or the injured worker is having difficulty with the restrictions assigned by the physician. Additional assistance may be available onsite, such as remain at work services, job retention program or onsite physical therapy.

  IW was not Released to Return to Work:
  - ✓ It is very important to notify Genex immediately.

  Accident Prevention: the safety or transitional work committee should be notified of the incident and should determine how to prevent occurrences.

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

EMPLOYER:

Name _____ Social Sec. _____

Home Address _____ Birth Date _____

City/State/Zip _____ Sex: ☐ Male ☐ Female

Telephone: ( ) _____ Alternate Phone: ( ) _____

Date of injury **or** onset of symptoms_____Time _____ ☐ am ☐ pm
Describe 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? _____

If yes, to whom did you report it? (Name and Title/Position) _____

When? (Date and Time)_____

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 provisions, 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. A copy of this form will serve as the original.

Employee Name (print) _____

Employee Signature _____ Date (required) _____

INDUSTRIAL INJURY FACT SHEET
EMPLOYER/SUPERVISOR

Employee Name: _____ **Soc. Sec.** _____

Employer: _____ **Date of Injury:** _____

Was an investigation completed concerning the circumstances of this injury? ☐ Yes ☐ No

Were there any witnesses to this injury? ☐ Yes ☐ No
If yes, witness statements should be attached.

Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: ☐ Yes ☐ No

_____

_____

_____

Has there been any recent disciplinary action taken against this employee? ☐ Yes ☐ No
If yes, please describe (and attach any written documentation):

_____

_____

Has the employee missed any work previously due to similar industrial or non-industrial conditions? If so, when? ☐ Yes ☐ No _____

Has the employee submitted medical documentation for the injury? ☐ Yes ☐ No
If so, please attach.
If known, please provide us with the name, address and telephone number of the attending physician: _____

_____

_____

_____

Has the employee returned to work? ☐ Yes ☐ No

Last day worked (date)_____ Returned to work (date)_____

If not, what is the current estimated date of return? _____

With the information you have, would you recommend the claim be accepted? ☐ Yes ☐ No

If no, why not? _____

_____ _____ _____
Employer's signature Title Date

PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.

STATEMENT OF WITNESS TO ACCIDENT

EMPLOYER:

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident_____ Shift _____

Occupation_____ Department _____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name_____ Your occupation _____

Your address_____ Your telephone number ( ) _____-_____

_____

Did you see an accident involving the above employee? ☐ Yes ☐ No

If not, how did you learn about the accident? _____

_____

If you did see an accident occur: Date of accident_____ Time of accident_____ ☐ am ☐ pm

Describe what you saw:_____

_____

_____

_____

_____	_____	_____
Your signature	Please print your name	Date

State of Ohio

County of_____

Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at_____**, Ohio this** _____ **day of**_____**, 20**_____**.**

(SEAL)

(signed)_____

Name (printed or typed_____

Notary Public, State of Ohio

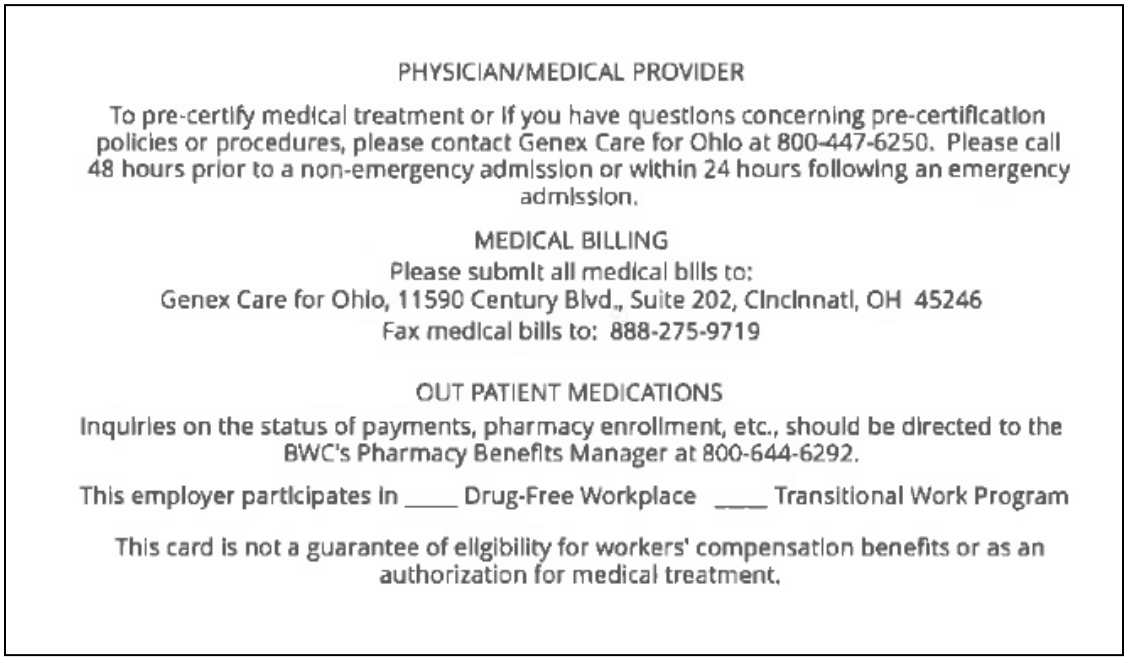
My Commission Expires_____ **(date)**

Front of Card:

«Employer»

«Policy»

Back of Card:



Always confirm that your provider is BWC Certified before receiving treatment. Your benefits may be reduced if you seek services at locations not listed. Some emergency room physicians, anesthesiologists, radiologists and pathologists may not be BWC Certified, even if the hospital is a BWC Certified Provider. For additional providers please contact Genex Care for Ohio 800.447.6250 or go to www.bwc.ohio.gov.

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**In Case of injury or illness on the job,
you may use the following medical providers in your area:**

Occupational Medicine:

Hospital/After Hours Care:

Always confirm that your provider is BWC Certified before receiving treatment. Your benefits may be reduced if you seek services at locations not listed. Some emergency room physicians, anesthesiologists, radiologists and pathologists may not be BWC Certified, even if the hospital is a BWC Certified Provider. For additional providers please contact Genex Care for Ohio 800.447.6250 or go to www.bwc.ohio.gov.

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Claim Questions:

Managed Care Organization (MCO):
Genex Care for Ohio
Phone: 800.447.6250
Fax: 888.275.9719
E: genexcareforohio@genexservices.com

Questions regarding Injury Reporting, Treatment Authorizations, Assistance with Provider Selections, Return to Work, Transitional Work, Onsite Therapy and Medical Bill Payment:

Medical Only Claims:
Valerie Miller
valerie.miller@genexservices.com
800.447.6250
Extension 17672

Lost Time Claims:
Cheryl Henderson RN, CCM
cheryl.henderson@genexservices.com
800-447-6250
Extension 17658

Managed Care Coordinator:
Michelle Pate LPN
michelle.pate@genexservices.com
800-447-6250
Extension 17666