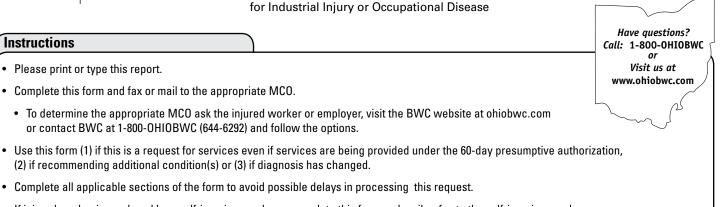


Instructions

Complete this form and fax or mail to the appropriate MCO.

Physician's Request for Medical Service or **Recommendation for Additional Conditions** for Industrial Injury or Occupational Disease

Completing form C-9



- If injured worker is employed by a self-insuring employer, complete this form and mail or fax to the self-insuring employer.
- Additional copies of this form can be obtained on our website at ohiobwc.com, or by calling BWC at 1-800-OHIOBWC (644-6292) and follow the options.

Section I – Injured worker

· Please print or type this report.

• Enter the injured worker's name, BWC claim number or social security number if claim number is not available, the date the injured worker was injured or contracted an occupational disease, address and telephone number.

Section II – Requested services

- Indicate the diagnosis and the ICD-9 codes.
- Indicate the beginning and ending date of the service being requested. Indicate the last exam or treatment date.
- List the requested services including frequency and duration. Attach copies of current medical reports necessary to support request. Include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment, office notes that contain subjective and objective findings and preexisting conditions.

Section III – Additional conditions

- Ocmplete if you are recommending additional conditions to the claim. Provide diagnosis and ICD-9 codes. Supporting medical documentation is required for all conditions listed. Include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment, office notes that contain subjective and objective findings and preexisting conditions.
 - BWC will notify all parties and the MCO of the decision.
- B Refers to the establishment of a relationship between the injury or occupational disease and the industrial accident or exposure. An explanation is required when answering yes or no.

Section IV – Physician information

- Check this box *only* if you are the Physician of Record.
- Print, type, or stamp physician/provider name and address.
- Physician/provider signature, BWC provider number and date of this report are mandatory.

Section V – MCO/SI Employer decision

- If completed by Self-Insuring Employer refer to SI Employer section.
- If the C-9 is not faxed or mailed back to the submitting physician within three business days of receipt or within five business days of receipt of the C-9-A, a request for additional information, the authorization for service shall be deemed granted subject to BWC policy excluding retroactive requests.
- Section V: Claim Inactive (further investigation required) The MCO cannot make a decision on this C-9 request. Further investigation is required and a decision will be issued in writing by BWC within 28 days. The MCO will notify the Provider of the BWC decision.
- An MCO can only use the disclaimer box on the C-9, or any other physician generated service request, when the claim or the condition for which the service is being requested, is not yet in an allowed status. Disclaimers shall not be used when authorizing treatment for allowed claims and conditions that are within the statute of limitation.

	• Instructions for completing C-9 on reverse s	or Recommen Conditions for Occupational I	dation for a	Additional	To Toll-free	note: phone nui fax numb		From Phone I Fax nur	
2	Injured worker name	Cla	aim number		SSN if cl	aim num	ber unknown	Date o	of injury
	3 Treating diagnosis ICD-9 code(s)			Date service be / /	egins	Date se	ervice ends /	Date of last of	/ / exam or treatment / /
uested :	Requested Services 1. 2. 3.			Fr	equency			Du	ration
al conditions	 If you are recommending additional conditions to the claim, supporting documentation is required. Provide diagnosis and ICD-9 code(s), and location and site for conditions you are requesting. In your opinion, based on the history from the injured worker, your clinical evaluation and expertise, is the diagnosis or condition causally related, either directly or proximately, to the alleged industrial accident or exposure? Yes, please explain No, please explain 								
IV. Physician into.		owingly accept nment, or both.	t any person who knowingly makes a false statement, misrepresentation, concealment of fact ts payment to which that person is not entitled, is subject to felony criminal prosecution and Physician/provider/authorized signature <i>(mandatory)</i> NC Provider number <i>(mandatory)</i>						
mployer decision	MCO If this page is not faxed or mailed back to the submitting physician within three business days of receipt or within five business days of receipt of information requested on the C-9-A, th authorization for treatment shall be deemed granted subject to BWC policy, excluding retroactive requests. APPROVED WITH DISCLAIMER - This medical payment authorization is based upon a claim or additional condition that is currently being considered by BWC/I as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, the services/supplies to which this medical payment authorizatio applies may not be covered by BWC and may be the responsibility of the injured worker. Approved Date service begins// Date service ends// Approved Date service begins// Date service ends// Denied explanation:								
	days to allow for a treatment decision. Failure to resp may result in denial. Withdrawn Dismissed BWC claim status: Allowed Denied MCO company/SI Employer name (please print, ty	rent supporting medical not be appealed. decision will be issued in writing by BWC within 28 days. I ICD-9-code(s) MCO name and signature (print, type or stamp and sign)							
				MCO number			Felephone nu ()	mber	Date

loyer	Self-insuring employer use only Fax or mail this page to the submitting physician within 10 days of receipt or the authorization for treatment shall be deemed granted per OAC 4123-19-03 (K)(5).						
Ē	Self-insuring employer signature	Date					
S		/	/				

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