Ohio | Bureau of Workers' Compensation

Request for Injured Worker Outpatient Medication Reimbursement

- The pharmacy can process a point of sale transaction to avoid the need to submit the C-17.
- The attachment of prescription labels with pricing information or a pharmacy printout with pricing information is required. Photocopies are acceptable. Cash register receipts are not sufficient.
- Pharmacist's signature and date are required.
- Injured workers only use this form for reimbursement of outpatient medication.
- There is a two-year statute of limitations for reimbursement.
- If the injured worker uses more than one pharmacy to fill prescriptions, he or she must submit a separate C-17 for each pharmacy.
- Bill medical supplies, durable medical equipment and other non-drug items on a separate invoice to the managed care organization (MCO). To identify the correct MCO, please log on to **ohiobwc.com,** or call **1-800-OHIOBWC,** and listen to the options.
- The amount paid will be pursuant to the approved BWC fee schedule for drugs.
- For drugs that are available generically, BWC will reimburse the maximum allowable cost amount assigned to that drug. If you or your physician requested the brand-name version of a drug when a generic drug was available, BWC will reimburse at the maximum allowable cost for the drug, which is based on the cost of the generic drug.
- Medications, including over-the-counter items, must be prescribed by a medical professional licensed to prescribe drugs and dispensed by a pharmacy provider enrolled with BWC. Drugs purchased from a physician's office for at-home use are not reimbursable.
- Compounded drugs are not reimbursable.
- Mail completed form to:

SXC Health Solutions
P.O. Box 5226
Lisle, IL 60532-5226

- For additional information, or if you need help to complete this form, please contact an SXC customer service representative by calling 1-800-OHIOBWC and listening to the options.

Check List

- ☐ Is the C-17 filled out completely for processing?
- ☐ Have you completed the Injured Worker Information section?
- ☐ Has the Injured Worker signed and dated the form?
- ☐ Has the pharmacy completed the Pharmacy Information and Prescription Detail sections?
- ☐ Has the pharmacist signed and dated the form?
- ☐ Have you included pharmacy labels with pricing information or a pharmacy printout with pricing information as required? Cash register receipts are not sufficient.

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Injured Worker Information

Date or request	Date of injury	BWC claim number *(Required)*
Injured worker name *(last, first, middle initial)*		
Injured worker address *(street or PO Box, city, state, and nine-digit ZIP code)*		

Pharmacy Information

Pharmacy *(name and store number)*	NABP/NCPDP number *(Required)*	Pharmacy phone
Pharmacy address *(street or P.O. Box, city, state, and nine-digit ZIP code)*		

Prescription Detail

Date Rx written	Prescriber's name		Prescriber NPI number	Prescription number
Date dispensed	National drug code		Drug name, strength, and dosage form	
Metric quantity	Estimated days supply	Refill ☐ YES ☐ NO	Total charge	

Date Rx written	Prescriber's name		Prescriber NPI number	Prescription number
Date dispensed	National drug code		Drug name, strength, and dosage form	
Metric quantity	Estimated days supply	Refill ☐ YES ☐ NO	Total charge	

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Date dispensed	National drug code		Drug name, strength, and dosage form	
Metric quantity	Estimated days supply	Refill ☐ YES ☐ NO	Total charge	

Any person who obtains compensation, medical or pharmaceutical benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation, medical or pharmaceutical benefits to which he/she is not entitled, is subject to felony criminal prosecution for fraud. By signing below, I certify I have read and understand the statements above and agree with these conditions.

Injured Worker

I certify below the information on this form is true and correct to the best of my knowledge and belief.

Injured Worker's signature *(Required)*	Date

Pharmacist

I certify below the information on this form is true and correct to the best of my knowledge and belief.

Pharmacist's signature *(Required)*	Date