Ohio | Bureau of Workers' Compensation

Instructions for Completing the Request for Temporary Total Compensation

This new Request for *Temporary Total Compensation* (C-84) application **replaces** the *Physician's Supplemental Report* previously used as medical evidence to support continued temporary total disability benefits.

Physician of record completed and signed the old application. This **new** C-84 asks the injured worker to complete Items 1 - 6 and sign on the front of the form. The physician of record completes Items 7 - 12 (along with the injured worker's name and claim number), and must provide his/her signature in Item 13. In addition, this application notifies both parties 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 a felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both."

It is the injured worker's responsibility to file this form with BWC. If the injured worker's employer is self-insuring, the injured worker must file this form with that self-insuring employer.

Instructions for Completing Items 1-6 for the Injured Worker

Item 1	Provide information that is up to date and accurate. BWC will use the address provided to mail all correspondence to you, including your compensation checks. A telephone number is helpful if we need to contact you.
Item 2	**List the last date you were off work because of your work–related disability.** **Return to work date** - If you returned to work, give the date you went back to work. If you have not returned to work, leave this blank.
Item 3	**Employer name (where injury/disease happened) –** Give the name of your employer at the time of your injury. Is light-duty or modified work available with this employer? Does your employer have any light-duty or modified work available within your physical capabilities? If you don't know, check the box.
Item 4	**Have you worked, in any capacity, (include full-time, part-time, self-employment or commission work) during the disability period shown above? –** Have you performed any work for any employer, including yourself, during the disability period listed in item 2? Please give accurate and complete information if you answered yes to item 2.
Item 5	**Have you received or filed for any of the following benefits since your injury? –** Indicate if you have received any of the listed benefits because of your injury. Provide claim numbers or dates if you answer yes to any of the benefits on the list. This does not include your personal/group medical insurance for non-work related conditions.
Item 6	**Injured worker signature –** Please sign and date this form when requesting temporary total disability compensation. If you cannot sign, mark the form in the presence of two witnesses. Signing the form means you have answered the questions as truthfully and completely as possible. It also means you are aware that providing false information or concealing information to obtain compensation may subject you to felony criminal prosecution, which may be punished by a fine, imprisonment or both.

Instructions for the physician are on the back

Instructions for Completing Items 7-13 for the Physician
(Along with the Injured Worker Name and Claim Number)

Item 7 **What was the injured worker's position of employment at the time of injury? Can the injured worker return to this position of employment? –** Please specify what the position of employment was at the time of injury. Do you feel that the injured worker is physically capable of returning to this position? Would a gradual return to work be feasible? If you have not received and desire a detailed job description, contact the BWC customer service team or the self-insuring employer.
Can the injured worker return to other employment, including light-duty work, alternative work, modified work or transitional work? – Please explain, listing any restrictions that may apply. Attach an additional sheet, if necessary.

Item 8 List diagnosis(es) for **allowed** conditions being treated, which prevent the injured worker from returning to work.
List diagnosis(es) for **other** allowed conditions being treated.

Item 9 **Disability dates due to the work-related injury/disease –** What are the dates that the injured worker will be unable to work because of the work-related injury/disease?
Return to work date: Actual date the injured worker is released by the physician of record to return to work or the date the injured worker actually went back to work.
Estimated: Is the date the physician of record **anticipates** the injured worker may be able to return to work.

Item 10 **The following clinical findings form the basis for my recommendations –** Provide objective and subjective findings to support your conclusions. This information will support your treatment plan and recommendations.

Item 11 **Has the work related injury(s) or disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement)? –** Based on your clinical findings, do you feel that the injured worker's condition has reached a stage at which no basic functional or physiological changes are expected, within reasonable medical probability, even with supportive treatment to maintain this level of functioning? What barriers exist to prevent normal recovery or maximum medical improvement?

Item 12 **Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? –** Do you think the injured worker is a feasible candidate for vocational rehabilitation services, which focus on return to work? These services could include transitional work, job modification or job search assistance. If not, what is your recommendation to assist the injured worker in returning to employment?

Item 13 **Physician of record signature - Mandatory –** Physician of record signature and provider number are mandatory. Please provide accurate and complete information to assist the timely processing of this request for temporary total disability compensation. Signing the form means you have answered the questions as truthfully and completely as possible. If you provide false information or conceal information to obtain payment, you may be subject to felony criminal prosecution and you may be punished by a fine or imprisonment.

Where Do I File the C-84, and How Do I Get Additional Assistance?

After you and your physician have completed this form, send it to the BWC customer service office nearest you. If your employer is self-insuring, send the form to your employer. If you are not sure if your employer is a self-insuring employer or need additional assistance in completing this form, contact your employer, or call toll-free within Ohio at 1-800-OHIOBWC. If you need assistance and your employer **is** self-insuring, contact the employer or BWC's self-insured department at 1-800-OHIOBWC, and listen to the options to reach a BWC customer service representative.

For More Information Or Assistance

Please contact your local BWC Customer Service Office, or call 1-800-OHIOBWC. BWC forms are available at all BWC customer service offices or by calling 1-800-OHIOBWC and listening to the options to reach a BWC customer service representative.

Ohio | Bureau of Workers' Compensation

Request for Temporary Total Compensation

Claim number

Instructions for Injured Worker
- Please print or type and complete items 1 - 6 on this form.
- Give this form to your physician of record to complete items 7 - 13 on the reverse side of the form.
- When both your portion and the physician's portion are completed, send this form to the local BWC customer service office or self-insuring employer.
- If you have any questions on completing this form, please call the local BWC customer service office or self-insuring employer.

To Be Completed By Injured Worker

1

Name		Date of injury	Telephone number ( )
Address	City	State	Nine-digit ZIP code

2 Last date worked due to current period of work related disability: Return-to-work date:

3 Employer name (where injury/disease happened) | Is modified or light-duty work available with this employer? ☐ Yes ☐ No ☐ Don't know

4 Have you worked, in any capacity, (include full-time, part-time, self-employment or commission work) during the disability period shown above? ☐ Yes ☐ No If yes, provide employer name:

Employer name (self, if self-employed)		Telephone number ( )	
Address	City	State	Nine-digit ZIP code

5 Have you received or filed for any of the following benefits since your injury?

Unemployment compensation ..... ☐ Yes ☐ No OBES claim number _____

Social Security retirement..... ☐ Yes ☐ No Social Security claim number _____

Sick leave ..... ☐ Yes ☐ No From _____ to _____

Public assistance..... ☐ Yes ☐ No Human services case number _____

Wage continuation..... ☐ Yes ☐ No From _____ to _____

Have you applied for or are you receiving other benefits from any other source regarding this injury? ☐ Yes ☐ No

If yes, give Agency/Company name _____ Claim number _____

Injured Worker Signature

6 I understand I am not permitted to work while receiving temporary total compensation. I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation 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.

Signature (if unable to sign, mark before two witnesses)	Date
Witness	Witness

Failure to complete this form, as instructed, may delay or suspend compensation payment.

Instructions to physician

- Please complete items 7 - 13, injured worker name and claim number on this form.
- You may attach additional medical documentation such as diagnostic test results and current treatment plan to support this request.
- Failure to provide complete information may delay or suspend compensation payments to the injured worker.

Injured worker name
Claim number

To Be Completed By Physician of Record

7

What was the injured worker's position of employment at the time of injury?

Can the injured worker return to this position of employment? ☐ Yes ☐ No

Can the injured worker return to other employment, including light-duty work, alternative work, modified work or transitional work? ☐ Yes ☐ No
Please explain, listing any restrictions that may apply. Attach additional sheet if necessary.

8

List diagnosis(es) for allowed conditions being treated, which prevent return to work.

List diagnosis(es) for other allowed conditions being treated.

9

Date of last exam or treatment

Next appointment date

Disability dates due to the work related injury/disease

From: To:

Return to work date

____ / _____ / _____ ☐ Actual ☐ Estimated ☐ Released

10

The following clinical findings are the basis for my recommendations:
Objective Subjective

11

Has the work-related injury(s) or disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement)? ☐ Yes ☐ No If yes give date _____
If no, indicate any barriers preventing normal recovery, or maximum medical improvement. Attach an additional sheet if necessary.

12

Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? ☐ Yes ☐ No Please explain:

Physician of Record Signature - Mandatory

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 or imprisonment or both.

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Physician of record name			BWC provider number - **mandatory**	
Address	City	State	Nine-digit ZIP code	Telephone number ( )
Physician of record signature				Date