

# — Injury reporting packet

**Geauga County**

**Employee**



**Employee instructions for work place injury**

1. Immediately report the injury to your Supervisor
2. Complete the Employee's Report of Incident and Injury If needed, seek medical attention at an Occupational Health Clinic
3. Take MCO ID Card Information and Medco 14 to Doctor
4. Return Medco 14 to your Supervisor immediately

Phone: 888-627-7586

sedgwickmco.com

Fax: 888-711-9284

*Detach ID card below and present at all medical appointments*



# INJURY ON THE JOB CLAIM PROCEDURES

<u>EMPLOYER AND BWC POLICY #</u>	<u>YOUR Worker's Comp Contact:</u>
Name: Geauga County	Name: Megan Erickson
Address: 12611 Ravenwood Dr., Suite 350	Title: Benefits Specialist
City, State, Zip: Chardon, OH 44024	Phone: 440-279-1671 Fax: 440-279-1309
BWC Policy Number: 32800001-0	Email: <a href="mailto:merickson@geauga.oh.gov">merickson@geauga.oh.gov</a>

## IF YOU EXPERIENCE AN ON-THE-JOB INJURY:

- Report the injury/incident to your supervisor IMMEDIATELY.
- Complete the Geauga County Employee's Incident/Accident Report and return to your supervisor immediately, if possible, or within 24 hours of the injury/accident. *If you were involved in a vehicle accident involving a county vehicle, complete the Vehicle Incident/Accident Report also and send that report to Kathy Hostutler: Fax: 440-279-1317.*
- If medical treatment is necessary, please use a BWC-certified medical provider (see enclosed).
- Give your MCO Identification Card and MEDCO-14 Form (in this packet) to the medical provider to ensure all bills and necessary documents are sent to the correct address.
- *Make sure you have your completed MEDCO-14 Form when you leave your doctor/urgent care.*
- Return the MEDCO-14 form to your supervisor immediately as notification of your medical condition.

## See enclosed insert for Medical Providers

### YOUR MANAGED CARE ORGANIZATION IS:

#### CompManagement Health Systems, Inc.

P.O. Box 1040

Fax: 1-800-334-4229

Dublin, Ohio 43017

Customer Service: 1-888-247-7799

Online Reporting: [www.chsmco.com](http://www.chsmco.com)

Injury Reporting: 1-888-247-4800



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.

Form containing sections: Injured worker information, 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 if the form is completed by someone other than the injured worker, treating physician, or employer.



**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-funded 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"/></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			
List all other conditions that <b>impact treatment</b> of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).			



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

Employer: Geauga County  
Location of Injury/Incident: \_\_\_\_\_

Policy No: 32800001-0

Name \_\_\_\_\_ Social Sec. No. \_\_\_\_\_  
Home Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex:  Male  Female  
City/State/Zip \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_

Date of injury or onset of symptoms \_\_\_\_\_ Time \_\_\_\_\_  am  pm  
Described 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 not? \_\_\_\_\_  
If yes, to whom did you report it? \_\_\_\_\_ Title/Position \_\_\_\_\_ When? \_\_\_\_\_

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

Employee Name (print) \_\_\_\_\_

Employee Signature \_\_\_\_\_

Date (required) \_\_\_\_\_

**Vehicle Incident/Accident Report**  
**REPORT THE ACCIDENT IMMEDIATELY AND PROVIDE ADDITIONAL DOCUMENTS AS SOON AND POSSIBLE.**

County Vehicle Year, Make, Model \_\_\_\_\_

Location/Address of Accident \_\_\_\_\_ Date/Time \_\_\_\_\_

Weather Conditions \_\_\_\_\_

Road Conditions \_\_\_\_\_

Traffic Controls \_\_\_\_\_

Responding Police Agency \_\_\_\_\_

Officer \_\_\_\_\_ Phone \_\_\_\_\_

Damage Description \_\_\_\_\_

Owner's Vehicle, Name and Address \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Agent \_\_\_\_\_ Phone \_\_\_\_\_

Describe action taken \_\_\_\_\_

Estimated Cost of Repair \_\_\_\_\_

Who will do the repairs? \_\_\_\_\_

Vehicle	Driver's Name & Address	DOB	Driver's License #	Vehicle Description & License Plate #
#1				
#2				
#3				
Injured Party: Name/Address/Phone			Describe Injury: Reported/Observed	

# Steps to take when a workplace injury occurs

Call 911 immediately in case of serious or life-threatening emergencies

## If an incident or injury occurs, we are here to help. Just follow these steps.

An injured employee, their employer or medical provider may report a work-related injury. Your company has chosen Sedgwick Managed Care Ohio to help you through this process.

### Employee instructions

1. Immediately notify your supervisor.
2. Complete the first section of the BWC First Report of Injury (FROI) form as completely as possible.
3. Seek appropriate medical treatment if needed, and provide the attached ID card at all medical appointments.
4. Keep your supervisor informed of your medical status and return all completed claim documentation to your employer promptly.

### Employer instructions

1. Assist in the completion of an injury/incident report, and/or the Employer Info section of the enclosed FROI.
2. If medical treatment is involved, ensure the incident is reported to Sedgwick MCO using one of the methods described under "Reporting a work-related injury to Sedgwick MCO:"

## Reporting a work-related injury to Sedgwick MCO



**Online:**  
Submit an injury form (FROI) online at [sedgwickmco.com](http://sedgwickmco.com).



**Phone:**  
Contact our customer service team at 888.627.7586 (available 24/7).



**Email:**  
Send *encrypted* injury/incident reports as soon as possible to: [injury.incident@sedgwickmco.com](mailto:injury.incident@sedgwickmco.com).



**Fax:**  
Send injury forms to 888.711.9284.

Early documentation and reporting of injuries promotes the best results for everyone.

Detach ID card below and present at all medical appointments

 sedgwick | managed care ohio

Workers' compensation identification card



24-hour customer service: 888.627.7586



Employer name: Geauga County  
Policy number: 32800001-0

## Key contacts and additional information

### Medical treatment questions, medical documentation and billing issues

Contact Sedgwick Managed Care Ohio:

Phone: 888.627.7586

Fax: 888.627.0074

Mail: P.O. Box 1040, Dublin, OH 43017

### Prescription questions

Call 800.644.6292 and follow the prompts.

### Ohio Bureau of Workers' Compensation (BWC)

Call 800.644.6292 or visit [bwc.ohio.gov](http://bwc.ohio.gov).

### Medical options and provider search

If medical treatment is required, see a BWC-certified medical provider. For more information, see the Sedgwick MCO website at [sedgwickmco.com](http://sedgwickmco.com).

## Transitional work benefits everyone

A safe and timely return to work is important! Together, we will explore opportunities for modified duty/ transitional work that can accommodate any physical limitations in order to speed your recovery, ease your transition back to work and minimize any hardship as a result of a workplace injury. Employee safety and recovery are the highest priorities. It's essential – and required – to keep Sedgwick MCO and your employer updated on your recovery status and work restrictions at all times.

Please provide MEDCO-14 forms with any physical restrictions, as employer may have modified duty available.

Please send all information within 24 hours of visit.

Injury report and FRO1 fax: 888.711.9284

Medical and authorization fax: 888.627.0074

Customer service: 888.627.7586

Prescription questions: 800.644.6292 (follow prompts)

Send all mail and medical bills to:

Sedgwick Managed Care Ohio

PO Box 1040

Dublin, OH 43017

*This card is not a  
guarantee of coverage.*

## Responsibilities

### Sedgwick MCO

- Initiate new claims with the BWC, collect and submit required information
- Return to work and medical case management
- Review and approval of medical treatment
- Medical bill payment
- Medical management of workers' compensation claims
- All associated managed care organization responsibilities

### BWC

- Claim allowance and compensability determination
- Claim number assignment
- Compensation award payment(s)
- Coordination of Industrial Commission hearings

### Medical providers

- Treating physicians must be BWC certified
- Promptly submit all medical documentation to Sedgwick MCO
- Clearly indicate work readiness and periods of disability utilizing the MEDCO-14 form

## Important BWC forms

### First report of injury (FRO1)

Initiates workers' compensation claim; complete and send to Sedgwick MCO

### MEDCO-14

Physician's statement of workability, recovery status; send to Sedgwick MCO

### C-9

Physician's request for treatment approval; addressed by Sedgwick MCO