MANAGED CARE ORGANIZATION (MCO) CHOICE FORM

This form pertains to workers' compensation claims only. A workers' compensation claim is filed when the employee provides the District with a completed 801 form.

BRIEF DESCRIPTION OF PROGRAM

Salem-Keizer Public Schools has contracted with an MCO panel that includes doctors from two specific health care provider groups as part of our MCO program. These doctors are specifically trained to deal with work-related injuries and must follow the State of Oregon's workers' compensation MCO regulations.

You are required to select an MCO organization for the treatment of your workers' compensation claim. The MCO you select will provide all medical treatment and services for the life of the claim according to the State MCO regulations. **Once you become enrolled, you cannot change MCO's.**

By checking the box below, I select the following as the MCO organization for my workers' compensation claim:

I select: ☐ Providence MCO 1-800-947-4707 ☐ Kaiser On-The-Job (503) 249-3531

ENROLLMENT INFORMATION

Please complete the sections below and return to the completed form to Risk Management. Keep a copy for your records.

Employee Name:	Date of Injury:
Employee #:	School or Dept Name:

Exceptions:

1. You may receive immediate emergency medical treatment from a medical provider who is not a member of the MCO, but you must choose an attending physician within one of the MCO panels for all subsequent treatment.
2. If you have an established, documented history of treatment with a primary care physician (an M.D. or D.O. who is a general practitioner, a family practitioner, or an internal medicine specialist), or for a limited time with an authorized nurse practitioner, you may continue to receive your medical services from that provider if he/she agrees to comply with all terms and conditions of the MCO regarding service delivery.

☐ I wish to treat with my current, primary care provider. (Please provide contact information below)

Provider's Name: _____ Phone: _____

Provider's Address: City: State: ZIP:

I understand that the links below provide information, including a directory of providers, for the MCO I have selected.

☐ Yes ☐ No

Providence MCO: http://www.providence.org/healthplans/mco/default.aspx

Kaiser On-the-Job: https://members.kaiserpermanente.org/kpweb/toc.do?theme=locate_members

My signature below confirms that I have read this document in its entirety. I have had the opportunity to contact Risk Management (x3070) with questions. I understand that the provider I selected will provide all treatment as it pertains to my workers' compensation claim.

Signature: Date: