Franklin County
Where Government Works

In this packet you will find:

1. Self-Insured Injury Report form (ARFIE)
2. Medical Release of Information Authorization
3. Workers' Compensation and Injury Identification Card
4. First Fill Pharmacy Card
5. MEDCO-14 Physicians Report of Workability
6. Medical Provider Locations

Franklin County Injury Packet

Revised 9/2016

Franklin County
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What happens if I'm injured at work?

1. Immediately notify your supervisor and seek medical treatment if necessary.

2. Complete the enclosed ***Accident Report (ARFIE)*** as soon as possible and send to Risk Management via email Risk@franklincountyohio.gov or by fax to 614-525-5715.

3. Fax the ***Authorization to Furnish Medical Records and Disclose Professional and Personal Information*** form to **Sedgwick, CMS at 614-658-0901.**

4. Refer to your Injury Packet for a list of ***BWC Certified medical providers*** and a ***Helios First fill Pharmacy*** card to cover any prescription purchases you need.

5. If you are seeking medical treatment, take your ***Workers' Compensation Identification card*** (included in packet) to all appointments. This card explains billing procedures and will minimize potential billing issues.

6. Please contact Risk Management with any questions you may have.
   Jerry Bower, Risk Manager **614-525-4642**
   Jenell Williams, Business Service Officer **614-525-6629**

In emergency cases, notify your supervisor and seek treatment immediately

What happens if my employee is injured at work?

1. Complete the supervisor section of the ***Accident Report (ARFIE)***. In case of severely disabling (life or death) traumatic injuries that require immediate hospitalization or if the employee is incapacitated, the supervisor shall complete the Accident Report (ARFIE) on behalf of the injured employee with as much information as possible and transmit it to Risk Management.

2. Send end completed forms to Risk Management via **Fax 614-525-5715 or Email Risk@franklincountyohio.gov**

All workplace deaths must be reported to the Public Employers' Risk Reduction Program (PERRP) at 1-800-671-6858 within 24 hours.

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FRANKLIN COUNTY RISK MANAGEMENT SELF-INSURED
Accident Report Form for INJURED EMPLOYEES (ARFIE)

AGENCY:	FRANKLIN COUNTY SI RISK NO. **20005728**	MUNIS Org:

Injured employee information

EMPLOYEE NAME:	SOCIAL SECURITY NO:	HIRE DATE: MM/YY	
HOME ADDRESS:	HOME or CELL PHONE:	AGE:	Date of Birth
CITY, COUNTY, STATE, ZIP CODE	WORK PHONE:	JOB TITLE:	

Accident information to be completed by injured person

SPECIFIC LOCATION WHERE ACCIDENT OR INJURY OCCURED:	DATE OF INJURY:	Time of Injury: _____ am/pm
DID ACCIDENT/INJURY OCCUR ON COUNTY PROPERTY? Yes ☐ No ☐	DATE REPORTED:	WORK SHIFT:
JOB DUTIES BEING PERFORMED AT TIME OF INJURY:	SUPERVISOR'S NAME:	
DID INJURED PARTY RETURN TO WORK? Yes ☐ No ☐ Date: _____	WAS MEDICAL TREATMENT SOUGHT? YES ☐ NO ☐	SUPERVISOR'S PHONE NO.
DESCRIBE ACCIDENT: In your own words, explain in detail how accident occurred [Use additional blank pages if necessary].		

INJURED BODY PART(S) (example: left arm, right index finger, upper left thigh)

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

Employee Signature #1: I certify that the information on this injury report is true and complete to the best of my knowledge.

Employee Signature Date

Employee Signature #2: 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 all relevant medical information, records and reports, relative to the issues necessary for the administration of my workers' compensation claim to the Industrial Commission, the Ohio Bureau of Workers' Compensation, the employer and its authorized representatives.

Employee Signature Date

Email completed form to risk@franklincountyohio.gov or fax to (614) 525-5715

Revised 9/2016

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FRANKLIN COUNTY RISK MANAGEMENT SELF-INSURED
Accident Report Form for INJURED EMPLOYEES (ARFIE)

ACCIDENT INFORMATION COMPLETED BY INJURED WORKER AND/OR SUPERVISOR

1. Was medical attention sought for the injury(s) sustained? Yes ☐ No ☐

If yes, list the doctor and/or the medical provider:

Doctor or Medical Provider :		Telephone:	
Address	City:	State:	Zip Code:

2. Did any other person witness the accident or injury? Yes ☐ No ☐
If yes, list their name(s) below:

a. _____ b. _____

b. _____ d. _____

3. Was more than one person injured in this accident? Yes ☐ No ☐
If yes, list their name(s) below:

a. _____ b. _____

c. _____ d. _____

4. Was any workplace machinery/equipment involved? Yes ☐ No ☐

If yes, list here:

Manufacturer:	Model:
Has equipment been modified? Yes ☐ No ☐ Do not know ☐	If yes, what was modified?

5. Was the injury caused by any outside contractor(s) or repair company(s)? Yes ☐ No ☐

If yes, please provide the following:

Name of Firm **Address of Firm** **City, State, Zip** **Telephone No.**

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FRANKLIN COUNTY RISK MANAGEMENT SELF-INSURED
Accident Report Form for INJURED EMPLOYEES (ARFIE)

6. Was this injury the result of an automobile accident? Yes ☐ No ☐
If you answered yes to Question 6, you are required to provide a copy of the local police auto accident report.

If you answered yes to Question 6, were you cited for any moving violation(s)? Yes ☐ No ☐

If yes, list the violation(s)

Once the employee fills out his/her portion of this report, the report should be forwarded to the Supervisor for completion.

Supervisor's Section: The Supervisor should review the accident report and the details of the accident as submitted by the employee. The Supervisor should provide relevant information including additional details, witness name(s), comments and/or dispute any or all of the injured party's statements or description of the accident in the space provided below. Attach additional pages if necessary.

Supervisor's Statement: As supervisor of the injured employer, I have reviewed this accident report and my comments are included above/attached.

Supervisor's Name & Signature:	**Date:**
Work Email Address:	**Supervisor's Work Phone/Cell #:**

Sent to Risk Management by:	**Date Sent:**	**Method Sent:** Fax ☐ Email ☐ Other ☐ _____

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AUTHORIZATION TO FURNISH MEDICAL RECORDS
AND DISCLOSE PROFESSIONAL AND PERSONAL INFORMATION

List the providers you are authorizing on the following page.

Name: _____ Date of injury: _____

SSN: _____ Address: _____

DOB: _____ City, State, Zip Code _____

TO WHOM IT MAY CONCERN:

I, _____, hereby authorize you and/or any other hospital, medical institution, doctor or medical practitioner, insurance company, pharmacy, school board, employer, U.S. Defense Department, Veteran's Administration, Social Security Administration, or any agency of any state, county or municipality, or employee of any of the above or any provider who has given me medical and/or psychological treatment, to furnish and release to the Office of the Franklin County Commissioners, or any of its authorized representatives or agents, any and all reports, records, files, and information pertaining to treatment of injuries sustained on date above.

This Authorization includes, but is not limited to, x-ray films, x-ray reports, pathology slides, tissue blocks, nurses' notes, diagnostic testing results, emergency room records and bills for services and applies from the past fifteen years from the date of this signed release to the present. This Authorization also applies to files and information regarding alcohol, drug and psychiatric/psychological reports, records, HIV test result, AIDS and AIDS related conditions. The sole purpose of this release is to further the administration of a workers' compensation claim(s) by my employer.

I waive and release the attached list of sources or facilities from any restriction imposed by law thereof, in disclosing any record, observation, diagnosis or communication to the Franklin County Commissioners or any of its authorized representatives or agents. I understand and agree that the information I have authorized to be released is exempt from the privacy requirements of the Health Information Portability and Accountability Act (HIPAA), pursuant to 45 CFR §164.512(e) and (l).

This Authorization is valid for five years from date hereof. I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. I understand that a copy of this Authorization shall serve in lieu of the original.

_____ _____
Date Employee Signature

Please remit Medical records to: **Sedgwick, CMS**
P.O. Box 14661
Lexington, KY 40512-4661
Fax 614.658.0901

Franklin County
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LIST OF PROVIDERS AUTHORIZED TO FURNISH MEDICAL RECORDS AND DISCLOSE PROFESSIONAL AND PERSONAL INFORMATION

1. Provider's Name: _____

   Provider's Address: _____

   Provider's Telephone: _____

   Date last treated: _____

2. Provider's Name: _____

   Provider's Address: _____

   Provider's Telephone: _____

   Date last treated: _____

3. Provider's Name: _____

   Provider's Address: _____

   Provider's Telephone: _____

   Date last treated: _____

4. Provider's Name: _____

   Provider's Address: _____

   Provider's Telephone: _____

   Date last treated: _____

5. Provider's Name: _____

   Provider's Address: _____

   Provider's Telephone: _____

   Date last treated: _____

6. Provider's Name: _____

   Provider's Address: _____

   Provider's Telephone: _____

   Date last treated: _____

Attach additional sheets if necessary

Franklin County
Where Government Works

Workers' Compensation and Injury Identification Card

Employer Risk number 20005728-0

Attention Provider:
Fax all information within 24 hours of visit to:
Sedgwick 614-658-0901

Send bills to:
SedgwickCMS
P.O Box 14661
Lexington, Kentucky 40512-4661

Customer Service (Claims Adjuster) 1-800-267-4001
Fax 614-658-0901

Revised 9/2016

Franklin County
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Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

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.) (Updates Yes☐ No ☐)

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 (Updates Yes☐ No ☐)

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 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:____/____/____. **Proceed to section 3C.**

3C **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 return to work date:____/____/____.
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: N = Never, O = Occasionally, F = Frequently, C = Continuously

Activity	N	O	F	C	Activity	N	O	F	C	Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C
Bend					Reach above shoulder					0 - 10 lbs.					0 to 25 lbs.				
Squat/kneel					Type/keyboard					11 - 20 lbs.					26 to 40 lbs.				
Twist/turn					Work with cold substances					21 - 40 lbs.					41 to 60 lbs.				
Climb					Work with hot substances					41 - 60 lbs.					61 to 100 lbs.				
										61 - 100 lbs.					100 + lbs.				

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.

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Injured worker name	Claim number	Date of injury

Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) (Updates Yes☐ No ☐)

4A 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.

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 ☐

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

Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

Maximum medical improvement (MMI) (Updates Yes☐ No ☐)

6 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: ____/____/____. 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.

Vocational rehabilitation (Updates Yes☐ No ☐)

7 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.

Treating physician signature - mandatory

8 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 (please print legibly)		Address, city, state, nine-digit ZIP code	
Treating physician's signature			
BWC provider (Peach) number	Date	Telephone number	Fax number

Franklin County
Where Government Works

HELIOS | P.O. Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Helios has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to a Helios Tmesys network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 866.599.5426 or visit www.tmesys.com and click on "Pharmacy Locator."

Questions? Need Help?
866.599.5426

tmesys®

Sedgwick — CARRIER/TPA
Franklin County B.O.C — EMPLOYER

INJURED WORKER NAME

SOCIAL SECURITY NUMBER
DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: www.tmesys.com\pharmacy-locator
Download Free Mobile App: www.tmesys.com\MyWorkComp

HELIOS

Attention Pharmacists: Enter RxBIN, RxPCN, and GROUP. Member ID # format is the date of injury, and SSN combined as follows: YYMMDD123456789.
Tmesys is the designated PBM for this patient.

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	_____		

HELIOS

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.

tmesys®

IMP14-1511-01

Revised 9/2016

Franklin County
Where Government Works

Downtown

WorkHealth Downtown
895 W. 3rd Ave.
Columbus, Ohio 43212
614-566-9191
Mon-Fri 7:30am -4:30pm

OhioHealth Urgent Care-Victorian Village
1132 Hunter Ave
Columbus, Ohio 43201
614-544-0822
Mon-Fri 9am-7pm Sat-Sun 9am-5pm

North

WorkHealth North
300 Polaris Parkway
Westerville, Ohio 43082
614-566-9675
Mon-Fri 7:30am-4:30pm

AccessMD Urgent Care-Clintonville
4400 North High Street
Columbus, Ohio 43214
614-263-4400
Mon-Fri 9am-7:30pm Sat-Sun 9am-5pm

OhioHealth Urgent Care-Dublin
6905 Hospital Drive
Dublin, Ohio 43016
614-923-0300
Mon-Sun 9am-9pm

East

Mt. Carmel Urgent Care
6435 East Broad Street
Columbus, Ohio 43213
614-355-8150
Mon-Fri 9am-9pm
Sat-Sun 9am-6pm

OhioHealth Urgent Care-Gahanna
5610 North Hamilton Road
Columbus, Ohio 43230
614-775-9870
Mon-Sun 8am-8pm

OhioHealth Urgent Care-Reynoldsburg
2014 Baltimore-Reynoldsburg
Reynoldsburg, Ohio 43068
614-522-6900
Mon-Sun 9am-7pm

AccessMD UrgentCare-Groveport
3813 S. Hamilton Road
Groveport, Ohio 43215
614-835-0400
Mon-Fri 8am-8pm Sat-Sun 9am-5pm

AccessMD Urgent Care-Stelzer Rd
2880 Stelzer Road
Columbus, Ohio 43219
614-472-2880
Mon-Fri 8:30am-7:30pm Sat-Sun 9am-5pm

South

WorkHealth Southwest
4079 Gantz Road, Suite C
Grove City, Ohio 43123
614-566-9675
Mon-Fri 7am -4pm

OhioHealth Urgent Care-Grove City
2030 Stringtown Road
Grove City, Ohio 43123
614-883-0160
Mon-Sun 9am-Midnight

Franklin County
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West

WorkHealth West
4523 Cemetery Road
Hilliard, Ohio 43026
614-566-9675
Mon-Fri 7am -4pm

AccessMD Urgent Care Hilliard
5677 Scioto Darby Road
Hilliard, Ohio 43206
614-921-0648
Mon-Fri 8:30am-7:30pm Sat-Sun 9am-5pm

AccessMD Urgent Care Clime Road
4300 Clime Road
Columbus, Ohio 43228
614-272-1100
Mon-Fri 8am -8pm Sat-Sun 9am -5pm

Delaware County

OhioHealth Urgent Care-Lewis Care
24 Hidden Ravines Drive
Powell, Ohio 43065
740-549-2700
Mon-Sun 9am-7pm

WorkHealth Delaware
801 OhioHealth Blvd.
Delaware, Ohio 43015
614-566-9675
Mon-Fri 8am-4:30pm

Sunbury Urgent Care
101 West Cherry Street Suite D
Sunbury, Ohio 43074
740-965-8305
Mon-Fri 9am-9pm Sat-Sun 9am-6pm

Wedgewood Urgent Care
10330 Sawmill Parkway
Powell, Ohio 43065
614-923-9200
Mon-Fri 9am-9pm Sat-Sun 9am-6pm

AccessMD Urgent Care-Delaware
1100 Sunbury Road #706
Delaware, Ohio 43015
740-363-3133
Mon-Fri 9-7:30pm Sat-Sun 9am-5pm

Fairfield County

Access Urgent Medical Care
1797 Hill Road North
Pickerington, Ohio 43147
614-833-6002
Mon-Sun 8am-8pm

Pickaway County

PHS Occupational Health
1434 Circleville Plaza
Circleville, Ohio 43113
740-420-7975
Mon-Fri 8am-4:30pm

Licking County

Newark Valley Urgent Care
1906 Tamarack Road
Newark, Ohio 43055
740-522-0222
Mon-Fri 9am-9pm Sat-Sun 9am-6pm

Union County

Memorial Hospital Urgent Care
1140 Charles Lane
Marysville, Ohio 43040
937-578-4310
Mon-Fri 9am-9pm Sat-Sun 9am-6pm