



Instructions

Complete this form or an equivalent form for every offer of transitional work made to an employee who returns to work with restrictions with a date of injury during the bonus period. Submit the completed form to your managed care organization (MCO), use the MCO fax number on page two.

| Employer information | | |
|----------------------|-------------------------|---------------|
| Name of company | Employer's phone number | Policy number |
| Name of employee | | Claim number |
| Date of injury | Job title | |

Transitional work offer

On _____ your physician of record/treating physician _____
 Date Physician name

released you to return to work with restrictions. We offer you the opportunity to participate in our transitional work plan in accordance with the restrictions from your physician beginning _____
 Program begin date

Employee acceptance Employee refusal

Employer acknowledgement

I certify the above information is correct to the best of my knowledge. 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, imprisonment or both.

| | |
|----------------------------|-------------|
| Printed name of employer | Title |
| Signature of employer X | Date signed |

Employee agreement

I agree to participate in transitional work activities within the restrictions indicated by my treating physician. I certify the above information is correct to the best of my knowledge. 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, imprisonment or both.

| | |
|----------------------------|-------------|
| Printed name of employee | |
| Signature of employee X | Date signed |

Agreement verification

Complete this section only if you cannot obtain the employee signature after they successfully return to work for one of the reasons stated below:

Communication barrier Refuse to sign Terminated Seasonal Quit Student/intern

Other _____

Attach employee timesheet/pay stub to verify actual return to work.



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| MCO fax numbers to submit medical information | | |
|--|--------------|--------------|
| 1-888-OHIOCOMP | 216-426-0651 | 888-644-7339 |
| 3-HAB | 513-221-2008 | 800-869-1872 |
| AultComp MCO Inc. | 330-830-4900 | 877-738-0058 |
| CareWorks | | 888-711-9284 |
| CompManagement Health Systems Inc. | | 800-334-4229 |
| Comp One | 330-259-0095 | 877-283-0921 |
| CorVel OhioMCO, Inc. | | 877-677-6756 |
| GENEX Care for Ohio | | 888-275-9719 |
| Health Management Solutions | 614-799-0869 | 888-303-6294 |
| Occupational Health Link | 614-825-1459 | 888-240-6381 |
| Sheakley UniComp | 513-326-8005 | 888-626-2667 |
| Spooner Medical Administrators, Inc. | 440-899-2411 | 800-542-9480 |
| The Health Plan | | 877-847-6927 |
| University Hospitals CompCare | | 800-654-3849 |
| Workstar Health Services | | 877-474-1440 |