

Injury reporting made easy!

Injured employee steps:

- 1** Immediately notify your employer of the injury.
- 2** Seek medical treatment from the nearest medical facility. A BWC-certified health-care provider must provide medical services after the initial treatment.
- 3** Show the MinuteMen OhioComp card to all medical providers treating your injury.
- 4** Complete the *BWC First Report of Injury* (FROI) form and any accident report that may be required by your employer.

Employer steps:

- 1** Complete the employer portion of BWC's *First Report of Injury* (FROI) form.
- 2** Fax the completed form to MinuteMen OhioComp at 1-888-644-7339.
- 3** Report the injury by phone to MinuteMen OhioComp at 1-888-644-6266 or 216-426-0646.

In an emergency, immediately notify your employer and seek treatment at the nearest medical facility. A BWC-certified healthcare provider must provide medical services after the initial treatment. Call MinuteMen OhioComp if you need help locating a BWC-certified medical provider.



INJURED WORKER IDENTIFICATION CARD

Please present to your medical provider when seeking initial medical treatment.



WORKERS' COMPENSATION IDENTIFICATION CARD

Employer Name:

Employer Risk/Policy No:

First Report of Injury • Case Management **1-888-644-6266**
Billing Questions

MEDICAL PROVIDER:

- Please Notify MinuteMen OhioComp For Pre-Authorization
- All Care Is To Be Based On Ohio Workers' Compensation Treatment Guidelines
- Treatment Should Be Rendered By An Ohio BWC - Certified / Enrolled Provider

Remit Bills To: 3740 Carnegie Ave., Ste. B200 • Cleveland, Ohio 44115
Claim Approval is Not Guaranteed

For Prescription-related matters, call 1-800-644-6292
www.bwc.ohio.gov



Attention: All Employees

What to do if you are injured on the job?

- 1. INJURED WORKERS: Immediately report the work-related injury or illness to your Supervisor.**
- 2. The work-related injury/illness is to be called within the work shift of the incident.** It is the responsibility of the employee and/or supervisor to see that this is done. You can call this number 24 hours a day and leave the required information on voice mail. The information required is as follows:
 - Name of Injured Worker
 - Date of Incident
 - Name of Supervisor
 - Work Phone Number
 - Time of Incident
 - Supervisor's Phone Number
 - Department/Agency
 - Name of Medical Provider
- 3. Submit work-related injury/illness report within 48 hours of incident to your agency/department workers compensation representative. Find your representative on the Workers Comp page under the Division of Employee Benefits website, hreb.summitoh.net.**
- 4. If you received medical attention inform the medical provider that you are receiving treatment for a work-related incident and that your MCO (managed care organization) is MinuteMen OhioComp.**
- 5. If your work-related injury/illness requires you to be off work for an extended period of time, please notify your Supervisor/Manager of your status.**

Preferred Workplace Injury Medical Providers

HOSPITALS

Akron City Hospital

525 East Market Street, Akron, Ohio 44309
(330) 375-3000

Western Reserve Hospital

1900 23rd Street, Cuyahoga Falls, OH 44223
(330) 971-7000

Akron General Medical Center

400 Wabash Avenue, Akron, OH 44307
(330) 344-6000

OCCUPATIONAL HEALTH

Concentra Urgent Care

1450 Firestone Parkway, Akron, OH 44301

Western Reserve Occupational Health

3913 Darrow Road, Suite 100, Stow, OH 44224
(330) 688-7900

Center for Corporate Health

1860 State Road, Suite C, Cuyahoga Falls, OH 44223

Crystal Clinic Quick Care

3975 Embassy Parkway, Suite 003, Akron, OH 44333
(330) 670-4242

Any questions you may have regarding workers' compensation benefits can be directed to Traci Badock at (330) 926-2496 of the County of Summit Division of Employee Benefits.

For questions regarding medical services, please contact your MCO, MinuteMen OhioComp at 1-888-644-6266



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.



HRD - DIVISION OF EMPLOYEE BENEFITS,
WORKERS COMPENSATION
1180 S. Main St., Suite 378
AKRON, OHIO 44301
Phone:(330)926-2496 ♦ Fax:(330)643-8625

INJURY/ILLNESS REPORT

**FORWARD ORIGINAL OF
THIS REPORT TO YOUR
AGENCY/DEPARTMENT
WORKERS COMPENSATION
REPRESENTATIVE**

PART I: EMPLOYEE'S STATEMENT (PLEASE PRINT, USE BLACK OR BLUE INK ONLY)

NAME _____ ADDRESS HOME _____
CITY _____ ZIP CODE _____ PHONE # (HOME) _____ PHONE # (WORK) _____
SS# _____ DATE OF BIRTH _____ AGE _____ MALE/FEMALE _____
AGENCY/DEPARTMENT EMPLOYED BY _____
JOB TITLE _____ COMPLETE ADDRESS OF WHERE YOU REGULARLY
REPORT TO WORK _____

DATE OF INJURY/ILLNESS _____ TIME OF INJURY/ILLNESS _____ AM/PM
DID THE INCIDENT OCCUR: BEFORE, DURING OR AFTER YOUR WORK SHIFT? _____
DID THE INCIDENT OCCUR WHILE AT WORK ON A NORMAL SHIFT OR WHILE ON OVERTIME? _____
DID THE INCIDENT OCCUR WHILE ACTUALLY ENGAGED IN WORK FOR THE COUNTY, WHILE COMING TO WORK, ON BREAK
OR LEAVING WORK? _____
COMPLETE ADDRESS OF LOCATION OF INJURY/ILLNESS _____

WAS THIS LOCATION ON THE EMPLOYER'S PREMISES? _____ YES _____ NO
DESCRIBE INJURY/ILLNESS (PART OF BODY EFFECTED AND NATURE OF INJURY OR ILLNESS) _____

IDENTIFY THE DUTIES PERFORMED WHEN THE ACCIDENT OR EXPOSURE OCCURRED _____

DESCRIBE IN DETAIL THE EVENTS WHICH RESULTED IN THE INJURY OR ILLNESS (FOR AN INJURY: WHAT WERE YOU DOING? HOW DID IT
HAPPEN? INCLUDE SPECIFIC OBJECTS, SUBSTANCES AND/OR MACHINES INVOLVED. IF YOU WERE LIFTING AN OBJECT, GIVE APPROXIMATE SIZE, WEIGHT AND DISTANCE
LIFTED. FOR AN ILLNESS: DESCRIBE THE SUBSTANCE AND DETAILS OF HOW YOU WERE EXPOSED TO THE SUBSTANCE AND TYPE OF WORK YOU WERE DOING.)

WAS THERE ANY PROPERTY DAMAGE? _____ YES _____ NO IF YES, WHAT PROPERTY WAS DAMAGED? _____

WERE THERE INJURIES TO OTHER EMPLOYEES OR THE PUBLIC? _____ YES _____ NO IF YES, WHO WAS INJURED?
(INCLUDE PHONE # WHERE INJURED PARTY CAN BE REACHED) _____

DID YOU RECEIVE MEDICAL TREATMENT? _____ YES _____ NO IF YES, DESCRIBE _____

NAME, COMPLETE ADDRESS AND PHONE # OF DOCTOR, HOSPITAL OR OTHER FACILITY PROVIDING SERVICE _____

NAME OF WITNESS(ES), COMPLETE ADDRESS AND PHONE # _____

WITNESS(ES) STATEMENTS ATTACHED? _____ YES _____ NO WHEN DID YOU REPORT THE INJURY/ILLNESS?

_____/_____/_____ TO WHOM DID YOU REPORT THE INJURY/ILLNESS? _____

DATE OF THIS REPORT ____/____/____ SIGNATURE OF EMPLOYEE _____

* IF YOU RECEIVE MEDICAL TREATMENT FOR YOUR INJURY/ILLNESS, PLEASE SUBMIT YOUR MEDICAL DOCUMENTATION TO YOUR SUPERVISOR WHEN YOU RETURN TO WORK.

PART II: SUPERVISOR'S REPORT

INJURED WORKER'S NAME _____

NATURE OF INJURY/ILLNESS (STATE EMPLOYEE'S COMPLAINTS) _____

REMARKS/OBSERVATIONS _____

DID EMPLOYEE DIE? _____ YES _____ NO DID EMPLOYEE REPORT BACK TO WORK? _____ YES _____ NO

IF YES, EMPLOYEE'S RETURN TO WORK DATE ____/____/____ IF THE EMPLOYEE HAS NOT RETURNED TO WORK, WHAT

IS THE ESTIMATED RETURN TO WORK DATE? ____/____/____

DATE INJURY/ILLNESS WAS REPORTED TO YOU? _____ TIME INJURY/ILLNESS WAS REPORTED TO YOU? _____ AM/PM

DID THE INJURED WORKER PROVIDE A MEDICAL RELEASE UPON RETURNING TO WORK? _____ YES _____ NO

PLEASE ATTACH THE MEDICAL RELEASE TO THE INJURY/ILLNESS REPORT FORM. (AN EMPLOYEE IS NOT PERMITTED TO

RETURN TO WORK UNLESS THEY SUBMIT A MEDICAL RELEASE FROM THEIR MEDICAL PROVIDER)

DID THE MEDICAL RELEASE INCLUDE RESTRICTIONS? _____ YES _____ NO

IF THE MEDICAL RELEASE INCLUDES RESTRICTIONS, DO THE RESTRICTIONS KEEP THE INJURED WORKER

FROM PERFORMING HIS/HER ORIGINAL JOB FUNCTIONS? (JOBS FUNCTIONS PERFORMED AT LEAST (1) ONE

TIME PER WEEK) _____ YES _____ NO

CAN THE EMPLOYER ACCOMMODATE THE INJURED WORKER RESTRICTIONS? _____ YES _____ NO

THE INJURED WORKER IS CLASSIFIED AS A (CHECK ONLY ONE)

_____ FULL-TIME _____ INTERMITTENT _____ PART-TIME _____ RELIEF WORK _____ OTHER

WHAT ACTIONS, EVENTS OR CONDITIONS CONTRIBUTED MOST DIRECTLY TO THIS ACCIDENT? _____

PRIOR TO THIS ACCIDENT, WERE ANY NEAR-MISSES REPORTED? _____ YES _____ NO IF SO DESCRIBE (INCLUDE DATES OF NEAR-MISSES)

DESCRIBE WHAT HAS BEEN DONE OR WILL BE DONE TO ELIMINATE OR MINIMIZE THE CAUSES LISTED ABOVE _____

SUPERVISOR'S NAME (PLEASE PRINT) _____

WORK NUMBER _____ E-MAIL ADDRESS _____

SUPERVISOR'S SIGNATURE _____

TITLE _____ DATE SIGNED ____/____/____

DEPARTMENT/DIVISION HEAD'S NAME (PLEASE PRINT) _____

WORK NUMBER _____ E-MAIL ADDRESS _____

DEPARTMENT/DIVISION HEAD'S SIGNATURE _____

TITLE _____ DATE SIGNED ____/____/____



SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES

THIS FORM CAN BE USED IN PLACE OF THE OSHA NO. 301P, AND IS TO BE USED TO SUPPLEMENT THE LOG AND SUMMARY OF OCCUPATIONAL INJURIES AND ILLNESSES (OSHA NO. 300P). EACH ESTABLISHMENT MUST MAINTAIN A RECORD OF EACH RECORDABLE OCCUPATIONAL INJURY OR ILLNESS. THIS REPORT MUST ALSO BE AVAILABLE IN THE ESTABLISHMENT WITHOUT DELAY AND AT A REASONABLE TIME FOR EXAMINATION BY A REPRESENTATIVE OF THE DEPARTMENT OF LABOR AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND STATES ACCORDED JURISDICTION UNDER THE ACT. OSHA RECORDS MUST BE MAINTAINED FOR A PERIOD OF NOT LESS THAN FIVE YEARS FOLLOWING THE END OF THE CALENDAR YEAR TO WHICH THEY RELATE.



TO BE COMPLETED BY THE WORKERS' COMPENSATION PERSONNEL [OSHA NO. _____]



If you're injured at work, we're here for you!

CLAIMS REPORTING

Notify your employer immediately and complete any required accident report.

Please report your injury to **MinuteMen OhioComp** within 24 hours.

Report an injury by phone:
1-888-644-6266 or
216-426-0646

Fax First Report of Injury to:
1-888-644-7339 or
216-426-0651

MEDICAL MANAGEMENT

Give this information to your doctor along with your **MinuteMen OhioComp** ID card.

Fax treatment requests (C-9) or medical reports to:
1-888-644-7339 or 216-426-0651

Mail medical information to:
MinuteMen OhioComp
3740 Carnegie Ave., Ste. B200
Cleveland, OH 44115

Medical Management questions:
Call 1-888-644-6266

MEDICAL BILL PAYMENT

MinuteMen OhioComp will pay injury related medical bills in approved claims.

Mail medical bills to:
MinuteMen OhioComp
3740 Carnegie Ave., Ste. B200
Cleveland, OH 44115

Billing questions:
Call 1-888-644-6266
ext. 1398

Prescription-related matters:
Call 1-800-644-6292

MINUTEMEN OHIOCOMP IS YOUR MCO! Visit minutemenmco.com to learn more about our services and support.