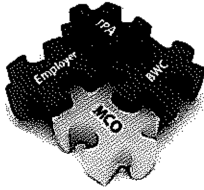
Ohio Employee Health Partnership
MCO 10017



2010 Employer/MCO Open Enrollment Form

Employer Policy Number:

Business Name:
DBA (If applicable):

Contact Name/Title:

Phone Number:

Number of Employees: __________ **Counties of Operation:** _

MCO Selected: **<u>OHIO EMPLOYEE HEALTH PARTNERSHIP - #10017</u>**

Employer Signature/Title: ____________________________**Date:** __________

To ensure our commitment to you, please indicate from the following menu, the services you request from our MCO:

1.	In-Person Quarterly Visits	Yes	No
2.	# Identification Cards- English	_______________	
3.	# Identification Cards - Spanish	_______________	
4.	# Identification Cards - Other	_______________	
5.	Employer Manual	Yes	No
6.	Quarterly Reports	Yes	No
7.	Occupational Health Clinic List	Yes	No
8.	Injury Packets	Yes - How Many?	No
9.	On-site training/education	Yes	No
10.	Other ____		

Thank you for choosing Ohio Employee Health Partnership. We welcome your partnership with our MCO and will commit to working with you to help you achieve your Workers' Compensation Program Goals!

Fax this completed form to: 1-877-605-8311

DON'T GIVE UP YOUR RIGHT TO CHOOSE!

Disclaimer – Employer's Right To Select
An employer may select any MCO that meets its individual business needs during MCO Open Enrollment. Selection of an MCO is not predicated upon employer selection of a Third Party Administrator and/or Group Rating Sponsor.