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 3 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 3 of this guide.)*

Employer's signature: _____

Employer name (print): _____

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
Policy processing
30 W. Spring St., 22nd floor
Columbus, OH 43215-2256
Fax: 614-719-5313