ACCESS URGENT
MEDICAL CARE

BWC MCO/TPA Information

INJURED WORKER: _____

EMPLOYER: _____

Contact Person: _____

BWC Policy/Risk Number *(from certificate)*: _____

Address: _____

City/Sate/Zip: _____

Phone No.: _____ **Fax No.:** _____

MCO/TPA NAME: _____

Address: _____

Phone No.: _____ **Fax No.:** _____

If your employer is self-insured, please write the Third Party Administrator's information above and the address that claims are to be sent to.

Please complete and fax this information to (614) 755-6379 as soon as possible. If this information is not provided within 48 business hours of treatment, all balances will be turned over to **patient responsibility.**

Thank you.