MCO Selection Form

Complete this form, then mail or fax it to BWC using the address or fax number found below. Remember to keep a copy for your records.

Employer policy number: ◯◯◯◯◯◯◯◯ *(Use the policy number found on your certificate of coverage.)*

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 County codes on page 4 of this guide.)*

Mailing address: ____________________

City: ______________ State: ______ ZIP code: ______

Name of MCO selected: ____________________

MCO number: ◯◯◯◯◯ *(Use the five-digit number from the Alphabetical MCO list on page 4 of this guide.)*

Employer's signature: ____________________

Employer name (print): ____________________

Employer title: ____________________

Date: M M – D D – Y Y Y Y

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: Open Enrollment
30 W. Spring St., 22nd Floor
Columbus, OH 43215-2256

Fax: 614-719-5313