Ohio Department of Medicaid

Provider Information Update

~ Return *only* if there is a change in your name/address/telephone number ~

The department's BCI database provider record file must reflect accurate information and can only be updated manually by our office. It is essential that our office be informed of any change in address or other information. Please provide us with your current information and return it to the address listed below.

IMPORTANT: BCI only sends partial Social Security Numbers on background checks. If your name *(as it appeared on the envelope)* does not match the exact name that appears on your background check, it may not be matched to you. You must provide the Ohio Department of Medicaid with your current name and address. If you have a name change, you must submit a copy of your marriage license, divorce decree, or other court document verifying the legal name change.

NOTE: You are required, by the terms of your Ohio Medicaid Provider Agreement, to update your address via the MITS Provider Portal (Medicaid.Ohio.gov) within 30 days of any change. Failure to do so may interrupt your claims processing. Name changes must be faxed to Provider Enrollment at (614) 995-5904 you must submit proof of the name change (e.g. copy of marriage license, divorce decree, or other documentation).

NOTE: The *www.myohiohcp.org* website is not a State of Ohio website. This website (portal) is for the case management of the waiver program and it's where providers can obtain All Service Plans (ASPs/Lists) info. You should also update your address at this website/or portal.

PLEASE PRINT CLEARLY

Provider Number	Name (last name, first name, and middle initial)
If name change, state reason for change *(e.g.marriage, divorce)* list former name and submit copy of court documentation *(e.g. marriage license, divorce decree, etc.)*.	Effective Date
Current Address *(Street Address, City, State, Zip Code)*	County of Residence
Previous Address *(If different from above)*	
Home Telephone *(Include Area Code)*	Cell Phone *(Include Area Code)*
E-mail Address	
How many *years* have you been a resident of the state of Ohio? Do **NOT** write "*all my life*" or any similar statement.	
Signature	Date

Return This Completed Form To

Ohio Department of Medicaid
Attn: BCI Coordinator
P.O. Box 182709
Columbus, OH 43218-2709

TELEPHONE: (800) 686-1516 FAX: (614) 995-5904

ODM 10108 (Rev. 11/2016)