Completing form C-9

Physician's Request for Medical Service or
Recommendation of Additional Conditions
for Industrial Injury or Occupational Disease

Have questions?
Call: **1-800-OHIOBWC**
or
Visit us at
www.ohiobwc.com

Instructions

- Please print or type this report.
- Complete this form and fax or mail to the appropriate MCO.
  - To determine the appropriate MCO ask the injured worker or employer, visit the BWC website at www.ohiobwc.com or contact BWC at 1-800-OHIOBWC (644-6292).
- Use this form (1) if this is a request for services even if services are being provided under the 60-day presumptive authorization, (2) if recommending additional condition(s) or (3) if diagnosis has changed.
- Complete all applicable sections of the form to avoid possible delays in processing this request.
- If injured worker is employed by a self-insuring employer, complete this form and mail or fax to the self-insuring employer.
- Additional copies of this form can be obtained on our website at www.ohiobwc.com, or by calling BWC at 1-800-OHIOBWC (644-6292) option 32.

Section I – Injured Worker

❶ Enter the injured worker's name, BWC claim number or social security number if claim number is not available, the date the injured worker was injured or contracted an occupational disease, address and telephone number.

Section II – Requested Services

❷ Indicate the diagnosis and the ICD-9 codes.

❸ Indicate the beginning and ending date of the service being requested. Indicate the last exam or treatment date.

❹ List the requested services including frequency and duration. Attach copies of current medical reports necessary to support request. Include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment, office notes that contain subjective and objective findings and preexisting conditions.

Section III – Additional Conditions

❺ Complete if you are recommending additional conditions to the claim. Provide diagnosis and ICD-9 codes. Supporting medical documentation is required for all conditions listed. Include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment, office notes that contain subjective and objective findings and preexisting conditions.

- BWC will notify all parties and the provider of the decision.

❻ Refers to the establishment of a relationship between the injury or occupational disease and the industrial accident or exposure. An explanation is required when answering yes or no.

Section IV – Physician Information

❼ Check this box ***only*** if you are the Physician of Record.

❽ Print, type, or stamp physician/provider name and address.

❾ Physician/provider signature, BWC provider number and date of this report are mandatory.

Section V – MCO/SI Employer Decision

- If completed by Self-Insuring Employer refer to ***SI Employer*** section.
- If the C-9 is not faxed or mailed back to the submitting physician within three business days of receipt or within five business days of receipt of the C-9-A, a request for additional information, the authorization for service shall be deemed granted subject to BWC policy excluding retroactive requests.
- Section V: Claim Inactive (further investigation required) The MCO cannot make a decision on this C-9 request. Further investigation is required and a decision will be issued in writing by BWC within 28 days. The MCO will notify the Provider of the BWC decision.
- An MCO can only use the disclaimer box on the C-9, or any other physician generated service request, when the claim or the condition for which the service is being requested, is not yet in an allowed status. Disclaimers shall not be used when authorizing treatment for allowed claims and conditions that are within the statute of limitation.
- Disputes to the decision may be filed in writing to the MCO within 14 days of receipt of written notice of an MCO determination.

BWC
Better Workers' Compensation
Built with *you* in mind.
www.ohiobwc.com

Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease

• Instructions for completing C-9 on reverse side.

FAX NOTE:

To	From
Toll-free phone number	Phone number
Toll-free fax number	Fax number

I. IW

1 Injured worker name	Claim number	SSN if claim number unknown	Date of injury
			/ /
Injured worker address		Telephone number	

II. Requested Services

2 Treating diagnosis ICD-9 code(s)	3 Date service begins	Date service ends	Date of last exam or treatment
	/ /	/ /	/ /

	4 Requested Services	Frequency	Duration
1.	Transitional Work Services (W0637) by Workability Network until released to full duty for task assignment and advancement, workability assessments, education in safe work methods, and assist w/ job modification	Up to 10 visits	
2.			
3.			
4.			

III. Additional Conditions

If you are recommending additional conditions to the claim, supporting documentation is required.

5 Provide diagnosis and ICD-9 code(s), and location and site for conditions you are requesting.

6 In your opinion, based on the history from the injured worker, your clinical evaluation and expertise, is the diagnosis or condition causally related, either directly or proximately, to the alleged industrial accident or exposure? ☐ Yes, please explain ☐ No, please explain

IV. Physician Info.

7 CHECK ☐ if Physician of Record

I certify that 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.

8 Physician/provider name and address *(please print, type, or stamp)*	9 Physician/provider/authorized signature *(mandatory)*	
	BWC Provider number *(mandatory)*	Date (M/D/Y) *(mandatory)*

V. MCO/SI Employer Decision

MCO If this page is not faxed or mailed back to the submitting physician within three business days of receipt or within five business days of receipt of information requested on the C-9-A, the authorization for treatment shall be deemed granted subject to BWC policy, excluding retroactive requests.

☐ Approved Date service begins _____ /_____ /_____ Date service ends _____ /_____ /_____

☐ Amended approval ____________________

☐ Denied Explanation: ____________________

☐ **Pending:** The documentation requested must be submitted to the MCO case manager within 10 business days to allow for a treatment decision. Failure to respond may result in denial.

☐ **Dismissed (Claim inactive – no supporting evidence):** The issue will be reconsidered upon resubmission of C-9 with current supporting medical evidence. This dismissal cannot be appealed.

☐ **Claim Inactive (MCO cannot make a decision on this request, further investigation required):** A decision will be issued in writing by BWC within 28 days.

BWC claim status: ☐ Allowed ☐ Denied ☐ Pending | List allowed ICD-9-code(s)

☐ ***DISCLAIMER - This medical payment authorization is based upon a claim or additional condition that is currently being adjudicated by BWC/IC as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, the services/supplies to which this medical payment authorization applies may not be covered by BWC and may be the responsibility of the injured worker.***

MCO company/SI Employer name (please print, type or stamp)	MCO name and signature (print, type or stamp and sign)		
	MCO number	Telephone number ( )	Date / /

SI Employer

Self-insuring employer use only Fax or mail this page to the submitting physician within 10 days of receipt or the authorization for treatment shall be deemed granted per OAC 4123-19-03 (K)(5).

Self-insuring employer signature	Date
	/ /