

Ohio Department of Medicaid
Subpoena

To

Name

Street Address

City, State, Zip Code

In the matter of:

Subpoena Number: _____

Pursuant to Section 5160.20 of the Revised Code, you are directed to appear and testify before the duly appointed representative of the Director of the Ohio Department of Medicaid to testify as a witness in the above matter. **PLEASE BRING THIS SUBPOENA WITH YOU.**

Place where you are to appear:

Date and time that you are to appear:

YOU ARE FURTHER DIRECTED TO BRING THE FOLLOWING WITH YOU:

Subpoena issued at the request of:

Name:

Address:

Telephone:

WITNESS my hand and seal of the
Ohio Department of Medicaid

This ____ day of _____, 20 ____

Chief Legal Counsel

Revised Code section 9.84 states that a witness in this proceeding may be accompanied, represented and advised by his or her attorney

RETURN OF SUBPOENA:

I served the person named above with this subpoena on the ____ day of _____, ____

by the following method: Personal Service Registered Mail Regular Mail

Other (specify) _____

Name

Title

Date