(Project Use Only - Corr32)

INITIAL NOTICE OF ENTITLEMENT TO TEMPORARY TOTAL DISABILITY BENEFITS
DUE PROCESS

mm/dd/yy

Addressed to:
(Injured Worker)

Dear <Injured Worker>:

The Ohio Bureau of Workers' Compensation (BWC) has issued payment of your temporary total disability benefits in the claim below.-

Claim number:	Employer's name:
Injury date:	Policy number:
Claim type:	Employer status:

According to workers' compensation law, the Ohio Revised Code, you may continue to receive these benefits as long as medical evidence supports temporary total disability due to your work-related injury.

Also, according to workers' compensation law, you are not entitled to temporary total benefits if you meet any of the conditions below.

(1) You return to any type of work, including full-time, part-time, self-employment and commission work with any employer. This includes employers other than the one you worked for when you were injured.
(2) Your treating physician says you are ready to go back to your former job.
(3) Your former employer or another employer offers you a new job within your physical capabilities.
(4) You have reached maximum medical improvement. (See enclosed fact sheet for details.)
(5) You have been receiving temporary total benefits for disability due to a substantially aggravated pre-existing condition and that condition has returned to a level that would have existed without the injury.

When your temporary total disability benefits stop, BWC offers other types of benefits and return-to-work programs to help you get back into the work force.

Should your disability continue, BWC will closely monitor the progress of your claim and may schedule you for an independent medical examination. The exam will help determine the appropriateness of medical treatment, rehabilitation potential and the extent of your work-related disability. BWC will notify you of the date, time and location of this exam. After the exam, you and your treating physician will receive copies of the medical report.

Please contact me at the number listed below with any questions or concerns.

Sincerely,

(Service Office Name)	Team #:
(Service Office Address)	Phone #:
(Service Office City/St)	Fax #:

cc: Injured Worker Rep
Employer
Employer Rep
Physician of Record

BWC LOST TIME DESIGN

CORRESPONDENCE DESCRIPTION

Initial Notice of Entitlement to Temporary Total Disability - Due Process

PURPOSE:

This notice provides an outline of the requirements for continued entitlement to temporary total disability compensation, outlines the requirements for medical examinations, and defines the term maximum medical improvement. This letter is the first step in providing due process to the injured worker should his/her benefits be terminated.

FREQUENCY:

Sent out when an injured worker receives an initial award of temporary total benefits; it may also be sent out if an injured worker has received lost time benefits in the past and temporary total benefits are reinstated.

VOLUME:

???

WHEN:

Nightly

RETENTION PERIOD:

This letter should be retained in the system for the life of the claim.

IDENTIFY LOST TIME DIALOGUE:

???

FORMS AND LETTER DESCRIPTION:

None

WHAT CAUSES CORRESPONDENCE TO BE SENT:

System generated when an initial award of temporary total disability compensation is issued; it may also be user generated if temporary total benefits are reinstated.

VARIABLE DATA:

Date of correspondence
Injured Worker Address
Injured Worker Name
Claim #
Claim Type
Type of Correspondence
Date of Injury
Employer Name
Risk #
Claims Rep/Team #/ Service Office/Phone #/Fax #

DISTRIBUTION:

Primary Distribution:

Injured Worker

Copies sent to:

Injured Worker Rep	Employer
Physician of Record	Employer Rep