Bureau of Workers' Compensation

Self-Insured Semiannual Report of Claim Payments

Instructions
- Complete one of these forms for **each** lost-time claim active during the six-month period or after injured worker has returned to work if sooner than six months.
- If you need additional listing space, use back of this form.
- Send completed forms to: **Ohio Bureau of Workers' Compensation**
  30 W. Spring St., Columbus, OH 43215-2256

Injured worker name	Date of injury	This report is for six-month reporting period ending (Date)
		BWC claim number
Employer name		BWC policy number
Claim allowed for: (list all allowed conditions)		Full weekly wage
		Average weekly wage (when applicable)
		Is disability reimbursement requested ☐ Yes ☐ No

Disability dates (Enter the date quit work and the date of return to work for each disability period during this six months.)

Date(s) quit work ▶					
Date(s) return to work ▶					

Compensation paid (If periods are conclusive, give only beginning and ending dates, show total number of weeks, rate and total amount paid. If periods are broken, give individual period.) Additional space on back

Type (*see codes below)	Period From	Period Through	Number of weeks	Weekly rate of comp	Weekly rate of set off	Total rate	Total amount

Date of first payment made in this six-month period	Date of last payment made in this six-month period

Medical expenses paid (For each type listed below, give the dollar amount paid for this six-month period)

Physician fee bills	$
Pharmacy bills	$
Hospital bills	$
Other medical expenses	$
Total of all medical expenses paid for this period	$

BWC Use Only

Certification

I approved the set off of temporary total compensation with the employer's wholly funded non-occupational insurance program in accordance with Ohio Revised Code 4123.56.

Injured worker signature _____ Date _____

By signing below, I do hereby certify the above payments have been issued to the claimant and/or services provider(s). I have the authority to execute this employer's report and certify the information contained herein is correct to the best of my information and belief. I request disability reimbursement when applicable.

Employer signature _____ Title _____ Date _____

Compensation type code				
C/O - Change of occupation	LMWL - Living maintenance wage loss	S&A - Sickness and accident (non occupational)	TT - Temporary total
DEATH - Death award	NWWL - Non-working wage loss	SC - Salary continuation	VSSR - Violation of specific safety requirement
DWRF - Disable workers relief fund	%PP - Percent permanent partial (Paragraph A)	TP - Temporary partial	WWL - Working wage loss
L/M - Living maintenance	PP - Permanent partial (Paragraph B)		
	PT - Permanent total		