NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Preferred Provider Organization (PPO) Registration Form
For Self-Insured Employers

Please complete ALL requested information:

Name of Employer:

Employer aliases (i.e. AKAs):

Address of employer:

County:

Employer contact name and address:

Name of certified PPO:

Effective date of employer participation in the PPO program:

Union employees? ☐ Yes ☐ No

Are any union employees in the program? ☐ Yes ☐ No

Total estimated number of employees covered by the PPO:

Date:

Mail, fax or email information to:
Research and Data Analysis Bureau
New York State Workers' Compensation Board
328 State Street, Schenectady NY 12305-2318
Fax#: (518) 388-1299
Email: MCNetworks@wcb.ny.gov