

Ohio Department of Medicaid  
**OHIO HEALTH PLANS**  
**LETTER TEMPLATE APPROVAL ROUTE SLIP**

Bureau	Section/Work Unit	
Contact Name	Contact Number	
Validate Link(s) and Phone Numbers Work Initial		Date
Section/Work Unit Supervisor Signature		Date
Bureau Chief Signature		Date
<b>Form Change Information</b>		
Form Name	Form Number	
Type of Change <input type="checkbox"/> Content/Format <input type="checkbox"/> MITS Date Interface		
Date Needed By		
Related to a Budgetary Initiative <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes Which One _____ Implementation Date _____		
<i>If immediate turnaround is necessary, please justify</i>		
Urgent	Date Needed By	
<b>System Change Information</b>		
Change Order (CO) Information		
Date Created	Created By	CO #
Impact _____ (1 Extensive/Widespread; 2 Significant/Large; 3 Moderate/Limited; 4 Minor/Localized) Urgency _____ (1 Critical; 2 High; 3 Medium; 4 Low)		
Format Change Completed By		Date
MITS Interface Change Completed By		Date
<b>Review &amp; Production</b>		
Changes Verified By		Date
Bureau Approval Signature		Date
Promotion Date		