



Bureau of Workers' Compensation

Filing of an Allegation Against a Self-insured Employer

Instructions

- Complete all employee and employer information.
- Mail the supporting documentation to: **Ohio Bureau of Workers' Compensation
Attn. Self-Insured Department
30 W. Spring St., 22nd Floor
Columbus, OH 43215-2256**
- Fax completed form to: **The BWC self-insured department at 614-621-1081**
- If a representative is filing the complaint on behalf of the injured worker, the representative **MUST** attach a copy of his or her *Injured Worker Authorized Representative (R-2)* card.

BWC Use only

| | |
|----------------|---------------|
| Inquiry number | Policy number |
|----------------|---------------|

Employee information

| | | | | | |
|---|--|----------------|------------------------|---------------------|-------------------------|
| Name | | Date of injury | Social Security number | | Claim number |
| Address | | City | State | Nine-digit ZIP code | Telephone number () |
| Representative name | | | | | |
| Address | | City | State | Nine-digit ZIP code | Telephone number () |
| Employer name | | | | | Telephone number () |
| Address | | City | State | Nine-digit ZIP code | |
| Have you contacted your employer about this issue? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to whom did you speak | | Name | | | Date |
| Employer response | | | | | |

Please state your concern below and attach supporting documents as needed.

Note: We will provide a copy of this allegation to the employer along with a request for a response. By law, the employer must respond to the self-insured department within 14 days of the date he or she receives notification of this complaint.

| | |
|--|------|
| Injured worker or representative signature | Date |
|--|------|

BWC Use Only

Initial compensation not timely paid in allowed claim 4123-19-03(K)(5)

Compensation not paid biweekly 4123-19-03(K)(7)

Compensation paid at incorrect rate 4123-19-03(K)(7)

Compensation payment refused/delayed in allowed claim 4123-19-03(K)(5)

Compensation not paid for entire period of disability (attach copies of C-84s for periods in question) 4123-19-03(K)(7)

Employer not responding timely to request for treatment 4123-19-03(K)(5)

Employer forces use of vacation/sick leave before paying compensation

Other (provide supporting documentation and use other side if needed)

Medical bills not timely paid in allowed claim (attach copies of bills) 4123-19-03(K)(5)

Employer refuses to acknowledge change in attending physician 4123-19-03(K)(5)

Employer refuses to pay travel expenses (attach copy of request) 4123-17-29

Employer refuses to pay living maintenance 4123-19-03(K)(5)

Employer improperly terminated compensation without a hearing, without a statement from attending physician regarding maximum medical improvement, and/or permanency of allowed condition 4123-3-32

Employer does not explain or assist injured worker with workers' compensation 4123-19-03(I)

Injured worker/representative refused access to claim file 4123-19-03(K)(9)

Copy of completed claim application for injured worker not provided by the employer 4123-19-03(K)(3)

ORC _____

OAC _____