



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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to whom did you speak?		Name			Date
Employer response					

State your concern below and attach supporting documents as needed.

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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
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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 _____