

### **Injury Reporting Packet**

### **ProMedica Key Contact Information**

Medical Bill Payment Information	Medical Management Information	Other important Information
Mail Medical Bills to: ProMedica Medical Management 2545 Farmers Drive, Suite 400 Columbus, OH 43235  Billing Questions Call ProMedica Customer Service at 888-202-3515	Medical Information 888-202-3515 Fax: 888-303-6294  Mail Medical Information to: 2545 Farmers Drive, Suite 400 Columbus, OH 43235  Prior Authorization Fax C-9 forms to 888-303-6294	Prescriptions: For questions about prescriptions, contact the Ohio Bureau of Workers' Compensation at 800-644-6292 (800-OHIO-BWC), or visit www.ohiobwc.gov.  Provider Search and Injury Reporting Visit www.promedicamco.com for online injury reporting and provider searches

Offices in Ohio and West Virginia:
Toledo | Columbus | Cleveland | Youngstown | Wheeling





### STEPS TO FOLLOW WHEN A WORK-RELATED INJURY OCCURS

**IN EMERGENCY SITUATIONS,** seek treatment immediately at the nearest medical facility.

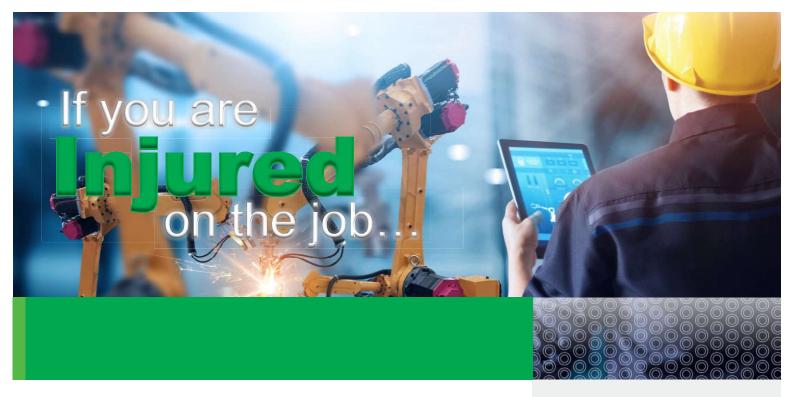
### IN NON-EMERGENCY SITUATIONS:

- ☑ Immediately notify your supervisor or designated person.
- ☑ Be sure to get a ProMedica Medical Management ID card.
- ☑ Seek treatment from the nearest medical facility. If you need help, your employer may assist you.
- ☑ Notify the treating provider that you have a work-related injury and all medical information should be sent to ProMedica Medical Management within 24 hours of treatment.
- ☑ Select a physician of record to provide any ongoing medical care you may need.
- ☑ ProMedica Medical Management will stay in contact with you, your employer, and the treating physician until you are released to work, or you have reached maximum medical improvement from your injury.

According to Health Partnership Program guidelines, injured workers may seek treatment from any BWC certified medical provider.

Offices in Ohio and West Virginia:
Toledo | Columbus | Cleveland | Youngstown | Wheeling
888-202-3515 | Fax: 888-303-6294





- Notify your supervisor immediately.
- In an emergency, seek treatment immediately at the nearest medical facility.
- 3) In a non-emergency, go to:

### **OhioHealth Urgent Care - Delaware**

1710 Columbus Pike Delaware, OH 43015 Phone: (740) 549-2700

Hours: Mon - Sun: 9:00 am - 9:00 pm

### **OhioHealth WorkHealth - Delaware Medical Campus**

801 OhioHealth Blvd Delaware, OH 43015 Phone: (614) 566-9675

Hours: Mon - Fri: 8:00 am - 4:30 pm

### After normal business hours:

### OhioHealth Grady Memorial Hospital - Emergency Room

561 W Central Ave Delaware, OH 43015 Phone: (740) 615-1000

Hours: 24/7

**4)** Report your injury within 24 hours to ProMedica Medical Management at 1-888-202-3515, press "0" for customer service.

- ProMedica Medical Management will report your injury to the Ohio Bureau of Workers' Compensation (BWC).
- ProMedica Medical Management will assign a case manager to assist with your care until you have recovered from your injury.
- ProMedica Medical Management will pay any authorized medical bills related to your approved work-related injury.



# ProMedica Medical Management Card

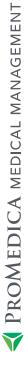


RISK #: 14128-0 OHIO WESLEYAN UNIV TO REPORT A WORKERS' COMPENSATION INJURY CALL: 1-888-202-3515

# DEAR PROMEDICA MEDICAL MANAGEMENT MEMBER

- Immediately notify your supervisor of your work related injury.
- Employer call 1-888-202-3515 (FAX 1-888-303-6294) to report the injury within 24 hours.
- Give ID card to employee (if applicable).
- Seek treatment with a BWC certified provider.
- Presentation of this card does not automatically imply compensability. Compensability will be determined by the Ohio Bureau of Workers' Compensation.

Front of ID Card



### CORPORATE OFFICE

2545 Farmers Drive, Suite 400 Columbus, Ohio 43235

888-202-3515

Fax: 888-303-6294

promedicamco.com

## Offices in Ohio and West Virginia:

Toledo | Columbus | Cleveland | Youngstown | Wheeling

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### **EMERGENCY SERVICES**

In the case of a life threatening work related emergency go to the nearest medical facility.

**Remit FROI's Provider Bills,** 1-888-202-3515 **C-9, Prior Authorization to:** Fax: 1-888-303-6

ProMedica Medical Management

2545 Farmers Drive, Suite 400 Columbus, Ohio 43235

Eax: 1-888-303-6294

Pharmacy Provider:
Call the Ohio BWC at
1-800-644-6292 or go

to: www.bwc.ohio.gov

Back of ID card



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

Submit the form to BWC in one of the following ways. **Online:** <u>bwc.ohio.gov</u>, **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 i	nformation	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			p = -3-										
First name, middle initial, last name						ury/disease	Social	Security number			Date of birth					
Mailing address; add	apartment number or P.O.	Box, if ap	pplicable				City				State	ZIP code				
Sex ☐ Male ☐ Fer	nale	Email	l address				Home p	phone number			Cell phone num	ber				
Employer name		Emplo	oyer address				City				State	ZIP code				
Was the injured work	er hired through a temp ag	ency?	l Yes □ No			lays of the week you usual Mon D Tues D Wed		☐ Fri ☐ Sat		Regular wo	ork hours (include To					
Date hired	Job title			State where	hired	State where supervised	l Wage r	ate; \$ per hour	Numb	er of hours	ours scheduled to work the week of this injury					
Work number for call-	-offs (Number injured work	er calls to	reach supervisor)	Part(s) of bo	dy affected (I	For example: Left knee, ri	ight index fin	ger)	l							
Accident description	(Describe the sequence of	events tha	at directly caused the	injury or death	1.)				nt cause the injured s 8 or more days							
Injured worker start ti	, , ,		Date employer notifie			workday missed due to	Date la	st worked	If the date.	injured wo	worker has returned to work, provide the					
	accident or exposure on e		premises?		njury? ☐ Ye re accident lo		y, state, and	ZIP code.	uale.	,	injured worker hospitalized overnight? es □ No					
Initial treatment date	Health-care office/	Facility nar	me	Treating physi	ician/Provide	r name	Telepho	one number		L res	Fax number					
Health-care office/Fa	cility street address						City				State	ZIP code				
If the injury resulted	I in death, answer the fol	lowing.														
Date of death	d by the injured worl		's marital status 🛚 S	Single 🗆 Marr	ied 🗆 Divor	ced 🗆 Separated 🗆 V	Vidowed	Decedent's r	number	of depende	ents					
<ul> <li>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.</li> <li>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.</li> <li>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.</li> <li>Furthermore, I understand that:         <ul> <li>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.</li> <li>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.</li> <li>Information or records maintained in my previous or future claims may affect decisions made in this claim.</li> <li>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).</li> </ul> </li> <li>Leartify that I have read, understand, and agree to the above statements and the information contained on this</li></ul>																
Initial treatment date	1.5		edical conditions you le physician of record			related to the reported wo	rk-related ac	cident or occupat	ional dis	sease? $\square$	e? □ Yes □ No					
Treating physician/P	rovider's name (Print)		Treating	g physician/Pro	ovider's signa	ture		BWC provider	number		Date					
To be completed by the employer Employer name				er county	Phone nu	mber	Fax number	er	Er	mail addres	SS S					
Employer policy number Federal ID number																
				porroot and valid	'	Princetion I reject the						orated as a corporation				
For all employers:  Certification – I certify the facts in this application are correct and valid.  For self-insuring employers only:  Medical only  Lost time  Clarification – I clarify and allow the claim for the condition(s) below.										i iisted beid						
Employer signature a	and title					Date										
To be completed Signature of person	d by the submitter if completing this form	the forn	n is completed b	y someone	other tha	n the injured worke	r, treating	physician, or	empl	oyer	Date					



### Physician's Report of Work Ability (MEDCO-14)

### 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:
  - o Have been awarded permanent and total disability.
  - o 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.

			Die fel									
ınj	ured worker name		Claim num	per	Date of injury							
Da	ite of <i>last</i> appointment/examination	Date of <i>this</i> appointment/ex	amination	Date of <i>next</i>	Date of <i>next</i> appointment/examination							
	Submission type (Select one of the c	options below.)										
<ul> <li>Initial MEDCO-14. Proceed to Section 2.</li> <li>Subsequent MEDCO-14, no changes Proceed to Section 6.</li> <li>Subsequent MEDCO-14, with changes. Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.</li> </ul>												
	Job description and work status		Reporting ch	anges from last	evaluation 🛘 No changes							
	Have you reviewed the injured worke	r's job description? 🛮 Yes [	□ No									
2	<ul> <li>o If yes, who provided the job description □ Injured worker □ Employer □ MCO/BWC</li> <li>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</li> <li>o If yes, are the restrictions: □ Permanent? □ Temporary?</li> </ul>											
	Disability information		Reporting ch	nanges from las	t evaluation ☐ No changes							
	Complete the chart below for all work-r	elated allowed conditions	being treate	d.								
	Narrative description of the work- related allowed condition	Site/Location if ICE applicable		ne condition preventing full duty release to job injured worker held on the date of injury								
					Yes ☐ No							
					Yes ☐ No							
3					Yes ☐ No							
					Yes ☐ No							
					Yes No							
	List all other conditions that <b>impact tre</b> conditions).	atment of the conditions liste	ed above (e.g	., co-morbidities	s or not yet allowed							

Injured worker name								Cla	aim number Date of injury																
	Abilities, cli	nica	al fir	ndin	ıas	and	d red	covery progress	sion	1			Rep	ortin	ng cha	naes	fron	า last	evaluation 🏻 No	ch	ana	es			
											allo								ety hazard? □ Y						
	<ul> <li>Dominant</li> </ul>					•													,						
					_			al abilities for the	act	ivitie	es ir	n the	cha	rt be	low ar	ıd pr	ovide	com	ments as necess	ary					
	Frequency so	ale							Str	eng	th le	evel	(lbs.)	Body side indicator											
	N = Never											ary	0-10					L = l							
	S = Seldom		1 ho							Ligh		_	0-20						Right						
	<b>O</b> = Occasions <b>F</b> = Frequent		o no 6 ho							= ivie = He	diur avv	n	0-50 0-10												
4	<b>C</b> = Constant											heav	y >10					*Indicate limitations ONLY							
	Activity	Frequency						Activity	Strength					Frequency					Activity		Side				
	Sit	N	S	0	F	C	Floo	or lift (0-17")	S	L	М	Н	VH	N S O F C		Front/Lateral reach		L	R	В					
	Stand/Walk	N	S	0	F	С	Kne	ee lift (18-29")	S	L	М	Н	VH	N	S O	F	С	Ove	rhead reach	L	R	В			
	Climb stairs	N	S	0	F	С	Wa	ist lift (30-36")	S	L	М	H	VH	N	S O	F	С	Wris	t flex/extension	匸	R	В			
	Squat/Kneel	N	S	o	F	С	Che	est lift (37-60")	s	L	М	丽	VH	N	s o	TF.	С	Gras	sp	ī	R	В			
	Crawl		S	=	F	С		erhead lift (>60")	s	L	М	丽	VH	N	S O	=	С		er manipulation	ī		В			
	Twist		S		F	С	Pus	sh/Pull	S	L	М	Ħ	VH	N	s o	ΪF	С		ooarding	L	R				
	Bend/Stoop		S	_			Car		s			_			s o			_	rate foot controls	_		В			
								•		<u> </u>		n no	rwo	ماد											
	<ul> <li>Injured wo</li> </ul>				_		_	urs per day and ns based only on				-			al cor	ditio	nc2	$\square \vee \emptyset$	es 🏻 No						
								estrictions in con																	
	•			•															urn to work, reaso	n(s	) fo	r			
	delayed re	cov	ery,	and	d pro	opos	sed t	reatment plan (e	e.g.,	mo	dalit	ties,	thera	pies	s, surg	ery),	inclu	uding	estimated duration						
		or ir	ndica	ate i	f all	or p	oart o	of this informatio	n is	in c	ffice	e no	tes (ii	nclu	de dat	e(s)	of no	tes).							
	Comments:																								
	Health and	Beł	navi	oral	As	sses	sme	ent: (HBA evaluate	s co	gnitiv	/e, e	motic	nal, s	ocial,	and be	havio	ral ba	rriers	that might impact phy	vsica	al he	ealth			
	problems and tr	eatm	nents	whic	h are	e ass	ociate	ed with the allowed p	hysi	cal ir	jury	in the	claim	.)						,					
	-						-	ot progressing, o	-	_		_			-					_	_				
	_												-			-			d healing? 🛚 Ye						
											_	-							stance to remain		vork	cor			
	return to wor	k. Is	s the	: injı	urec	ow t	rker	currently able to	pai	rtici	oate	in a	VOC	ation	al reh	abilit	ation	prog	ıram? ☐ Yes ☐	No					
	Maximum m	nedi	cal	imp	rov	eme	ent (	MMI) status					Rep	ortin	ig cha	nges	fron	ı last	evaluation   No	ch	ang	es			
	MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be																								
5	expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-																								
	related injury(s) or occupational disease reached MMI based on the definition above? ☐ Yes ☐ No																								
	• If yes, give MMI date:/ Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. So, periodic medical treatment may still be requested and, if approved, provided.																								
					_			•					-					іт арі	provea, providea.						
	Treating phy	ysic	ian	S S	gna	atur	e – r	nandatory (See	ех	cep	tion	s at	the	top	of the	forn	1.)								
	I certify the information on this form 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 be punished, under appropriate criminal provisions, by a fine or imprisonment or both.																								
6	-								a III	ie 0	1111	μιις	лине Т				ctctc	nin							
	Treating physician's name (Print legibly.)												Address, city, state, nine-digit ZIP					s-uigit ZIP code							
	Treating phy	sicia	an's	siar	natı	ıre							$\overline{}$												
		_	_		_	_ L														_	_				
	BWC provide	er (F	EA	CH)	nur	mbe	r	Date						Tel	ephon	e nu	mbei	-	Fax number						
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