Ohio Department of Medicaid

Voluntary Termination
Of Ohio Medicaid Provider Agreement

*(Submit this form **only** if you want to terminate your provider agreement)*

Date:

To: Bureau of Network Management
From: Provider Number _____
Provider Name: _____

Address: _____

I, _____ am voluntarily relinquishing my independent provider number and request
(Print Name)

that **my provider agreement be terminated effective the date of this notice**. I no longer provide services to consumers on the Ohio Home Care Waiver. I understand that if I voluntarily terminate my provider agreement I must reapply, and be accepted, before providing services in the future.

_____ _____
Signature Date

IF YOU ARE VOLUNTARILY TERMINATING YOUR PROVIDER AGREEMENT, RETURN THIS FORM TO

Ohio Department of Medicaid
Attn: BCI Coordinator
P.O. Box 183017
Columbus, OH 43218-3017

TELEPHONE (800) 922-3042 / **FAX** (614) 995-5904