PROCEDURE FOR WORKERS' COMPENSATION CLAIM FORMS

TO: Injured Employee

FROM: Director of Business Affairs

Attached you will find a packet of forms which need to be filled out in order to properly file an Injured Workers' Claim through the Bureau of Workers' Compensation.

Injured Employee:

A. 1. Notify your principal/administrative supervisor immediately. Take this packet of forms to St. John Westshore Hospital (preferred) or a hospital that accepts Workers' Compensation claims.

2. First Report of Injury, Occupational Disease or Death form – Fill out the first two sections (Injured Worker) and (Injury/Disease/Death). The hospital or doctor should make a copy and FAX that copy to CompManagement, Inc. at 614.766.6888.

B. ALL FORMS SHOULD BE COMPLETELY FILLED OUT AND RETURNED TO THE DIRECTOR OF BUSINESS AFFAIRS WITHIN A FEW DAYS OF THE INJURY.

1. Fill out form **Part I. Injured Employee's Statement.**
2. Fill out form **PART III. Authorization for Release of Medical Information.**
3. If you are not able to return to work on the following workday, fill out form **Part IV. Sick Leave Option.**

FAILURE TO FOLLOW THE ABOVE PROCEDURES MAY RESULT IN THE INJURED WORKER BEING HELD RESPONSIBLE FOR ANY CLAIMS RELATED TO THE INJURY BY THE BUREAU OF WORKER'S COMPENSATION.

ONGOING CARE (any treatment after initial visit) MUST BE PROVIDED BY A COMPMANAGEMENT, INC. PROVIDER IN ORDER TO ENSURE THE MEDICAL BILLS GET PAID.

If you have any questions while filling out this paperwork, please contact the Business Office at 440.835.6319.

WESTLAKE CITY SCHOOLS EMPLOYEE ACCIDENT REPORT

Part I: Injured Employee's Statement

I, _____, certify that on _____ at
(Name) (Date)

_____(AM or PM), I sustained an injury to my _____
(Part of Body)

which occurred as follows: (Please describe the accident in detail stating which part of body was injured) _____

_____

_____

_____

Have you had any previous accidents? ____ Yes ____ No If yes, when? _____

Part of body that was injured _____

Job Title: _____ Building:_____ Age:_____ Sex:____

Place accident occurred (i.e. building, grounds, etc.) _____

Did the accident occur on employer's property? ____ Yes ____ No

Name of Witnesses _____

To whom did you report the accident? _____

Date and Time Reported _____

Hospital and/or Doctor _____

Address of Hospital and/or Doctor _____

City _____ State _____ Zip _____ Phone: _____

Signature of Employee _____ Date: _____

Employee's Address _____

City _____ State _____ Zip _____ Phone:_____

Employee's Social Security Number _____

WESTLAKE CITY SCHOOLS EMPLOYEE ACCIDENT REPORT

PART II: Principal/Administrative Supervisor's Report
(Complete form and return to the Business Office)

Employee's Name: _____ Date of Injury _____

Nature of Injury (state employee's complaints and part of body that was injured) _____

_____

_____

How did the accident occur? _____

_____

Cause of the accident _____

_____

_____

Was the accident preventable? ___Yes ___No If yes, please explain _____

_____

_____

What action(s) was taken to prevent reoccurrence? _____

_____

Injured employee was sent to _____
(state name and address of doctor and/or hospital)

Did employee report back to work? ___Yes ___No Date returned to work _____

State employee's normal weekly work schedule _____

_____

_____ _____
Principal/Administrative Supervisor Signature Date

Revised Packet: 9/18/09

WESTLAKE CITY SCHOOLS EMPLOYEE ACCIDENT REPORT

Part III: Authorization for Release of Medical Information

Claim No.: _____

Date of Injury: _____

Date of Birth: _____

Claimant's Name: _____

Social Security Number: _____

Requested Condition(s): _____

As provided by Section 4123.651(C) of the Ohio Revised Code, I hereby permit the release of medical information, records, and reports relative to the issues necessary for the administration of my workers' compensation claim to my employer or their authorized representative, as such medical information, record and reports pertain to a condition allowed or requested in my claim, or to consider the payment or to determine the eligibility of payment of compensation and medical benefits under my workers' compensation claim.

_____
Signature of Claimant

_____
Date

WESTLAKE CITY SCHOOLS EMPLOYEE ACCIDENT REPORT

PART IV: Sick Leave Option

Employee's Name: _____

Date of Injury: _____

The purpose of this document is to notify any eligible employee who sustains a comprehensible workers' compensation injury of their right to elect to use accrued sick leave or the option of applying for Bureau of Workers' Compensation disability (temporary total compensation) benefits.

Sick leave can be used when there is an industrial injury.

The injured worker can, however, notify the employer of an election to stop using sick leave at a future date. The worker then files a request to the BWC for temporary total compensation accompanied by a statement from the employer as to the last day sick leave is paid.

OPTION 1	**OPTION 2**
I acknowledge the above and elect to receive accrued sick leave in lieu of compensation from the BWC. I also understand compensation can be elected for a period subsequent to sick leave period subsequent to sick leave benefits but benefits but may not overlap.	I acknowledge the above and elect to receive temporary total compensation from the Bureau of Workers' Compensation for which I may be eligible. (Note: A written request for Leave of Absence must accompany this form.)

---- Sign Only One ----

_____	_____
Employee's Signature	Employee's Signature
_____	_____
Date	Date

WESTLAKE CITY SCHOOLS EMPLOYEE ACCIDENT REPORT

Part V: Witness Statement
(Complete form and return to the Business Office)

Name of injured worker _____

Date of Injury _____ Time of Injury_____ (AM or PM)

Place of Injury _____

Nature of Injury _____

Description of Injury _____

_____

_____

Did you see the accident? _____

Describe how you became aware of the accident _____

_____

How was the accident described to you by the injured person? _____

_____

_____

Who else was aware of the accident? _____

Describe the part of body that you know was injured _____

_____

Describe any known previous injuries or problems this person has with the same part of the body _____

Any other information you wish to provide _____

_____

Print Name: _____

Signature: _____ Date: _____

Revised Packet: 9/18/09

CompManagement
Health Systems, Inc.

Key Contact Information

Medical Management Information

FAX Medical Information:
- 1-800-334-4229

MAIL Medical Information:
- CHS
  PO Box 1040
  Dublin, OH 43017

Prior Authorization:
- Fax C-9 form to
  1-800-334-4229

Medical Bill Payment Information

MAIL Medical Bills:
- CHS
  PO Box 1040
  Dublin, OH 43017

Billing Questions:
- Call CHS
  Customer Service
  toll-free 1-888-247-7799

Other Important Information

Prescriptions:
- For questions regarding prescriptions, contact SXC Health Solutions, toll-free at 1-800-OHIOBWC, press zero (0), select option three (3)

Provider Search:
- Visit www.chsmco.com for provider searches

PO Box 1040, Dublin OH 43017 | 7731 E. Kemper Rd., Cincinnati OH 45249 | 5700 Lombardo Center Drive, Ste 150, Seven Hills OH 44131 | 3454 Oak Alley Court, Ste 500 Toledo, OH 43606
Toll-free phone: 1-888-247-7799 | www.chsmco.com

WESTLAKE SCHOOLS OCCUPATIONAL HEALTH CLINICS

CUYAHOGA	Rocky River Urgent Care	19895 Detroit Rd	Rocky River, OH 44116	440-356-5500
CUYAHOGA	Ridge Park Urgent Care	7580 North Cliff Ave.	Brooklyn, OH 44144	216-363-2044
CUYAHOGA	Southwest General Urgicare - Brook Park	15900 Snow Rd ste 300	Brook Park, OH 44142	440-816-8744
CUYAHOGA	University Hospital Westlake Health Center	960 Clague Rd.	Westlake, OH	440-250-5366
LORAIN	EMH Medworks	39000 Center Ridge Rd	N Ridgeville, OH 44039	440-329-7490