Reset Form

Ohio Department of Medicaid

AUTHORIZATION AGREEMENT FOR STATE MEDICAID ICF-MR INDIVIDUAL ASSESSMENT

Attention Medicaid Providers

Provider record files must reflect accurate information. In order to provide secure/certified electronic reports, we must maintain current facility information and e-mail addresses at all times. It is your facility's sole responsibility to provide ODJFS with the correct contact information and e-mail address.

NOTE: Reports are to be Distributed by Secure/Certified Electronic Mail

Medicaid Provider Number *(seven digits)*		
Facility Name		
Facility Mailing Address		
City	State	Zip Code
Contact Name	Contact Phone Number *(Including Area Code)*	

Indicate below the E-mail address where secure/certified e-mails with IAF reports will be received and monitored.

Email Address

By signing below, I state that I am authorized to make changes in the delivery of IAF reports from the facility's US postal service address to secure/certified e-mail. I understand that it is the facility's responsibility to inform the Bureau of Long-Term Care Services and Supports at Medicaid of any changes to the facility's e-mail address. Failure to do so could result in not receiving or being able to correct IAF reports on a timely basis.

Name of Person Authorized to Sign *(Please Print)*	Signature of Person Authorized to Sign	Date

Complete and return this form to:

Ohio Department of Medicaid
Bureau of Long-Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709

If questions, contact: 614-752-3402