

**Ohio Department of Medicaid  
MEDICAID PROVIDER INTERIM SETTLEMENT**

Covering the period from \_\_\_\_\_ to \_\_\_\_\_

Provider Name:	Provider Number:
Street Address:	Federal ID Number:
City, State & Zip:	Date Submitted to OFS:

Programs From Which Amount is Due to Medicaid/(Provider)	Services Period	SFY Interim Settlement
1. Title XIX	From: _____ To: _____	
2. Title V	From: _____ To: _____	
3. Total	From: _____ To: _____	

The above is an interim settlement and as such is subject to audit. This interim settlement is being made to bring the amounts due state or provider closer to those, which will come about as a result of a final settlement. You will be notified of the final settlement by the Bureau of Health Plan Policy – Financial Management Unit upon issuance of a final settlement report at a later date.

If there is a balance “due provider” on line 1, a warrant will be issued by the Ohio Department of Medicaid. If there is a balance “due provider” on line 2, a separate warrant will be issued by the Ohio Department of Health. Warrants will be sent under separate cover from the issuing department.

For Department of Health Use Only		
Warrant Number	Date of Warrant	Amount of Warrant

**Distribution: Office of Fiscal Services**

**Originator: Bureau of Health Plan Policy – Financial Management Unit**