

MCO

Selection Form



Complete the form below, and mail it to the address listed at the bottom.

Please make sure BWC receives your signed form within 30 days of you receiving this selection guide.

Employer policy number: (Use the eight-digit number located on your certificate of coverage, which is attached to the envelope.)

Company name: _____

Doing business as: _____

Contact name: _____

Number of employees: _____

Phone number with extension: () - ext.

Fax number: () -

County of operation: (Use the two-digit number from the MCO county table on page 7.)

Mailing address: _____

City: _____ State: ZIP code:

Name of MCO selected: _____

MCO number: (Use five-digit number that appears under the MCO's name in the MCO alphabetical table beginning on page 8.)

Employer's right to select

An employer may select any MCO that meets its individual business needs. The MCO selection is solely the employer's choice.

Mail or fax form to: Ohio Bureau of Workers' Compensation Attn: Policy processing
30 W. Spring St, 22nd floor
Columbus, OH 43215-2256 Fax: (614) 728-0278

Employer signature: _____

Employer name (print): _____

Employer title: _____

Date: - -