



Instructions

- Complete all employee and employer information and forward with supporting documentation to:
ATTN: Self-Insured Department, Ohio Bureau of Workers' Compensation
30 W. Spring St., Columbus, Ohio 43215-2256.
- If a representative is filing the complaint on behalf of the injured worker, the representative **MUST** attach a copy of his or her current authorization card (R-2).

BWC Use only

Inquiry number	Policy number
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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
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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 _____