Ohio Department of Medicaid

SIGNATURE AUTHORIZATION

I, _____, Deputy Director with the Ohio Department of

Medicaid, do hereby designate _____

with authority to sign my name to:

for which a Deputy Director's name is required.

This authorization shall remain in full force effective _____ until specifically revoked.

_____

Pursuant to the foregoing the signature shall be affixed as follows:

DEPUTY DIRECTOR WITH THE OHIO DEPARTMENT OF MEDICAID

_____

as signed by

LEGAL REVIEW/APPROVAL: Must be signed and dated by Office of Legal Counsel before authorization is valid.

_____ _____

Office of Legal Counsel Date

Ohio Department of Medicaid

SIGNATURE AUTHORIZATION – INSTRUCTIONS

FIELD I: Enter the name of the deputy director that is granting authorization for designee to sign their name

FIELD II: Enter the name of the designee that is being granted authorization to sign for the deputy director

FIELD III: Enter signature items that designee is authorized to sign on behalf of the deputy director

FIELD IV: Enter the start date

FIELD V: Enter the deputy director's name and title. Deputy Director will sign their name on the line.

FIELD VI: Auto populated field – do not change.

FIELD VII: Auto populated field – do not change. Designee will sign the deputy director's name and place their initials behind the signature on the line.

Once Deputy Director and designee signature has been affixed to form, it should be submitted to the office of legal counsel for review and approval.