Ohio Department of Medicaid

EXITING INFORMATION AND FORWARDING INSTRUCTIONS FROM LONG-TERM CARE FACILITY OPERATORS/PROVIDERS (NFs and ICFs-MR) DISCONTINUING PARTICIPATION IN THE OHIO MEDICAID PROGRAM

The information on this form may be used to forward the final proposed adjudication order, any correspondence pertaining to the exiting operator/provider, and for payment of encumbered funds which may become due to the exiting operator/provider. ***This form must be completed and returned to the appropriate coordinator at the address shown below within ten (10) business days from the effective date of the change, termination, closure or voluntary withdrawal. If any of the information reported on this form changes after initial submission, please send a revised form to the appropriate Medicaid coordinator to keep the information current.***

FOR A CHANGE OF OPERATOR/PROVIDER (CHOP)	**FOR A TERMINATION, CLOSURE OR VOLUNTARY WITHDRAWAL**
CHOP Coordinator Ohio Department of Medicaid Bureau of Long Term Care Facilities Facility Contracting Section P.O. Box 182709 Columbus, Ohio 43218-2709	Closure Coordinator Ohio Department Medicaid Bureau of Long Term Care Facilities Facility Contracting Section P.O. Box 182709 Columbus, Ohio 43218-2709

SECTION 1 – FACILITY NAME, ADDRESS AND EXITING OPERATOR/PROVIDER INFORMATION

Facility (DBA) Name	
Facility Address	
City, State, Zip Code	County
Exiting Operator/Provider's Last Day For Facility Operation *(M/D/YYYY)*	
Exiting Operator/Provider Name *(legal entity)*	

SECTION 2 – EXITING OPERATOR/PROVIDER IDENTIFIER NUMBERS

Medicaid Legacy Number *(formerly the Medicaid provider number)*	National Provider Identifier (NPI)
CMS Certification Number (CCN) *(formerly the Medicare provider number)*	Federal I.D.

SECTION 3 – EXITING OPERATOR/PROVIDER MAILING AND CONTACT INFORMATION

Mailing Name	
Mailing Address - *Address to which correspondence may be mailed. Post office box or drop box addresses will not be accepted.*	
City, State, Zip Code	County
Name of Contact for Questions Regarding Mailing Information	E-mail Address
Telephone Number	Fax Number

SECTION 4 – EXITING OPERATOR/PROVIDER PAYMENT AND CONTACT INFORMATION

"Pay To" Name		
Payment Address - *Address to which the warrant and remittance advice may be mailed.*		
City, State, Zip Code		County
Federal I.D. For "Pay To" Entity		
Name of Contact for Questions Regarding Payment Information	E-mail Address	
Telephone Number	Fax Number	

SECTION 5 – ADDITIONAL INFORMATION OR INSTRUCTIONS REGARDING EXITING ENTITY

SECTION 6 - CERTIFICATION AND SIGNATURE

Complete this section, including the authorized signature and date, to certify that the information provided on this form is correct and complete. This section must be completed on all submissions.

Name *(print or type)*		Title *(print or type)*
Authorized Signature		Date
Telephone Number	Fax Number	E-mail Address