



**MINUTEMEN**  
**EOR SOLUTIONS**  
WORKFORCE MANAGEMENT SERVICES

## Work Injury Report

**Please submit injury report to:**

Vince Fazio  
vincent.fazio@minutemenhr.com  
216-452-0100

Jessica Urbaniak  
jessica.urbaniak@minutemeneor.com  
216-672-4282

Minutemen EOR Solutions  
3740 Carnegie Ave. Cleveland, OH 44115

# 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](http://www.bwc.ohio.gov)



Submit the form to BWC in one of the following ways. Online: 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.

## EMPLOYEE'S STATEMENT

I, \_\_\_\_\_ certify that on \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ (a.m. or p.m.), I  
(Name) (Date) (Time)

sustained an injury to my \_\_\_\_\_ that occurred as follows:  
(Part of Body)

(Describe the incident in detail, stating part of body injured) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has this body part been previously injured?  Yes  No If yes, when? \_\_\_\_\_

Place incident occurred \_\_\_\_\_

Did the incident occur while you were working (on the clock)?  Yes  No

Did the incident occur while you were performing your regularly assigned job/duty?  Yes  No

Did the incident occur on employer's property?  Yes  No

Name(s) of Witness(s) \_\_\_\_\_

Date/Time and to whom the accident was reported to \_\_\_\_\_

Name of Medical Provider and Treating Physician \_\_\_\_\_

Provider Address \_\_\_\_\_ Provider Phone # \_\_\_\_\_

Employee address \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Hire \_\_\_\_\_

Building/Occupation \_\_\_\_\_ Supervisor \_\_\_\_\_

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

# ANATOMY FORM

Instructions for Employee:

Please circle the injured body part(s) then sign and date this form.

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date





Instructions

- Please print or type.
List the provider(s) you are authorizing to release medical records in the space indicated on this form.
Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

You can obtain this form online at www.bwc.ohio.gov

C-101 - Authorization to Release Medical Information: Injured workers should use this form to authorize the release of medical records relative to their work-related injury(s). By signing this form, the injured worker authorizes medical providers who have rendered services relative to the injury to release information to BWC, the Industrial Commission, the employer, the managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives. The form is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), although BWC is exempt from HIPAA requirements.

Form with fields: Injured worker name (first, M.I., last), Date of injury, Claim number, Address, City, State, Nine-digit ZIP code, Employer name, Employer MCO or QHP

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (

\_\_\_\_\_ ) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Form with fields: Injured worker (or guardian or personal representative) signature, Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. \_\_\_\_\_



**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 <b>last</b> appointment/examination		Date of <b>this</b> appointment/examination	Date of <b>next</b> appointment/examination
<b>Submission type (Select one of the options below.)</b>			
<b>1</b>	<input type="checkbox"/> Initial MEDCO-14. <b>Proceed to Section 2.</b> <input type="checkbox"/> Subsequent MEDCO-14, <b>no</b> changes <b>Proceed to Section 6.</b> <input type="checkbox"/> Subsequent MEDCO-14, <b>with changes.</b> Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.		
<b>Job description and work status</b>		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes	
<b>2</b>	<ul style="list-style-type: none"> <li>• Have you reviewed the injured worker's job description?   <input type="checkbox"/> Yes   <input type="checkbox"/> No           <ul style="list-style-type: none"> <li>○ <b>If yes</b>, who provided the job description   <input type="checkbox"/> Injured worker   <input type="checkbox"/> Employer   <input type="checkbox"/> MCO/BWC</li> </ul> </li> <li>• Does the injured worker have any physical or health restrictions <b>related to the allowed conditions in the claim</b> on the date of this exam?   <input type="checkbox"/> Yes   <input type="checkbox"/> No           <ul style="list-style-type: none"> <li>○ <b>If yes</b>, are the restrictions:   <input type="checkbox"/> Permanent?   <input type="checkbox"/> Temporary?</li> <li>○ <b>If no</b>, check the box to indicate the injured worker is released to return to full duty as of the date of this exam.   <input type="checkbox"/></li> </ul> <b>Proceed to Section 6.</b> </li> <li>• 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?   <input type="checkbox"/> Yes   <input type="checkbox"/> No           <ul style="list-style-type: none"> <li>○ <b>If yes</b>, <b>Proceed to Section 6.</b></li> <li>○ <b>If no</b>, provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____.</li> </ul> <b>Proceed to Section 3.</b> </li> </ul>		
<b>Disability information</b>		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes	
Complete the chart below for all <b>work-related allowed conditions being treated.</b>			
<b>3</b>	Narrative description of the <b>work-related allowed condition</b>	Site/Location if applicable	ICD code
			Is the condition preventing full duty release to the job injured worker held on the date of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
List all other conditions that <b>impact treatment</b> of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).			

Injured worker name	Claim number	Date of injury
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<b>Abilities, clinical findings, and recovery progression</b>	<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes																																																									
<ul style="list-style-type: none"> <li>• Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Dominant hand: <input type="checkbox"/> Right <input type="checkbox"/> Left</li> <li>• Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.</li> </ul>																																																										
<b>Frequency scale</b>	<b>Strength level (lbs.)</b>	<b>Body side indicator</b>																																																								
<b>N</b> = Never <b>S</b> = Seldom 0-1 hour <b>O</b> = Occasional 1-3 hours <b>F</b> = Frequent 3-6 hours <b>C</b> = Constant 6-8 hours	<b>S</b> = Sedentary 0-10 <b>L</b> = Light 0-20 <b>M</b> = Medium 0-50 <b>H</b> = Heavy 0-100 <b>VH</b> = Very heavy >100	<b>L</b> = Left <b>R</b> = Right <b>B</b> = Both  <small>*Indicate limitations ONLY</small>																																																								
<b>4</b>	<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width:10%;">Activity</th> <th style="width:15%;">Frequency</th> <th style="width:15%;">Activity</th> <th style="width:15%;">Strength</th> <th style="width:15%;">Frequency</th> <th style="width:15%;">Activity</th> <th style="width:10%;">Side</th> </tr> </thead> <tbody> <tr> <td>Sit</td> <td>N S O F C</td> <td>Floor lift (0-17")</td> <td>S L M H VH</td> <td>N S O F C</td> <td>Front/Lateral reach</td> <td>L R B</td> </tr> <tr> <td>Stand/Walk</td> <td>N S O F C</td> <td>Knee lift (18-29")</td> <td>S L M H VH</td> <td>N S O F C</td> <td>Overhead reach</td> <td>L R B</td> </tr> <tr> <td>Climb stairs</td> <td>N S O F C</td> <td>Waist lift (30-36")</td> <td>S L M H VH</td> <td>N S O F C</td> <td>Wrist flex/extension</td> <td>L R B</td> </tr> <tr> <td>Squat/Kneel</td> <td>N S O F C</td> <td>Chest lift (37-60")</td> <td>S L M H VH</td> <td>N S O F C</td> <td>Grasp</td> <td>L R B</td> </tr> <tr> <td>Crawl</td> <td>N S O F C</td> <td>Overhead lift (&gt;60")</td> <td>S L M H VH</td> <td>N S O F C</td> <td>Finger manipulation</td> <td>L R B</td> </tr> <tr> <td>Twist</td> <td>N S O F C</td> <td>Push/Pull</td> <td>S L M H VH</td> <td>N S O F C</td> <td>Keyboarding</td> <td>L R B</td> </tr> <tr> <td>Bend/Stoop</td> <td>N S O F C</td> <td>Carry</td> <td>S L M H VH</td> <td>N S O F C</td> <td>Operate foot controls</td> <td>L R B</td> </tr> </tbody> </table>		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
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<ul style="list-style-type: none"> <li>• Injured worker can work _____ hours per day and _____ hours per week.</li> <li>• Are there any functional restrictions based only on the allowed psychological conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No           <ul style="list-style-type: none"> <li>○ If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.</li> </ul> </li> <li>• 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).</li> </ul> <p><b>Comments:</b></p>          <p><b>Health and Behavioral Assessment:</b> (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.)</p> <ul style="list-style-type: none"> <li>• Is the injured worker's recovery not progressing, or progressing slower than expected? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p><b>Vocational rehabilitation</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<b>Maximum medical improvement (MMI) status</b>	<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes
<p><b>5</b> <b>MMI</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• <b>If yes</b>, give MMI date: ____/____/____. <b>Note:</b> 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.</li> </ul>	

<b>Treating physician's signature – mandatory (See exceptions at the top of the form.)</b>			
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



# 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](http://minutemenmco.com) to learn more about our services and support.

## SUPERVISOR'S REPORT

Employee Name \_\_\_\_\_ Employee Phone Number \_\_\_\_\_

Date and Time of Injury \_\_\_\_\_ Job Title \_\_\_\_\_ Hourly Rate \_\_\_\_\_

Job Description \_\_\_\_\_

Regular Workdays \_\_\_\_\_ Shift Start and End Time \_\_\_\_\_

Nature of Injury (State employee's complaints and body part injured)

In view of a camera? \_\_\_\_\_

Cause of the incident? \_\_\_\_\_

Did employee leave worksite to seek treatment?    Yes        No

Time employee left \_\_\_\_\_

Was the incident preventable?    Yes        No

If yes, explain \_\_\_\_\_

What actions have been taken to prevent a re-occurrence of incident? \_\_\_\_\_

Where was employee sent for treatment? \_\_\_\_\_

Did employee report back to work?    Yes        No

Does Employee have work restrictions? (List) \_\_\_\_\_

Date returned to work \_\_\_\_\_ In what capacity?     Full Duty     Light Duty

Address Where Accident Took Place \_\_\_\_\_

Do you certify this claim?    Yes        No

Supervisor's Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor's Phone \_\_\_\_\_

## WITNESS STATEMENT

Name of injured worker: \_\_\_\_\_

Date of injury \_\_\_\_\_ Time of injury: \_\_\_\_\_ (a.m. or p.m.)

Place of injury: \_\_\_\_\_

Description of injury: \_\_\_\_\_

Description of how injury occurred: \_\_\_\_\_

\_\_\_\_\_

Did you see the accident?  Yes  No

Describe how you became aware of the incident \_\_\_\_\_

\_\_\_\_\_

How did the injured person describe the accident to you? \_\_\_\_\_

\_\_\_\_\_

Who else was aware of the accident? \_\_\_\_\_

Was the injured employee on the clock or on duty when the incident occurred? \_\_\_\_\_

Describe any known previous injuries or problems this person has with the same part of the body:

\_\_\_\_\_

Any other information you wish to provide? \_\_\_\_\_

\_\_\_\_\_

Witness's Name \_\_\_\_\_ Witness's Address \_\_\_\_\_

Witness's Phone: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_