Ohio | Bureau of Workers' Compensation

Orrville Safety Council

First Report of Injury & Early Reporting

Completing the FROI

- What do you want?
- Who can file a claim?
- How do you file?
- Parties involved?

Claim Allowance

- Four Elements of Compensability
  - Employer/employee relationship
  - Accidental in character
  - In the course of employment
  - Arising out of employment

  - Injured Worker: prove <u>all four</u>
  - Employer: disprove <u>one</u>

Last name, first name, middle initial			Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address			Sex ☐ Male ☐ Female		Number of dependents
City	State	9-digit ZIP code	Country if different from USA		Department name
Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____			What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From _____ To _____
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.					Occupation or job title

Employer name					
Mailing address (number and street, city or town, state, ZIP code and county)					
Location, if different from mailing address					
Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No (If no, give accident location, street address, city, state and ZIP code)					
Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified		State where supervised

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)	Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature	Date	E-mail address	Telephone number	Work number ( )

Completing the FROI

Health-care provider name	Telephone number ( )	Fax number ( )	Initial treatment date
Street address	City	State	9-digit ZIP code
Diagnosis(es): Include ICD code(s)			
Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No		
E code	11-digit BWC provider number	Date	
Health-care provider signature			

Completing the FROI

Employer policy number		**Check if** ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm		
Telephone number ( )	Fax number ( )	E-mail address	Federal ID number	Manual number
Was employee treated in an emergency room? ☐ Yes ☐ No		Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No		
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code				
☐ **Certification** - The employer certifies that the facts in this application are correct and valid.		☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:	**For self-insuring employers only** ☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below: ☐ **Medical only** ☐ **Lost time**	
Employer signature and title			Date	OSHA case number

Early Reporting Benefits

- Fresh and accurate
- Open & improved communication
- Accurate assessment
- Early determination
- Mitigated stress

Early Reporting Benefits

- Proper treatment
- Improved outcomes
- Reduced complexity
- Timely benefits
- Lower overall costs

Questions

- Claims Service Specialist or MCO
- Employer Service Specialist

- Scott St. Clair
  - scott.s.1@bwc.state.oh.us
  - 740-435-4251

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