Bureau of Workers' Compensation

Filing of an Allegation Against a Self-insured Employer

Submit the form to BWC in one of the following ways.
Online: bwc.ohio.gov
Email: BWCSelfInsuredComplaints@bwc.ohio.gov
Fax: 614-621-1081
Mail: BWC Mail Processing Center
Attn: Employer Services
30 W. Spring St.
Columbus, OH 43215-2256

BWC use only	
Inquiry number	Policy number

Important: If you email, fax, or mail the form to BWC, be sure to sign and date the form BWC cannot process it without a signature.

Employee information

Name	Date of injury	Social Security number	Claim number

Address	City

Employee email address	State	Nine-digit ZIP code	Telephone number ( )

Representative name	Representative email address

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

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, employers must respond to the self-insured department within 14 days of the date they receive notification of this complaint.

Injured worker or representatives' signature	Date

BWC Use Only

Initial compensation not timely paid in allowed claim 4123-19-03(L)(5)

Compensation not paid biweekly 4123-19- 03(L)(7) 4123-3-10-(A) (2)

Compensation paid at incorrect rate 4123-19- 03(L) (7)

Compensation payment refused/delayed in allowed claim 4123-19-03(L)(9)

Compensation not paid for entire period of disability (Attach copies of C-84s for periods in question.) 4123-19-03(L)(9)

Employer not responding timely to request for treatment 4123-19-03(L)(7)

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(L)(5)

Employer refuses to acknowledge change in attending physician 4123-19-03(L)(6)

Employer refuses to pay travel expenses (Attach copy of request) 4123-17-29

Employer refuses to pay living maintenance 4123-19-03(L)(9

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(L)(11)

Copy of completed claim application for injured worker not provided by the employer 4123-19-03(L)(3)

ORC _____

OAC _____