Ohio | Bureau of Workers' Compensation

# Request for Medical Information

| Claim number | Injured worker name | Date of injury/disability |
|---|---|---|
| | | |

We have received notice of a work-related injury for the claim mentioned above. For us to process this claim, it is necessary for us to have a copy of your treatment records. _____

**Per BWC Rule (4123-6-20.1) providers cannot charge to complete this form**

**Please provide the following items checked below.**

☐ 1. Date first seen: _____

☐ 2. Complaints: _____

_____

☐ 3. History of injury: _____

_____

☐ 4. Objective physical findings: _____

_____

☐ 5. Diagnosis: _____

_____

☐ 6. What diagnostics, if any, did you use in determining the diagnosis? _____

☐ 7. If occupational disease, first date injured worker sought treatment for this condition: _____
and date the medical diagnosis was determined to be work related: _____

☐ 8. Treatment: _____

☐ 9. Date last seen: _____

☐ 10. Prognosis: _____

☐ 11. Was injured worker disabled from employment? ☐ Yes ☐ No
If yes, indicate dates: from _____ to _____ inclusive.

☐ 12. Opinion as to causal relationship between history of injury and diagnosis: _____

_____

_____

☐ 13. Did injured worker have any known pre-existing condition which may have contributed to diagnosis and disability?
☐ Yes ☐ No
If yes, please explain and state whether you believe this pre-existing condition was aggravated by this injury:

_____

_____

☐ 14. Specifically requesting the following documents: _____

_____

I certify the information on this form is true and correct. 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, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

_____ _____

Signature of physician Date signed

_____

Type/print physician name