

Submit completed signed application with attachments to:
 Bureau of Managed Health Care
 PO Box 182709
 Columbus, OH 43218-2709

(For State Use Only)

OHIO DEPARTMENT OF MEDICAID
Ohio Medicaid Provider Number Application for Managed Care Plans

Organizational Provider Type: Managed Care Plan (77)

Provider Identification: (Print or type entries)

Organization Name		
Abbreviated Organization Name (If your name exceeds 30 spaces, indicate preferred abbreviation.)		
Employer Identification Number ____ - _____	You must attach a signed W-9 form *	Social Security Number (Proprietor) _____ - _____

Address Information:

Physical Location of Business (Applicants: If more than one location, list Primary.)

Building Name / OR / Department / OR / In care of			
Business Address (Number, Street, Avenue, Route, etc. [P.O. and Drop Boxes are not acceptable])			Suite Number
City	County	State	Zip Code (Zip + 4, if possible)
Telephone Number (____) _____ - _____			

“Pay to” Address (Name & Address to which Remittance Advice is to be mailed)

(If Address is not different from “Physical Location of Business” address, leave blank)

Building Name / OR / Department / OR / In care of			
Address			Suite Number
City	State	Zip Code (Zip + 4, if possible)	

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)

(If Address is not different from “Physical Location of Business” address, leave blank.)

Building Name / OR / Department / OR / In care of			
Address (P.O. and Drop Boxes are not acceptable)			Suite Number
City	State	Zip Code (Zip + 4, if possible)	

This Form May NOT Be Duplicated

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Handbook and Manual Information Website:

All handbook and manual information can be found on the website:

HTTP://emanuals.odjfs.state.oh.us/emanuals

EFT Authorization:

Please complete the "Authorized Agreement for State Medicaid Payments" to apply for Electronic Funds Transfer (EFT).*

Note: please remember to include a "VOIDED" check with the account and transit routing/ABA number of the provider account.

Have you ever been issued an Ohio Medicaid 7-digit Provider Number?

YES NO If YES, you must list them in the boxes below.

7-digit Provider No.	County						

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

STOP

Have you remembered . . .

to complete, sign, date, and attach your Form **W-9**,

to complete, sign, date and attach your **EFT Application** with a **VOIDED CHECK** that includes the account and transit routing/ABA number of the provider's account,

to double check the **Application** to make sure all applicable information has been included,

to look for footnotes (*) on the Application and attach the necessary material,

to provide us with **ALL** names, addresses, and legal numbers as required,

to complete **ALL** date fields,

to have authorized representative sign and date the Application on page four.

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OHIO MEDICAID PROVIDER NUMBER APPLICATION
FOR MANAGED CARE PLANS

I certify that I am the chief operating officer, or chief executive officer of the business organization that is applying for the provider number. I certify that the information I have given on this application is accurate, complete and truthful.

Authorized Representative Name and Title *(please print)*:

Authorized Representative Signature:

Date: __/__/____ (mm/dd/yyyy)

APPLICATIONS SUBMITTED WITHOUT THE REQUIRED ATTACHMENTS WILL BE CONSIDERED INCOMPLETE AND RETURNED TO APPLICANT

For State Use Only

Signature of Authorized Agent:

Date: __/__/____ (mm/dd/yyyy)

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Date Received (1)	Date Received (2)	Date Received (3)	Date Received (4)
Date Returned (1)	Date Returned (2)	Date Returned (3)	Date Returned (4)

Date Processed	Effective Date	Provider Number
Operator's Number	Application Number	Ticket Number

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