

**OHIO MEDICAID PROGRAM
DEPARTMENT OF JOB AND FAMILY SERVICES
PROVIDER CHANGE OF ADDRESS FORM**

Medicaid Provider #
Date:

Dear Medicaid Provider:

The department's Provider Record file must reflect accurate information. It is essential that our office be informed of any change of address. The department was recently made aware that your provider address has changed. Please provide us with current address information by **completing all four blocks** on this form and returning it to the Provider Enrollment Unit.

You must inform the department within thirty days of any changes to your provider information including, but not limited to, address changes.

Please return to:

Provider Enrollment Unit
P.O. Box 1461
Columbus, Ohio 43216-1461
Telephone: 1-800-686-1516

- I am using Electronic Funds Transfer and would like to continue using the same Tax ID and account information.
- I am using Electronic Funds Transfer but have changed account information. (Complete a new Authorization Agreement for Electronic Transfer of State Medicaid Payments form.)

Telephone Number: _____ - _____ - _____

Please Print or Type

Block 1. Provider Name

Block 2. Provider Address (This is the address that your facility is physically located) No P.O. Box or Drop Box addresses accepted
County Name: _____

Block 3. Pay-To-Address (This is the address to which the warrant is mailed)

Block 4. Mailing Address (This is the address to which all department correspondence is mailed, excluding warrants) No P.O. Box or Drop Box addresses accepted

Please print name and title, sign, and date below to certify the information contained in this form is correct.

Individual Practitioner Name and Title (please print)	Individual Practitioner Signature	Date
For Groups and Organizations: Authorized Representative Name and Title (please print)	Authorized Representative Signature	Date