INCOMPLETE FORMS CANNOT BE PROCESSED

Paul Lancia
Marketing Rep.

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Ext. 9652 or Ext. 9445

MISSOURI AGREEMENT FORM

COMPANY NAME: _____

DBA: _____
(DOING BUSINESS AS ANY OTHER COMPANY NAME)

ADDRESS: _____

_____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

(PLEASE LIST ALL OTHER LOCATIONS ON THE BACK OF THIS FORM. IF THERE ARE NO OTHER LOCATIONS, PLEASE CHECK HERE ☐ .)

EMPLOYER CONTACT: _____ TITLE: _____

ESTIMATED # OF EMPLOYEES: _____

TELEPHONE NUMBER: ( ) _____ EXT: _____ FAX: ( ) _____

INSURANCE CARRIER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ EFF DATE: _____ EXP DATE: _____

TERMS AND CONDITIONS

CompManagement warrants that it is a Preferred Provider Organization (PPO) providing a network of hospitals, primary care physicians, sub-specialists and rehabilitation centers offering savings for the health care services of the network to employers or Workers' Compensation insurers where such services are not provided pursuant to a policy of group health insurance as part of an employee benefit plan or not offered on a prepaid basis. CompManagement warrants that it does not make medical decisions.

This agreement made between CompManagement and Employer listed above, is hereby entered into in accordance with the following:

1.) The CompManagement Provider Network will report savings to clients of CompManagement on a monthly and quarterly basis.
2.) This contract to utilize the CompManagement Network of Providers shall be for a term from the date signed to the next Workers' Compensation insurance policy renewal date and then renewed on an annual basis to coincide with the insurance renewal. Either Party may cancel this contract upon 30 days written notice.

This agreement has been executed with the understanding that it is the employer's right to choose a health care provider as set forth under Section 287.140 RSMo.

AUTHORIZED SIGNEE: _____ TITLE: _____

SIGNATURE: _____ DATE: _____

AGENCY NAME: _____ TELEPHONE #: ( ) _____

FAX #: ( ) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BROKER NAME: _____ DATE: _____

Please list all subsidiary and branch locations and the estimated number of employees at each location: (If additional space is needed, please attach a separate sheet.)

DIVISION:__________ ESTIMATED #. OF EMPLOYEES: __________

ADDRESS: __________

____

CITY: __________ COUNTY: __________ STATE: __________ ZIP: __________

DIVISION:__________ ESTIMATED # OF EMPLOYEES: __________

ADDRESS: __________

____

CITY: __________ COUNTY: __________ STATE: __________ ZIP: __________

DIVISION:__________ ESTIMATED # OF EMPLOYEES: __________

ADDRESS: __________

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CITY: __________ COUNTY: __________ STATE: __________ ZIP: __________

DIVISION:__________ ESTIMATED # OF EMPLOYEES: __________

ADDRESS: __________

____

CITY: __________ COUNTY: __________ STATE: __________ ZIP: __________

DIVISION:__________ ESTIMATED # OF EMPLOYEES: __________

ADDRESS: __________

____

CITY: __________ COUNTY: __________ STATE: __________ ZIP: __________