SELF-INSURED

Injury Reporting Packet

Ohio University

1.800.837.3200 / YORKRISK.COM
In the event of a work-related injury, please see one of the medical providers recommended by your employer listed below and follow these important steps:

01  Report the Accident
Report the accident to your supervisor.

02  Select a Provider
Select a medical provider from the following list for immediate care*

03  Additional Providers
For additional providers, call York from 8 a.m. – 5 p.m.
1.800.837.3200

Provider Listings for Workers’ Compensation

HOSPITAL:

O’Bleness Hospital
55 Hospital Drive
Athens, Ohio 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 570
Athens, Ohio 45701
(740) 331-7060

HOURS OF OPERATION:
Monday – Friday, 7:00 a.m. – 4:00 p.m.

Ohio Health Physician Group
Heritage College Primary Care and Geriatrics
Parks Hall
West Green Drive
Athens, Ohio 45701
(740) 592-7020

HOURS OF OPERATION:
Monday – Friday, 8:00 a.m. – 5:00 p.m.

*Employees may receive treatment from any BWC certified provider.
Ohio University has selected York to manage its workers’ compensation medical benefits. If injured at work, please follow these important steps:

1. Complete an Ohio University Incident Report Form and an Ohio Bureau of Workers’ Compensation (BWC) First Report of Injury (FROI) form and submit to the Human Resources Department within 24 hours of your workplace injury. You can fax these forms to Human Resources at (740) 593-0386.

2. Show this card to every medical provider that treats your injury.
Ohio University
BWC Policy #: 20005755-0

Employer Contact:
Human Resources Department Contact:
Eric James @ (740) 593-1641
Fax @ (740) 593-0386

FOR PROVIDER:
Please notify York at 1-800-837-3200 for pre-admission certification and prior authorization. All care to be based on workers’ compensation treatment guidelines.

Billing Address (for all non-pharmacy bills):
York
P.O. Box 8101
Dublin, OH 43016

Phone: 1.800.837.3200
Fax: 614.764.7629

FOR EMPLOYEE:
This card is for information purposes only. This card is not a guarantee of coverage.

Pharmacy Benefits:
Call Optum at 1.800.547.3330
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. However, should you sustain a workplace injury the following are answers to typical questions you may have about your on-the-job injury.

What if I need more than First Aid for my injury?
All accidents should be reported to your supervisor immediately, regardless of the level of medical treatment you need. You will be asked to complete an accident report and an Ohio Bureau of Workers’ Compensation (BWC) First Report of Injury (FROI) to start your workers’ compensation claim. Both forms are 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 Ohio University’s Human Resources Department’s Eric James at (740) 593-1641 or your York nurse at 1-800-837-3200 to identify quality licensed providers in your area.

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

What happens if I cannot return to work?
Ohio University’s Human Resources team and your York medical case managers 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. We 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 York.

Report all injuries to your manager or supervisor immediately!
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.

What happens when my physician releases me to work?
Ohio University’s Human Resources management and the York medical case manager will make every effort to help you return to your job as soon as possible. They 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 Human Resources representative or your York medical case manager. They will work with your treating physician on an appropriate treatment plan or, if necessary, 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. 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:

York
P.O. Box 8101
Dublin, OH 43016

Why does Ohio University investigate accidents?
One way to prevent future accidents is to learn more 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.

Who do I call if I have questions?
Contact Ohio University’s Human Resources Department’s Eric James at (740) 593-1641. Any questions concerning physician visits, change of physician or medical treatment requests can be directed to your medical case manager at 1-800-837-3200.
OHIO UNIVERSITY EMPLOYEE INCIDENT REPORT

FOR UNIVERSITY EMPLOYEE INCIDENTS: Supervisor (and employee) must complete form immediately after a work-related injury, illness or incident. Employee must report any injury to their supervisor/acting supervisor before the end of their shift. Attach additional sheets if necessary. Supervisors must investigate the incident thoroughly and submit the form within one working day to: Human Resources at Training Center Room #120 at 169 West Union Street, by fax at (740) 593-0386, or by phone at (740) 597-1994 or email jamese@ohio.edu.

1. Employee (please check one) □ Classified □ Administrative □ Bargaining □ Faculty □ Student Employee □ Other (If “other” please describe)  
2. Name_________________________ 3. Employee #__________________ 4. Date of Birth_____________ 5. Gender_______  
13. Bldg/Area/Shop_____________________ 14. Date Hired______________ 15. Job Title_____________  
16. Date incident occurred___________ 17. Time of Incident______ AM☐ PM☐  
18. Time Employee Began Work________ AM☐ PM☐  
19. Full name and phone # of any witnesses_________________________________________  
20. What was the individual doing and where just before the incident? Describe the activity, any tools, equipment, or material the individual was using/carrying. Be specific. Examples: "climbing a ladder while carrying roofing materials," "leaving Memorial Auditorium through north doors." Please state the location on campus at time of the incident. ___________________________________________________________  
21. What happened? How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet." Please list any unsafe conditions/acts or violation of safety rules or practices. What went wrong? ___________________________________________________________  
22. What was the injury or illness? Tell us the part of the body that was affected and how. Be more specific than "hurt" or "pain" or "sore." Examples: "possible strained lower back" or "potentially sprained left ankle." ___________________________________________________________  
23. What object or substance directly injured the individual? Examples: "concrete floor." "bricks on sidewalk." If this question does not apply to the incident, leave blank  
24. Name of Health Care Provider for this incident_________________________ Dr.______________ Date:___________  
25. Was employee performing regular job duties? ☐Yes ☐No  
26. Was employee trained in the specific job/activity involved in this incident? ☐Yes (Date Trained: ____________) ☐No (If No, explain)  
27. What has been/will be done to prevent this type of incident (corrections, actions, repairs, training, etc.) ____________________________________________  
28. Any pre-existing injury/condition of which you’re aware that could have contributed to this ☐No ☐Yes  
29. Date injury reported to supervisor by employee____________________ 30. Date Investigated___________ (If date investigated is different from date reported, why?)  
31. Death? ☐No ☐Yes  If yes, date:_________________________  
32. Was the employee wearing slip-resistant shoes? ☐No ☐Yes 33. Using proper PPE? ☐No ☐Yes  
34. Name of manager on duty at time of injury_________________________  
35. Supervisor’s Name (please print)___________________________________________ 36. Phone #______________________  
37. Supervisor’s Email Address_____________________________________________  
38. Signature of injured/ill person______________________________________________ 39. Date Report Completed_________________________  
40. Supervisor’s Signature_____________________________________________________

NOTICE: Supervisor: please give a copy of this form to the employee upon completion.
Employee Incident Report Statement

Date ______________

Print Name _______________________________________

Signature _______________________________________
Manager Incident Report Statement

Date ______________

Supervisor to complete:
Was a Safety Work Rule violated ________________________________

Supervisor to complete:
What Safety Work Rule was violated ________________________________

Supervisor to complete:
Permanent employees - discipline/counseling requested? ________________________________
Student employee: Number of strikes applied? ________________________________
Outcome? ________________________________

Print Name ________________________________

Signature ________________________________

AllShare/Safety/Incident Report Forms/Incident Report Statement/revised 01/2016
Ohio Bureau of Workers’ Compensation

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.

(R.C. 23.915,48)

Employer name: Human Resources & Training Center #120
Mailing address: 169 West Union Street, Athens, Ohio 45701

Injured worker and injury/death info.

Last name, first name, middle initial
Home mailing address
City State 9-digit ZIP code
Wage rate $ Per Hour Month Week

Do you have a unique identification number for your employer? [ ] Yes [ ] No

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers’ Compensation? [ ] Yes [ ] No

If yes, please explain.

Ohio University

Employer number: 2005755-0

Was the place of accident or exposure on employer’s premises? [ ] Yes [ ] No

Date of injury/death

Date hired

Place of injury

Date of injury/death

Time of injury

If fatal, give date of death

Time employee began work

Date last worked

Regular work hours

Location, if different from mailing address

Was the place of accident or exposure on employer’s premises? [ ] Yes [ ] No

Date of injury/death

Time of injury

If fatal, give date of death

Time employee began work

Date last worked

Regular work hours

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)

Type of injury/disease and part(s) of body affected

(For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers’ Compensation Act for work-related injuries that I did not suffer. 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 allowed, 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 employees of record or their authorized representatives and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature

Date

E-mail address

TelephoneNumber

Work number

Health-care provider name

Telephone number

Fax number

Initial treatment date

Street address

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 policy number

Telephone number

Fax number

E-mail address

Federal ID number

Manual number

Was employee treated in an emergency room? [ ] Yes [ ] No

Was employee hospitalized overnight as an inpatient? [ ] Yes [ ] No

Certification - The employer certifies that the facts in this application are correct and valid.

Rejection - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

Certification - The employer certifies that the facts in this application are correct and valid.

Rejection - The employer rejects the validity of this claim for the reason(s) listed below:

Medical only

Lost time

Employer signature and title

Date

OSHA case number

This form meets OSHA 301 requirements

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

FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)
Authorization to Release Medical Information

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. __________________________
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.)**

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 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 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.)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Lifting/carrying</th>
<th>Pushing/pulling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>O</td>
</tr>
<tr>
<td>Bend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squat/kneel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twist/turn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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.**
<table>
<thead>
<tr>
<th>Injured worker name</th>
<th>Claim number</th>
<th>Date of injury</th>
</tr>
</thead>
</table>

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

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>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

(Updates 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 ☐)

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.

5

**Maximum medical improvement (MMI)**

(Updates Yes ☐ No ☐)

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).

6

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 ☐)

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.

7

**Treating physician signature - mandatory**

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.

8

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

BWC-3914 (Rev. Aug. 21, 2015)

MEDCO-14
Optum 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 an Optum 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 and all major chains, are included in the network. To find a network pharmacy call 1-888-764-1284 or visit tmesys.com.

**Questions? Need Help?**

1-888-764-1284

**Workers’ Compensation Prescription Drug Program**

<table>
<thead>
<tr>
<th>York</th>
<th>OHIO UNIVERSITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CARRIER/TPA EMPLOYER</td>
</tr>
<tr>
<td>2.</td>
<td>INJURED WORKER NAME</td>
</tr>
<tr>
<td>3.</td>
<td>Please provide directly to Pharmacist</td>
</tr>
<tr>
<td>4.</td>
<td>SOCIAL SECURITY NUMBER</td>
</tr>
<tr>
<td>5.</td>
<td>DATE OF INJURY (YYYYMMDD)</td>
</tr>
<tr>
<td>6.</td>
<td>DISTRIBUTED BY (SIGNATURE)</td>
</tr>
<tr>
<td>7.</td>
<td>DATE</td>
</tr>
</tbody>
</table>

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

**Employer:**

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as “Optum.”