Ohio Department of Medicaid

MCP – HOSPITAL SERVICES FORM – ATTACHMENT C

The provider must complete a copy of this form for each hospital covered by the terms and conditions of this addendum. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the signature block must be included on each page. MCP acknowledges changes on the date received. Effective Date will be determined by the MCP.

MCP Name: _____

1. Hospital Information

Hospital Name:				
Address:	City:	State:	Zip:	County:
Tax ID Number:	NPI:			

2. Hospital Services Categories

Please check the applicable line for each category of service the above-named hospital covers.

☐ Adult General Medical/Surgical Services	☐ Neonatal Intensive Care -- Level 3	☐ Special Care
☐ Pediatric General Medical/Surgical Services	☐ Adult Intensive Care	☐ Psychiatric Services
☐ Obstetrical Services	☐ Midwife Services	☐ Practitioner Services
☐ Nursery Services	☐ Outpatient Surgery	☐ Inpatient Psychiatric Care/Institution for Mental Disease
☐ Nursery Services Level 1 & 2	☐ Pediatric Intensive Care	☐ Other *(Please specify)*: _____

3. Hospital does not provide the following hospital service(s) because of an objection on moral or religious grounds. List services: