

Enclosure 2

Vendor Selection Form

(Please complete a separate form for each plan or FEHB Sub-Code)

Plan Name:

FEHB Sub-Code:

Please mark all boxes below that apply:

- Health Plan will conduct the CAHPS® 2.0H Adult Commercial Survey
- Health Plan will conduct the CAHPS® 2.0H Child Commercial Survey
- Health Plan has fewer than 500 FEHB Subscribers/Contracts and will not be conducting CAHPS® Surveys in 2001

NCQA Certified Vendor's Name who will be conducting the survey _____

Vendor Contact, Address, E-Mail and Telephone Number:

Health Plan Contact, Address, E-Mail and Telephone Number:

Plan Contact & Address for Invoice (if different from above):

Please send the form by overnight mail or fax it to:

U.S. Office of Personnel Management
Retirement and Insurance Service
Office of Insurance Programs
Attention: CAHPS® Team
1900 E Street, NW. Room 3415
Washington, DC 20415

email address: rpierce@opm.gov
Fax #: (202) 606-0633 or 606-0036

(Please complete and return to OPM by December 8, 2000)