



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.



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	
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 or concealing 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



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



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