

*In the event you experience a workplace injury or illness...*

# FOLLOW THESE 4 STEPS!

# 1



## SEEK MEDICAL ATTENTION

In case of emergency, call 911 or have someone transport you to the nearest emergency facility. *Your safety and wellbeing are the primary concern.*

# 2



## NOTIFY YOUR EMPLOYER

Tell your supervisor or manager of your injury or illness as soon as possible. They will investigate and document the details of the event.

# 3



## REPORT INJURY TO SHEAKLEY

Immediately notify Sheakley of the injury or illness using the First Report of Injury (FROI) form. Completed forms may be submitted to [unicompfroi@sheakley.com](mailto:unicompfroi@sheakley.com).

# 4



## WORK TOWARDS RECOVERY

Your employer, your physician(s), and Sheakley will collaborate to ensure you receive the necessary care to facilitate a speedy recovery and return to work.



SheakleyUniComp

| An Ohio Workers' Compensation  
Managed Care Organization





888.743.2559

[sheakley.com/mco](http://sheakley.com/mco)




To report a workplace injury, contact us at:

 Cincinnati: 513.618.1249

 Toll-Free: 888.743.2559

 Cincinnati: 513.326.8005

 Toll-Free: 888.626.2667

Email First Report of Injury to:

 Email: [unicompfroi@sheakley.com](mailto:unicompfroi@sheakley.com)



**Bureau of Workers'  
Compensation**

1-800.OHIO.BWC [www.bwc.ohio.gov](http://www.bwc.ohio.gov)

• For PRESCRIPTION billing  
• and other RX information call:  
• 800.644.6292 (follow prompts)



Submit medical documentation &  
requests for prior authorization to:

Cincinnati: 513.618.1249  
Toll-Free: 888.743.2559  
Fax: 513.326.8005 or  
888.626.2667  
Email: [MCO@sheakley.com](mailto:MCO@sheakley.com)



Send all bills or notifications  
of treatment to:

Sheakley UniComp, Inc.  
Attn: MCO Dept.  
9987 Carver Rd Ste 300  
Blue Ash, Ohio 45242  
Email: [MCO@sheakley.com](mailto:MCO@sheakley.com)

OHIO WESLEYAN UNIVERSITY- policy # 14128-0

## What Should I do if I am Injured at Work?

1. Report any injury to your supervisor **immediately** no matter how minor.
2. **In case of Emergency seek immediate treatment from the nearest medical facility or call 911.**
3. **If Non-Emergency:** \*\*\*If your employer has a preferred provider contact HR/Safety\*\*\* If not, use the following: Seek Treatment from a BWC-Certified medical provider which is **required** by the Ohio BWC.  
For assistance in locating a BWC-Certified medical provider:
  - Contact Sheakley UniComp, Inc. at 1.888.743.2559 or 1.513.618.1249
  - HealthSmart Provider Directory at [www.HealthSmart.com](http://www.HealthSmart.com)
  - Ohio BWC at [www.bwc.ohio.gov](http://www.bwc.ohio.gov) under **Medical Providers** then **Look-Ups**
4. If you are not able to return to work full duty, you are to inform the medical provider light/modified duty or transitional work is available.
5. After receiving treatment, you need to **immediately** notify your supervisor or contact person if the medical provider places you on light/modified duty or takes you off work completely.

**Within 24 hours** of seeking medical treatment, the employer or injured worker should call Sheakley UniComp, Inc. to report the injury or to complete the BWC's First Report of Injury (FROI) form. Please fax the FROI with the injured worker's signature and any medical documentation to 1.888.626.2667 or 1.513.326.8005 or email it to [unicompfroi@sheakley.com](mailto:unicompfroi@sheakley.com).

<b><u>Submit all medical bills to:</u></b> Sheakley UniComp, Inc. 9987 Carver Road Ste 300 Blue Ash, OH 45242 888.626.2667 (fax)	<b><u>Submit all prescriptions bills to:</u></b> BWC Pharmacy 30 W. Spring Street L21 Columbus, Ohio 43215 Fax: 866.213.6066 Email: <a href="mailto:Pharmacy.benefits@bwc.ohio.gov">Pharmacy.benefits@bwc.ohio.gov</a>
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Contact your employer about any compensation of your wages while off work related to your injury. They will be able to inform you of what your options are.

For a full description of your rights and responsibilities as an Injured Worker, please visit our web site at [www.sheakley.com](http://www.sheakley.com) – Workers' Comp MCO – Injured Worker.



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

Submit the form to BWC in one of the following ways. Online: www.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.

Form with multiple sections: Injured worker information, Accident description, Date of death, To be completed by the injured worker, To be completed by the treating provider, To be completed by the employer, and To be completed by the submitter.



**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 <i>last</i> appointment/examination		Date of <i>this</i> appointment/examination	Date of <i>next</i> appointment/examination	
<b>Submission type (Select one of the options below.)</b>				
<b>1</b>	<input type="checkbox"/> Initial MEDCO-14. <b>Proceed to Section 2.</b> <input type="checkbox"/> Subsequent MEDCO-14, <b>no</b> changes <b>Proceed to Section 6.</b> <input type="checkbox"/> Subsequent MEDCO-14, <b>with changes.</b> Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.			
	<b>Job description and work status</b>		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes	
	<ul style="list-style-type: none"> <li>• Have you reviewed the injured worker's job description? <input type="checkbox"/> Yes <input type="checkbox"/> No           <ul style="list-style-type: none"> <li>○ <b>If yes</b>, who provided the job description <input type="checkbox"/> Injured worker <input type="checkbox"/> Employer <input type="checkbox"/> MCO/BWC</li> </ul> </li> <li>• Does the injured worker have any physical or health restrictions <b>related to the allowed conditions in the claim</b> on the date of this exam? <input type="checkbox"/> Yes <input type="checkbox"/> No           <ul style="list-style-type: none"> <li>○ <b>If yes</b>, are the restrictions: <input type="checkbox"/> Permanent? <input type="checkbox"/> Temporary?</li> <li>○ <b>If no</b>, check the box to indicate the injured worker is released to return to full duty as of the date of this exam. <input type="checkbox"/> <b>Proceed to Section 6.</b></li> </ul> </li> <li>• 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? <input type="checkbox"/> Yes <input type="checkbox"/> No           <ul style="list-style-type: none"> <li>○ <b>If yes</b>, <b>Proceed to Section 6.</b></li> <li>○ <b>If no</b>, provide date restrictions began ___/___/___ and estimated full duty return-to-work date ___/___/___.</li> </ul> </li> </ul> <p><b>Proceed to Section 3.</b></p>			
<b>Disability information</b>		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes		
Complete the chart below for all <b>work-related allowed conditions being treated.</b>				
<b>3</b>	Narrative description of the <b>work-related allowed condition</b>	Site/Location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
List all other conditions that <b>impact treatment</b> of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).				

Injured worker name	Claim number	Date of injury
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**Abilities, clinical findings, and recovery progression**  Reporting changes from last evaluation  No changes

- Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard?  Yes  No
- Dominant hand:  Right  Left
- Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.

Frequency scale	Strength level (lbs.)	Body side indicator
N = Never S = Seldom 0-1 hour O = Occasional 1-3 hours F = Frequent 3-6 hours C = Constant 6-8 hours	S = Sedentary 0-10 L = Light 0-20 M = Medium 0-50 H = Heavy 0-100 VH = Very heavy >100	L = Left R = Right B = Both  *Indicate limitations ONLY

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Activity	Frequency	Activity	Strength	Frequency	Activity	Side
Sit	N S O F C	Floor lift (0-17")	S L M H VH	N S O F C	Front/Lateral reach	L R B
Stand/Walk	N S O F C	Knee lift (18-29")	S L M H VH	N S O F C	Overhead reach	L R B
Climb stairs	N S O F C	Waist lift (30-36")	S L M H VH	N S O F C	Wrist flex/extension	L R B
Squat/Kneel	N S O F C	Chest lift (37-60")	S L M H VH	N S O F C	Grasp	L R B
Crawl	N S O F C	Overhead lift (>60")	S L M H VH	N S O F C	Finger manipulation	L R B
Twist	N S O F C	Push/Pull	S L M H VH	N S O F C	Keyboarding	L R B
Bend/Stoop	N S O F C	Carry	S L M H VH	N S O F C	Operate foot controls	L R B

- Injured worker can work \_\_\_\_\_ hours per day and \_\_\_\_\_ hours per week.
- Are there any functional restrictions based only on the allowed psychological conditions?  Yes  No
  - If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.
- Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).

**Comments:**

**Health and Behavioral Assessment:** (HBA evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.)

- Is the injured worker's recovery not progressing, or progressing slower than expected?  Yes  No
- Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing?  Yes  No

**Vocational rehabilitation** is a voluntary program for an eligible injured worker who needs assistance to remain at work or return to work. Is the injured worker currently able to participate in a vocational rehabilitation program?  Yes  No

**Maximum medical improvement (MMI) status**  Reporting changes from last evaluation  No changes

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**MMI** is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be 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.

**Treating physician's signature – mandatory (See exceptions at the top of the form.)**

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.

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Treating physician's name (Print legibly.)		Address, city, state, nine-digit ZIP code	
Treating physician's signature			
BWC provider (PEACH) number	Date	Telephone number	Fax number