


WORKSTAR
HEALTH SERVICES INC.

Complete this form, then mail or fax to us at 800-256-9940.

Employer policy number: _____ (Use the 8 digit number located 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 MCO county table in the Open Enrollment Guide.)

Mailing Address: _____

City: _____ State: ____ Zip Code: _____

Name of MCO Selected: **WorkStar Health Services, Inc.**

MCO number: **10074**

Employer Signature: _____

Employer name (print): _____

Employer Title: _____

Date: _____



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:

WorkStar Health Services, Inc.
7116 Sennet Place, Suite 201
West Chester, OH 45069
Fax: 800-256-9940