Employee and Employer Instructions for completing the SC (Salary Continuation) or OIL (Occupational Injury Leave) Hourly Payment Request Form

A full-time permanent employee on a transitional work assignment equivalent to his/her regularly scheduled hours who has continuing treatment related to his/her workers' compensation claim must first attempt to schedule the appointment during non-working hours. If the employee is unable to schedule the appointment during non-working hours, the employee must work with the employer to flex his/her schedule to accommodate the appointment. After these two (2) options have been exhausted, the employee may use any remaining salary continuation or OIL hours to attend the appointment, not to exceed one (1) hour per appointment, with a maximum of three (3) appointments per week.

Employee Section – Complete in its entirety
The injured employee is responsible for completing the employee section

The employee must check both options to be eligible to request this benefit

1) attempted to schedule my appointment during non-working hours and;
2) worked with my employer to flex my schedule to accommodate the appointment

The employee should take this form to his/her medical appointment and ask the provider to complete the medical provider's section.

Once the provider's section is complete and the employee returns to work from his/her appointment, the form should be submitted to the agency workers' compensation benefits coordinator.

WILMAPC PROVIDER

IN ORDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE BENEFITS, YOU MUST SEEK MEDICAL TREATMENT FROM A PROVIDER ON THE WILMAPC APPROVED PROVIDER LIST.

YOU MAY CONTACT YOUR MCO REPRESENTATIVE OR ACCESS THE WILMAPC PROVIDER LIST BY THE WEBSITE BELOW:

http://www.das.ohio.gov/wilmapc

Medical Provider Section – Complete in its entirety

The employee's medical provider needs to verify that the employee was actually seen in his/her office on the requested date.

Employer Section – Complete in its entirety
The employer is responsible for completing the employer section.

The employer may contact the employee's physician to verify that the employee attempted to schedule the initial appointment during non-working hours.

Once the form is complete, fax to the Third Party Administrator at **(614) 764-1749**.

SC or OIL Hourly Payment Request Form

Employee and Employer Statement

Please read the instructions before completing the application

OFFICE USE ONLY
Date Received in Office

Employee Section

Employee's name:	BWC Claim #:
Date of Injury:	State of Ohio User ID #:
Name of provider (please print):	Provider phone #:

I am a full-time permanent employee on a transitional work assignment equivalent to my regularly scheduled hours and am continuing to seek treatment related to my workers' compensation claim.

I am requesting **ONE HOUR** of: _____ Salary Continuation (SC) **or** _____ Occupational Injury Leave (OIL)

to attend a medical appointment on**:** Date: _____ From: _____ am/pm To: _____ am/pm

In order to be eligible to receive payment in an increment of one hour, I have;

_____ attempted to schedule my appointment during non-working hours and;

_____ worked with my employer to flex my schedule to accommodate the appointment

I understand that if I have not explored the above two options, I am not eligible to receive payment for my medical appointment.

Employee Signature:	Date:

Medical Provider Section

Must be an Approved WILMAPC Provider

Office Stamp:	**OR**: Name: _____ Address: _____ City, State & Zip: _____ Telephone Number: _____

I verify that the above named injured worker was seen in this office on _____ (DATE) at _____ (TIME)

Provider Signature:	Date:

Employer Section

Employer name:	BWC Policy #:

Is the employee participating in a transitional work assignment and working regularly scheduled hours? _____ Yes _____ No

Has the employee attempted to schedule his/her appointment during non working hours? _____ Yes _____ No

Has the employee worked with the employer in attempt to flex his/her schedule to accommodate the appointment? _____ Yes _____ No

Employer recommends: _____ Approval _____ Denial

Comments:

Employer Designee Signature:	Date: