Ohio | Bureau of Workers' Compensation

Self-Insured Claims Reimbursement (Sysco) Application

Instructions

- Please answer all questions. If not applicable, use symbol with N/A.
- Submit completed applications to the: SIINQ@bwc.state.oh.us or via fax 614-621-1246.
- You must submit all supporting documentation, or BWC will not consider the Sysco reimbursement request.

Self-Insured employer	
Employer name	Policy number 2000
Address, City, State, ZIP code	Contact phone number

Third-party administrator	
Company name	Contact person
Address, City, State, ZIP code	
Email address	Contact phone number

Injured worker	
Injured worker name	Claim number
Address, City, State, ZIP code	Date of injury

History: Please submit supporting documentation to include all relevant hearing orders (final determination), positive proof of medical benefits (fee bills with ICD-9 codes) and prescription benefits (check copies) and indemnity payments (check copies). Indicate any recoveries as part of the overpayment credit on the *Report of Paid Compensation and Case Reserves* (SI-40). If you have more than one type of indemnity, please submit on additional form.

Basis for request

Total amount and type of indemnity: $_____ From_____ To_____

Total Amount of medical: $_____

Total Amount of prescriptions: $_____

Total amount of request: $_____

Is there a final determination? ☐ Yes ☐ No

Has claim been settled? ☐ Yes ☐ No If no, are negotiations pending? ☐ Yes ☐ No

Signature _____ **Date** _____

(Requestor)