Employer: KENT STATE UNIVERSITY
Risk: 10003142000

BWC website: www.bwc.ohio.gov

Workers’ Compensation Managed Care

TO REPORT AN INJURY CONTACT:

Customer Service & Treatment Approval:
(440) 899-2400 or 1-800-542-9479

Fee bills should be submitted to:

Spooner Medical Administrators, Inc.
28301 Ranney Parkway
Westlake, OH 44145
By signing this form, I:

• Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers’ compensation laws;
• Waive and release my right to receive compensation and benefits under the workers’ compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;
• Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;
• Confirm that I have not received compensation and/or benefits under the workers’ compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.

Injured worker and injury/disease/death info.

Last name, first name, middle initial ___________________________ ___________________________ ___________________________

Home mailing address ___________________________ ___________________________ ___________________________

City ___________________________ State ___________________________ 9-digit ZIP code ___________________________

Wage rate ___________________________ Per: ______ Hour ______ Month ______ Week ______

What days of the week do you usually work? ______ Sun ______ Mon ______ Tues ______ Wed ______ Thur ______ Fri ______ Sat ______

Date of injury/disease ______ Time of injury ______ a.m. ______ p.m. ______

If fatal, give date of death ______ 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.) ___________________________ ___________________________ ___________________________

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 ___________________________ ___________________________ ___________________________

Health-care provider name ___________________________ ___________________________ ___________________________

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 ___________________________ ___________________________ ___________________________

Employer name ___________________________ ___________________________ ___________________________

Mailing address (number and street, city or town, state, ZIP code and county) ___________________________ ___________________________ ___________________________ ___________________________

Location, 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 ___________________________ 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.) ___________________________ ___________________________ ___________________________

Employer policy number ___________________________ 10-digit BWC provider number ___________________________ Date ___________________________

Telephone number ___________________________ Fax number ___________________________ E-mail address ___________________________

Federal ID number ___________________________ Manual number ___________________________ ___________________________

Employer signature and title ___________________________ ___________________________ ___________________________

BWC-1101 (Rev. 6/12/2014)

FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)
Injured worker name
Claim number

<table>
<thead>
<tr>
<th>Date of injury</th>
<th>Date of last appointment/examination</th>
<th>Date of this appointment/examination</th>
<th>Date of next appointment/examination</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**MEDCO-14 submission** (Select one of the options below.)

1. □ I have never completed a MEDCO-14. **Proceed to section 2.**
   □ I have previously completed a MEDCO-14, and all of the information remains the same. **Proceed to and complete section 8.**
   □ I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

**Employment/Occupation** (Complete this section and proceed to section 3.)

2. Have you reviewed the description of the injured worker’s job held on the date of injury (former position of employment)? Yes □ No □
   If yes, please indicate who (select all sources) provided the job description: □ Injured worker □ Employer □ MCO □ BWC

**Work status/Injured worker’s capabilities**

3A. Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes □ No □
   If yes, are the restrictions: □ Permanent □ Temporary **Proceed to section 3B.**
   If no, please check the box to indicate that the injured worker is released to work as of the date of this exam. □ **Proceed to section 8.**

3B. If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes □ No □
   If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. □ **Proceed to section 8.**
   If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
   Date: _____/_____/_____.
   Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.
   Date: _____/_____/_____.

**Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No).**
   If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible work return date to work: _____/_____/_____.
   The injured worker can perform: **Proceed to section 8.**
   The injured worker can perform simple grasping with: □ Left hand □ Right hand □ Both
   The injured worker can perform repetitive wrist motion with: □ Left hand □ Right hand □ Both
   The injured worker’s dominant hand is: □ Left □ Right
   The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: □ Left foot □ Right foot □ Both
   If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:
   * Operate heavy machinery: □ Yes □ No
   * Drive: □ Yes □ No
   * Perform other critical job tasks as defined by any source listed above in section 2: □ Yes □ No

**Please indicate the following:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>N</th>
<th>O</th>
<th>F</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bend</td>
<td>0</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach above shoulder</td>
<td>0</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type/keyboard</td>
<td>20</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with cold subst</td>
<td>40</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with hot subst</td>
<td>60</td>
<td>100</td>
<td>100</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>N</th>
<th>O</th>
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<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Climb</td>
<td>60</td>
<td>100</td>
<td>100</td>
<td></td>
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</table>

How many total hours can the injured worker work: _____ per week _____ per day?

In an eight-hour workday, how many total hours can the injured worker: Sit: _____ hours □ Continuously □ With break
   Walk: _____ hours □ Continuously □ With break Stand: _____ hours □ Continuously □ With break

Does the injured worker have any functional restrictions based only on allowed psychological conditions? □ Yes □ No
   If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.

Additionally, in this space, please provide any additional information addressing the injured worker’s capabilities and/or job accommodations which may not be addressed above.

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

Proceed to section 4.
**Disability Information**

Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

<table>
<thead>
<tr>
<th>Narrative description of the work-related allowed condition</th>
<th>Site/location if applicable</th>
<th>ICD code</th>
<th>Is the condition preventing full duty release to the job injured worker held on the date of injury?</th>
</tr>
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<tbody>
<tr>
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<td>Yes □ No □</td>
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<td>Yes □ No □</td>
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<td>Yes □ No □</td>
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<td>Yes □ No □</td>
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<td>Yes □ No □</td>
</tr>
</tbody>
</table>

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

5 The injured worker is progressing: □ As expected □ Better than expected □ Slower than expected

Provide your clinical and objective supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker’s delay in recovery.

6 Maximum Medical Improvement (MMI)

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 above? □ Yes □ No

If yes, give MMI date: ______/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

7 Vocational Rehabilitation

Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker’s restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? □ Yes □ No

If no, please explain why and provide your recommendations to help the injured worker return to employment.

8 Treating Physician Signature - Mandatory

I certify the information on this form is correct to the best of my knowledge. I am aware that anyone 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 (please print legibly)

Address, city, state, nine-digit ZIP code

Treating physician’s signature

BWC provider (Peach) number

Date

Telephone number

Fax number
I just got injured at work, What do I need to know?

❖ Spooner Medical Administrators, Inc. is the company that your employer selected to help with their workers’ compensation claims.
  o We will call you first to answer any questions you have and also call your employer to let them know how you are doing.

❖ The Ohio Bureau of Workers’ Compensation is in charge of approving your claim and will send you a letter with their decision about your claim.

❖ You will receive a letter with a medical card from the BWC that can be used for work-related injuries.
  o If you need to see a doctor because of your injury, then you should show the doctor the card for their file.

❖ The doctor that treats you must be certified by the Ohio Bureau of Workers’ Compensation.
  o If needed, we can assist you with finding a doctor.

❖ The doctor must get our approval for more treatment after the initial visit.

❖ You are not required to pay the doctor for approved treatment for your allowed workers’ compensation claim.
  o If you receive a bill, call our office.
  o If you have paid for medical services out of your own pocket, then you can apply for reimbursement by sending the bill and proof of payment to our office. Please note that online purchases (i.e. Amazon) do not qualify for reimbursement and not all purchases will qualify. Call your case manager before making any purchases.

❖ The Bureau of Workers’ Compensation is in charge of paying for your medication for your work injury.

❖ The Bureau of Workers’ Compensation is in charge of calculating payment for lost work time that meets their guidelines.

Spooner Medical Administrators, Inc. services include case management, prior authorization of medical treatment and payment of medical bills. Contact us with any question you have about your claim or the workers’ compensation process.

Spooner Medical Administrators, Incorporated
Phone (440)899-2400 or (800)542-9479
Fax (440)899-2411 or (800)542-9480
www.spoonermai.com

Fee bills should be submitted to:
28301 Ranney Parkway
Westlake, Oh 44145
EMPLOYEE’S REPORT OF INJURY
(To be completed and signed by the employee)

Company name ___________________________ Division ___________________ Clock No. __________
Name (print) ______________________________ Date of birth ____________________________
Address _________________________________ City ___________________________ State ______ Zip ______
Phone number (_____) ______________________ Department __________________ Date of hire ______
Date of Injury ____________________________ Time: A.M. __________________ Date injury reported ______
To whom did you report the injury? __________________________________________________________
Where were you when the injury occurred? __________________________________________________
Witness(es): __________________________________________________________________________
What activity were you performing when the injury occurred? _________________________________
(example: lifting, pushing, etc.) ____________________________________________________________
Describe how the injury happened: __________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Type of injury and what body part was injured? ______________________________________________
(On the back of this form draw a circle around the exact part of the body which was injured)
Give name and address of treating physician/hospital: __________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Have you had prior claims or treatment related to the same body part (s)? Yes _____ No _____
This is my description of the accident. 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 the Industrial Commission of Ohio, the Ohio Bureau of Workers’ Compensation, the employer and its authorized representative, Spooner, Inc., as such medical information, records and reports may possibly pertain to a condition either allowed or alleged in my claim, or to consider payment or to determine the eligibility of payment of compensation and medical benefits under my Workers’ Compensation claim. A copy shall be as good as the original.

Employee’s Signature __________________________________________________ Date form completed ______

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