Ohio | Bureau of Workers' Compensation

Instructions for Completing the Motion

Instructions

Below is an explanation of how to complete the form.

Section I – Injured worker

- Complete name, street address, city, state, ZIP code and claim number.

Section II – This *Motion* is a request to consider the following

- Additional condition – Please state the diagnosis of the medical condition(s) you wish BWC or the Industrial Commission of Ohio (IC) to consider.
  - If requesting a psychiatric or psychological condition, please include the statement below.

    I am aware I am filing this motion to request BWC recognize my psychiatric or psychological condition as being a result of the injury for which this claim is allowed.
    Signature _____ Date _____
- Wage adjustment – Please state the current wage amount and the amount you want adjusted.
- Self-insured claim dispute – Please state the issue you dispute, such as payment of medical bills compensation, authorization of treatment, allowance of medical condition, allowance of claim.
- Other – Please state any other issue or request that you wish BWC or the IC to consider. Please be specific in your request by outlining in detail the action you want BWC or the IC to take.

Note: Do not use this form to file an appeal to a BWC or IC hearing order. Use *Notice of Appeal* (IC-12).

Section III – In support of this *Motion* the following evidence is included

- Additional condition – Please indicate documentation on file that supports your request, or attach medical documentation, such as medical reports, which includes a physician statement addressing the causal relationship between the requested diagnosis and the industrial injury; diagnostic test results, radiology exam results, operative reports, etc.
- Wage adjustment – Please indicate documentation on file that supports your request, or attach earning statements, pay stubs, C-94A wage statement form, payroll report, W2, other tax forms, etc.
- Self-insured claim dispute – Please indicate documentation on file that supports your request, or attach copies of authorization requests, medical bills or other evidence.
- Other – Please indicate documentation on file that supports your request, or attach specific evidence that supports the action you wish taken.
- Certificate of Service: By signing and dating this form you certify you have sent copies of it and supporting documentation to all parties in the claim and their representatives.
- Please indicate the party filing the form by checking the appropriate box.

Ohio | **Bureau of Workers' Compensation**

Motion

Instructions

- Parties to the claim requesting a decision by BWC or the Industrial Commission of Ohio must use this form if any other form or application does not apply. Parties to the claim include the injured worker, employer and/or their authorized representatives and BWC. For a complete list of injured worker and employer forms visit **ohiobwc.com,** or call BWC at **1-800-OHIOBWC.**
- **Health-care providers or managed care organizations (MCOs) do not use this form.** Health-care providers or MCOs must use the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9).
- You must submit proof with this form to support the requested action. When requesting an additional condition, please include medical documentation, such as medical reports that include a physician statement addressing causal relationship between the requested condition and the industrial injury, diagnostic test results, radiology exam results, operative reports, etc. When requesting full or average weekly wage adjustments, include earning statements, such as pay stubs, C-94A wage statement form, payroll report, W2, tax forms, etc.
- The applicant must mail a copy of the *Motion* to all parties and/or their authorized representatives to the claim and will indicate a copy has been mailed by signing Certificate of Service below.

Section I

Injured worker name		Claim number	
Street address	City	State	Nine-digit ZIP code

This *Motion* is a request to consider the following:

Section II

In support of this *Motion,* the following evidence is included: (Please indicate the evidence included to support the request, such as medical reports that include a physician statement addressing causal relationship between the requested condition and the industrial injury, earning statements or any other evidence to support the requested action as outlined in the instructions.)

Section III

Certificate of Service: I certify I have served a copy of this *Motion* on all parties and representatives to the claim.

Signed _____ Date signed _____

☐ Injured worker ☐ Employer ☐ Authorized representative ☐ Administrator of the Ohio Bureau of Workers' Compensation