

Injury Reporting

— **PACKET** —

CareWorks

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

Workplace Injury. Take the Right Steps.

INJURED EMPLOYEE 4-STEP PROCESS

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

EMPLOYER 2-STEP PROCESS

- 1 Complete the “Employment” section of the BWC First Report of Injury form.
- 2 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.

Helping
Simplify
the First
Report of
Injury
(FROI)
Process

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.

CareWorks

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Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

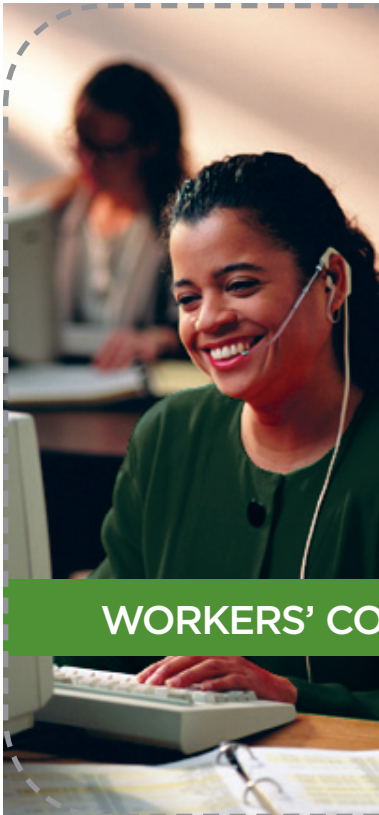
By signing this form, I:
• Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;
• Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational 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;
• Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for 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 prosecution for fraud. (R.C. 2913.48)

Form section: Injured worker and injury/disease/death info. Fields include: Last name, first name, middle initial; Social Security number; Marital status; Date of birth; Home mailing address; Sex; Number of dependents; City; State; 9-digit ZIP code; Country if different from USA; Wage rate; Regular work hours; Occupation or job title; Employer name; Mailing address; Location; Was the place of accident or exposure on employer's premises?; Date of injury/disease; Time of injury; Date last worked; Date returned to work; Date hired; State where hired; Date employer notified; State where supervised; Description of accident; Type of injury/disease and part(s) of body affected.

Form section: Treatment info. Fields include: Health-care provider name; Telephone number; Fax number; Initial treatment date; Street address; City; State; 9-digit ZIP code; Diagnosis(es); Will the incident cause the injured worker to miss eight or more days of work?; Is the injury causally related to the industrial incident?; E code; 11-digit BWC provider number; Date; Health-care provider signature.

Form section: Employer info. Fields include: Employer policy number; Telephone number; Fax number; E-mail address; Federal ID number; Manual number; Was employee treated in an emergency room?; Was employee hospitalized overnight as an inpatient?; If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code; Certification/Rejection/For self-insuring employers only; Employer signature and title; 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

CareWorks



FOR WORKERS' COMPENSATION INJURY MANAGEMENT ONLY

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
c/o Medical Mutual of Ohio
P.O. Box 94748
Cleveland, Ohio 44101-4748

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.careworks.com



ACCREDITED
CASE MANAGEMENT

For prescription drug information, contact 1-800-OHIOBWC or visit www.ohiobwc.com.

CareWorks

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
c/o Medical Mutual of Ohio
P.O. Box 94748
Cleveland, Ohio 44101-4748

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.ohiobwc.com.

Provider Search and Injury Reporting

- Visit www.careworks.com for online injury reporting and provider searches.