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**

This report is for six-month reporting period ending
(Date)

Injured worker name	Date of injury	BWC claim number
Employer name		BWC policy number
Claim allowed for: (list all allowed conditions)		Full weekly wage
		Average weekly wage (when applicable)
		Is handicap 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 handicap reimbursement when applicable.

Employer signature ______ Title ______ Date ______

Compensation type code

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