Bureau of Workers' Compensation

Request for Injured Worker Outpatient Medication Reimbursement (C-17)

The Request for Injured Worker Outpatient Medication Reimbursement (C-17) form is used for medication reimbursement. The medication must be written as a prescription and dispensed by an enrolled pharmacy. Medication bought at a physician's office for at-home use is not reimbursable. A C-17 is not used for medical supplies, durable medical equipment, and other non-drug items. These items should be billed directly to the managed care organization (MCO).

Instructions – to avoid submitting a C-17, the pharmacy can process a point-of-sale transaction.

- A separate C-17 is required for each pharmacy.
- Complete all sections **including injured worker and pharmacist signature.**
- Prescription labels or a pharmacy printout with pricing information must be sent. Photocopies are acceptable. A pharmacy cash register receipt **is not** acceptable.
- BWC must receive the C-17 within **one year** from the date of service.
- Mail, email, or fax the completed C-17 and prescription labels with pricing information to **BWC**.

Mailing Address	BWC Pharmacy 30 W. Spring Street L21 Columbus, Ohio 43215
Email	Pharmacy.benefits@bwc.ohio.gov
Fax	1-866-213-6066

Questions – call BWC Pharmacy at 1-877-543-6446.

Reimbursement – to avoid a delay in reimbursement, wait to submit the C-17 until after BWC has approved the claim.

- BWC's pharmacy benefits manager will mail a check for reimbursement or a letter explaining why reimbursement could not be processed.
- Reimbursement will be considered for prescriptions that meet the requirements of BWC's outpatient medication formulary and payment rules.
- Brand name medications are reimbursed at the generic drug price when a generic medication was available.

C-17 reminders

- ☐ Complete every section on the form including both signatures.
- ☐ Include the pharmacy labels or a pharmacy printout with pricing information.
- ☐ **A pharmacy cash register receipt is not acceptable.**
- ☐ Confirm that BWC has approved your claim.
- ☐ Confirm your address is up to date in your claim.
- ☐ Submit completed C-17 and documentation to BWC.

Bureau of Workers' Compensation

Request for Injured Worker Outpatient Medication Reimbursement (C-17)

Injured worker information

Date of request	Date of injury	BWC claim number

Injured worker name	Phone number

Injured worker address *(street or PO Box, city, state, and zip code)*

Pharmacy information

Pharmacy *(name and store number)*	NPI number	Pharmacy phone

Pharmacy address *(street or P.O. Box, city, state, and ZIP code)*

Prescription detail

Date Rx written	Date of service	Prescription number	Rx out-of-pocket amount paid ($)

Drug name, strength, and dosage form	National drug code (NDC)	Quantity

Days' supply	Prescriber's name	Prescriber's NPI number

Date Rx written	Date of service	Prescription number	Rx out-of-pocket amount paid ($)

Drug name, strength, and dosage form	National drug code (NDC)	Quantity

Days' supply	Prescriber's name	Prescriber's NPI number

Date Rx written	Date of service	Prescription number	Rx out-of-pocket amount paid ($)

Drug name, strength, and dosage form	National drug code (NDC)	Quantity

Days' supply	Prescriber's name	Prescriber's NPI number

Date Rx written	Date of service	Prescription number	Rx out-of-pocket amount paid ($)

Drug name, strength, and dosage form	National drug code (NDC)	Quantity

Days' supply	Prescriber's name	Prescriber's NPI number

Any person who obtains compensation, medical, or pharmaceutical benefits from BWC or self-insuring employers by knowingly misrepresenting orconcealing facts, making false statements, or accepting compensation, medical, or pharmaceutical benefits to which he/she is not entitled, is subject to felony criminal prosecution for fraud. By signing below, I certify I have read and understand the statements above and agree with these conditions.

I certify below the information on this form is true and correct to the best of my knowledge and belief.

Injured worker's signature	**Date**
Pharmacist's signature	**Date**

Bureau of Workers' Compensation

Physician's Report of Work Ability (MEDCO-14)

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 ***last*** appointment/examination	Date of ***this*** appointment/examination	Date of ***next*** appointment/examination

1 Submission type (Select one of the options below.)

☐ Initial MEDCO-14. ***Proceed to Section 2.***
☐ Subsequent MEDCO-14, **no** changes ***Proceed to Section 6.***
☐ Subsequent MEDCO-14, **with changes.** Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.

2 Job description and work status ☐ Reporting changes from last evaluation ☐ No changes

- Have you reviewed the injured worker's job description? ☐ Yes ☐ No
  - **If yes,** who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC
- Does the injured worker have any physical or health restrictions **related to the allowed conditions in the claim** on the date of this exam? ☐ Yes ☐ No
  - **If yes,** are the restrictions: ☐ Permanent? ☐ Temporary?
  - **If no,** check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ ***Proceed to Section 6.***
- 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? ☐ Yes ☐ No
  - **If yes,** ***Proceed to Section 6.***
  - **If no,** provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. ***Proceed to Section 3.***

3 Disability information ☐ Reporting changes from last evaluation ☐ No changes

Complete the chart below for all **work-related allowed conditions being treated**.

Narrative description of the **work-related allowed condition**	Site/Location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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

Injured worker name	Claim number	Date of injury

4 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**

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

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

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.*

6 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.

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

Ohio | 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:** 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.

Injured worker information

First name, middle initial, last name	Date of injury/disease	Social Security number	Date of birth

Mailing address; add apartment number or P.O. Box, if applicable	City	State	ZIP code

Sex ☐ Male ☐ Female	Email address	Home phone number	Cell phone number

Employer name	Employer address	City	State	ZIP code
UT Health Science Campus				

Was the injured worker hired through a temp agency? ☐ Yes ☐ No If yes, name of temp agency	Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	Regular work hours (include a.m. p.m.) From To

Date hired	Job title	State where hired	State where supervised	Wage rate; $ per hour	Number of hours scheduled to work the week of this injury

Work number for call-offs (Number injured worker calls to reach supervisor)	Part(s) of body affected (For example: Left knee, right index finger)

Accident description (Describe the sequence of events that directly caused the injury or death.)	**Will the incident cause the injured worker to miss 8 or more days from work?** ☐ Yes ☐ No

Injured worker start time _____ ☐ am ☐ pm	Time of injury _____ ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ Yes ☐ No	Date last worked	If the injured worker has returned to work, provide the date.

Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.	Was injured worker hospitalized overnight? ☐ Yes ☐ No

Initial treatment date	Health-care office/Facility name	Treating physician/Provider name	Telephone number	Fax number

Health-care office/Facility street address	City	State	ZIP code

If the injury resulted in death, answer the following.

Date of death Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

To be completed by the injured worker

By signing this form, I:

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**
- **Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**
- **Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**

Furthermore, I understand that:

- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation.
- Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).

I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.

Injured worker signature	Date

To be completed by the treating provider

Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). **Important:** If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".

Initial treatment date	Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ No

Treating physician/Provider's name (Print)	Treating physician/Provider's signature	BWC provider number	Date

To be completed by the employer

Employer name	Employer county	Phone number	Fax number	Email address
UNIVERSITY TOLEDO HEALTH SCIENCE	Lucas			

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation
10003148		

For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.

For self-insuring employers only: ☐ Medical only ☐ Lost time

Clarification – I clarify and allow the claim for the condition(s) below.

Employer signature and title	Date

To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer

Signature of person completing this form	Date