

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES**  
**CLINICAL LABORATORY IMPROVEMENT AMENDMENTS**  
**(CLIA)**  
**REGISTRATION FORM**

This form is to be completed by any provider who will be performing laboratory services and billing Ohio Medicaid for any CPT code in the 80,000 range.

Provider Name: _____	Provider Social Security #: _____
Provider Address: _____ (Site of laboratory)	Provider Tax I.D. #: _____
_____	Provider CLIA #: _____
_____	Medicaid Provider #: _____ (Associated with CLIA #)

Name of Contact Person: \_\_\_\_\_

Phone Number of Contact Person: \_\_\_\_\_

Mailing Address of Contact Person: \_\_\_\_\_  
(If different from above)

\_\_\_\_\_

\_\_\_\_\_

After completing this form, please return to the following address:

Provider Network Management Section  
Provider Enrollment Unit  
P.O. Box 1461  
Columbus, Ohio 43216-1461  
Fax number (614) 995-5904