What happens when my physician releases me to work?

Ohio University and The Matrix Companies will make every effort to help you return to your job as soon as possible. Ohio University will help your physician return you to light duty work or a transitional work program if there are restrictions on your activity that prevent you from performing your regular job duties.

What if I am not satisfied with the medical treatment I am getting from my doctor?

If you are dissatisfied with your doctor, we encourage you to talk to your Corporate Human Resources or your Matrix Account Executive. They will work with your treating physician on an appropriate treatment plan or, if necessary, they will assist you in finding another doctor with whom you are more comfortable. You ultimately have the freedom to choose any licensed physician who will accept workers' compensation injuries.

Why does Ohio University investigate accidents?

One way to prevent future accidents is to learn about your workplace injury. After a complete investigation, your manager or supervisor may be able to make meaningful changes, reducing the chance that another employee will be injured in the same manner.

What should I do if medical bills are sent to me?

If you receive bills from your doctor or the hospital, please send them to:

The Matrix Companies
644 Linn Street, Suite 900
Cincinnati, OH 45203

Who do I call if I have questions?

Contact Eric James at Ohio University at (740)593.1641. Any questions concerning physician visits, change of physician or medical treatment requests can be directed to your Matrix Account Executive at (877) 550.7973.

Provider Listings for Workers' Compensation

HOSPITAL

O'Bleness Hospital 55 Hospital Drive Athens, OH 45701 (740) 593.5551	HOURS OF OPERATION: Open 24 Hours a Day 7 Days a Week

OCCUPATIONAL HEALTH:

OhioHealth WorkHealth Athens (Located within the Castrop Health Center) 75 Hospital Drive, Suite 270 Athens, OH 45701	HOURS OF OPERATION: Monday - Friday, 7AM - 4PM (740) 331.7060
Ohio Health Physician Group Heritage College Primary Care and Geriatrics; Parks Hall West Green Drive Athens, OH 45701	HOURS OF OPERATION: Monday - Friday, 8AM - 5PM (740) 592.7020

OHIO UNIVERSITY | HUMAN RESOURCES

Employee Information

What to do in the event of an injury while working at Ohio University.

Ohio University's goal is to provide a safe work environment designed to prevent workplace injuries.

In the event of a work-related injury, please see one of the medical providers recommended by your employer and follow these important steps:

REPORT ALL INJURIES TO YOUR SUPERVISOR IMMEDIATELY

Report the Accident

All accidents should be reported to your manager or supervisor immediately, regardless of the level of medical treatment you need. You will be asked to complete an Ohio Bureau of Workers' Compensation (BWC) First Report of Injury (FROI) to start your workers' compensation claim. This form is included in this packet.

In emergency situations, you should seek immediate medical attention and complete these forms as quickly as you are able.

In non-emergency situations, you may seek medical treatment from a licensed provider of your choosing or you may call your Matrix Account Executive at (877) 550.7973 to identify quality licensed providers in your area.

Select a Provider

Select a medical provider from the list (see back-side of pamphlet) for immediate care*

*Employees may receive treatment from any BWC certified provider.

What happens to the First Report of Injury (FROI) form that I fill out with my physician?

The Human Resources department will keep a copy of your FROI form for your workers' compensation file. The FROI will also be sent to Matrix so they may process your claim. In some instances, Matrix will also file a copy of the FROI with the Ohio Bureau of Workers' Compensation (BWC).

Who will pay for my Doctor's bills?

As a self-insured employer, Ohio University will pay for authorized physician visits and related treatments if the injury was caused by an on-the-job accident. Matrix will issue payment for appropriate medical treatment directly to your physician on behalf of Ohio University.

How do I get my prescriptions filled?

This injury packet contains an AliusRX instant access card that will allow you to get a first fill on your initial prescription. First fill services are provided through the AliusRX Prescription program. If you require refills or additional medication for an allowed work-related injury, you will receive additional information in the mail from AliusRX. Additional information on how the prescription program works is available through Matrix.

What happens if I cannot return to work?

The Ohio University Human Resources team and your Matrix Account Executive will work cooperatively with you and your doctor to monitor and maintain quality appropriate treatment to ensure the most efficient and safe return to work. They will maintain communication with you throughout the duration of the claim.

Will I be paid for the time I miss from work due to my injury?

Ohio University will comply with BWC guidelines. If you miss work for more than seven (7) calendar days because of an allowed work-related injury, your time off work will be paid based upon a percentage of your average weekly earnings. In order to receive payments, all of your time off must be supported by your treating physician.

When do I receive my wage payments?

If your treating physician has taken you off of work, has submitted the appropriate forms, and your claim is allowed, benefits will be paid within twenty one (21) days from the date the paperwork is received by Matrix.

Do I need a doctor's release to return to work?

If you have missed work as a result of your injury, your doctor must provide a medical release or fit for duty report in order to return to work. This injury packet contains a standard release form (Medco-14) that is commonly used to identify your work capabilities. **Have your doctor complete this form and fax to Ohio University's Human Resources Department at (740) 593.0386 or you can return the form to Human Resources.**

Your employer has selected the Matrix Companies to manage its workers' compensation medical benefits. If injured at work, please follow these important steps:

1. Complete an Incident Report and First Report of Injury (FROI) form and submit to the Human Resources Department within 24 hours of your workplace injury. **You can fax this information to (740) 593.0386.**
2. Show this card to every medical provider that treats your workplace injury.

SELF-INSURED WORKERS' COMPENSATION I.D. CARD

OHIO UNIVERSITY | HUMAN RESOURCES

FOR WORKERS' COMPENSATION USE ONLY (SELF-INSURED)

Ohio University

BWC POLICY #20005755-0

Employer Contact: Eric James

Office: 740.593.1641 Fax: 740. 593.0386

Attention Provider: Please notify Matrix Claims Management at 1.877.550.7973 for pre-admission certification and prior authorization. All care to be based on workers' compensation treatment guidelines.

Billing Address (for all non-pharmacy bills): Matrix Claims Management
644 Linn Street, Suite 900 Cincinnati, OH 45203 Phone: 1.877.550.7973 Fax: 513.842.8010

Attention Employee: This card may be used for conditions in your workers' compensation claim and is not a guarantee of coverage. No other person can use this card to obtain medical care. Please contact Matrix to develop a treatment plan and obtain provider names.

Pharmacy Benefits: Call AliusRX at 740.661.4463

OHIO UNIVERSITY

EMPLOYEE INCIDENT REPORT

IMPORTANT: In the event of a work-related injury, the injured employee should obtain first aid as needed and notify the immediate supervisor of the incident as soon as practicable.

READ THESE INSTRUCTIONS BEFORE PROCEEDING

The Employee Incident Report **MUST** be completed for every work-related incident, accident, or illness, preferably within 24 hours of the incident. (Please print neatly in ink or complete electronically.)

Employee Responsibilities:

1. Seek medical treatment if necessary.
2. Notify supervisor/designated charge person.
3. **Fully complete "Employee Information" and "Accident Information" sections. Sign and date the report.**
4. Give form to supervisor/charge person for signature, and completion of the Manager Incident Report Statement.

Supervisor/Manager/Charge Person Responsibilities:

1. If the employee needs or desires medical treatment, assist in the arrangement of appropriate care.
2. Review the report, and sign as indicated in "TO BE COMPLETED BY SUPERVISOR/CHARGE PERSON."
3. **Complete the Supervisor Section of this report (page 3).**
4. Make a copy of this report for your records and provide the original to the employee.

Immediately submit a copy of these completed forms to Enterprise Risk & Workers Compensation by either:

- Email: insurance@ohio.edu
- Fax: 740-593-0386

WORKERS' COMPENSATION RIGHTS

Employees have the right to apply for Workers' Compensation benefits. They have one year from the date of injury to do so. For more information regarding Workers' Compensation, call 740-593-1641. For additional information and resources, visit **www.ohio.edu/hr/additional-resources/workers-compensation.**

SECTION 1: EMPLOYEE INFORMATION (all fields required)

Employee Type (Check One) ☐ Classified/Bargaining ☐ Administrative ☐ Faculty ☐ Student

Employee Name: _____ OU Employee #:_____

Home Mailing Address:_____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Date of Birth: _____ Gender: _____

Job Title: _____ Department: _____

Work Phone: _____ Date Hired: _____

For property damage, please complete Section 5

OHIO UNIVERSITY

EMPLOYEE INCIDENT REPORT

SECTION 2: ACCIDENT INFORMATION COMPLETED BY EMPLOYEE (provide as much detail as possible)

Supervisor Name: _____ Supervisor Phone: _____

Accident/Incident Date: _____ Accident/Incident Time: _____ Time Shift Began:_____

Location of accident/Incident: _____

Briefly explain the accident/incident and what was being done prior:

_____

_____

_____

_____

Witness (name and phone): _____

Medical Treatment necessary: ☐ Yes ☐ No Was this part of your normal job duty: ☐ Yes ☐ No

Did employee seek medical treatment? ☐ Yes ☐ No If yes, where? _____

Type of injury or illness: (Tell us the part of the body that was affected and how) _____

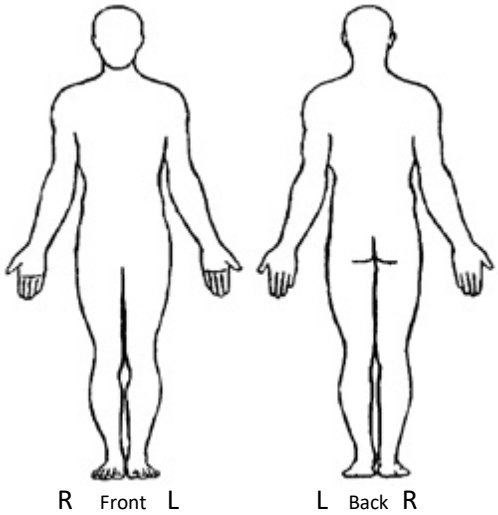
_____

_____

Any pre-existing injury/condition of which you are aware that could have contributed to this? _____

Was the employee wearing slip-resistant shoes? ☐ Yes ☐ No Was the employee using proper PPE? ☐ Yes ☐ No

Body part(s) affected/injured (circle on diagram)



	L	R
Eyes/Ears/Face	☐	☐
Neck/Shoulders/Arms/Elbows	☐	☐
Hips/Legs/Knees	☐	☐
Ankles/Feet/Toes	☐	☐
Back (Upper/Lower)	☐	☐
Head	☐	
Internal Organs	☐	

Other: _____

SECTION 3: EMPLOYEE AUTHORIZATION

I certify the information on this form is true and authorize the release of medical information regarding this accident to OU workers' compensation claim administrators.

Employee Signature: _____ Date: _____

OHIO UNIVERSITY

EMPLOYEE INCIDENT REPORT

SECTION 4: TO BE COMPLETED BY SUPERVISOR/PERSON IN CHARGE

Supervisor Name: _____ Supervisor Phone: _____

Date accident/injury reported to supervisor: _____ Date investigated: _____

Was the employee performing regular job duties? ☐ Yes ☐ No Was a Safety Work Rule Violated? ☐ Yes ☐ No

Was the employee trained in the specific job/activity involved in this accident/injury? ☐ Yes ☐ No

(If no to any questions above, please explain in supervisor statement section)

Was required personal protective equipment used? ☐ Yes ☐ No

If no, explain: _____

Was a witness statement submitted with the Employee Incident Report? ☐ Yes ☐ No

Supervisor Statement:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Supervisor Signature: _____ Date: _____

SUBMIT

OHIO UNIVERSITY

PROPERTY INCIDENT REPORT

SECTION 5: PROPERTY INCIDENT REPORT

Instructions:

- For university fleet vehicle accidents, complete the Ohio University Accident Reporting Kit
- If a section does not apply, indicate "N/A."
- Contact 740-597-1992 with questions.
- Submit the completed form to Enterprise Risk Management:
  - Campus mail Grosvenor Hall 345
  - fax (740) 593-0386
  - email insurance@ohio.edu

Date and time of incident: _____ Location of incident: _____

Damaged property: _____

Incident reported by: _____ Work Department: _____

Supervisor: _____ Supervisor Phone: _____

Name of Police Officer: _____ Police report made: ☐ Yes ☐ No

City/State: _____ Police Report # _____

Witnesses Name: _____ Witness Phone: _____

Describe accident/incident and damage: _____

_____

_____

_____

_____

Additional Information: _____

_____

_____

Completed By (print): _____ Signature: _____ Date: _____

Ohio | Bureau of Workers' Compensation

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
Ohio University	Grosvenor Hall 345, 1 Ohio University	Athens	Ohio	45701

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	Time of injury	Date employer notified	Was any part of a workday missed due to the injury?	Date last worked	If the injured worker has returned to work, provide the date.
_____ ☐ am ☐ pm	_____ ☐ am ☐ pm		☐ Yes ☐ No		

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
Ohio University	Athens	740-593-1641	740-593-0386	jamese@ohio.edu

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation
20005755		

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

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

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

- 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.

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.

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. _____

_____.

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.

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

alius health
The difference is clear

First Fill Instructions for The Matrix Companies

Dear Injured Claimant,

Alius Health is a business partner of The Matrix Companies and has been selected to administer your injury prescription drug plan. Attached is your temporary prescription card allowing up to a 10-day supply of medication. Once your claim has been accepted by The Matrix Companies, a replacement prescription card will be sent to you if you require ongoing treatment. The new card will allow monthly medications related to your injury.

Our extensive pharmacy network includes those below. Simply present this letter along with your prescription(s) to a participating pharmacy. To verify if your preferred pharmacy is in the network, you can use our pharmacy locator on www.Aliushealth.com or call 740-661-4463. Our office hours are Monday through Friday 9am – 7pm Eastern Standard Time.

Name:

Member ID: ALIUS

(use last 4 digits of ssn plus date of birth)

Person Code: 01
RxGroup #: ALHFF13202121
RxBIN/IIN: 610729
RxPCN: ALIUS

ATTENTION PHARMACISTS: Please process prescriptions through **Script Care**. For questions, please call Alius Health 740-661-4463

ATTENTION INJURED CLAIMANT: The use of this prescription card is restricted to your allowed injury condition only. Possession of this card does not guarantee benefits.

*In some instances, an individual pharmacy may be removed from the network due to non-conformity

Albertsons	Discount Drug Mart	Good Neighbor Pharmacy	Long's Drug	Sam's Club
BI-LO	Drug Emporium	H E B Drug stores	Medicine Shoppe	Shopko
Bartell Drugs	Family Pharmacy	Health mart	Meijer	Shoprite
Brooks Pharmacy	Fred's	Hy-Vee	Publix	Supervalu
Costco	Fruth Pharmacy	Kroger	Rite Aid	Walgreens
CVS	Giant Eagle Pharmacy	Lewis Drug	Safeway	Walmart

Estimado Trabajador,

Alius Health es socio de The Matrix Companies ya ha sido seleccionado para administrar su plan de medicamentos recetados para su lesiones. Aquí esta su tarjeta de prescripción temporal que permite hasta 10 días de medicamento. Una vez que su reclamación ha sido aceptada por The Matrix Companies se le enviara una tarjeta de reemplazo para requerir tratamiento continuo. La tarjeta nueva le va a permitir medicamentos mensualmente relacionados a su lesion.

Nuestra extensa red de farmacias include las siguientes. Simplemente present esta carta junto con su recetas a una farmacia participantes. Para verificar si su farmacia preferida esta en nuestra red de farmacias puede utilizar nuestro localizador de farmacia en www.Aliushealth.com o llamar 740-661-4463. Nuestra horas de operación son de Lunes a Viernes de 9:00am-7:00pm tiempo de oeste.