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? ☐ Yes ☐ 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) 4123-3-10-(A) (2)

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 4123.56

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 ______________________________