State Use Only

Ohio Department of Job and Family Services
GROUP PRACTICE PROVIDER INFORMATION

To add individual practitioners to your group, please complete and return this form to the address shown below.

Group Name
Street Address
City, State and Zip Code

Group Provider Number
Date

List individual practitioners participating in your group. If additional space is required, use back of this form.

Individual Name (print or type)	**Address**	**Individual Ohio Medicaid 7-digit Provider Number**

The Group Provider so named above does certify and agree to the following:

1. Written authorization or a contractual agreement between each individual practitioner and the group entity (employer, facility, health care delivery system, etc.) is on file permitting the group provider, so named above, to submit charges to the Ohio Department of Job and Family Services and receive payments on behalf of the individual attending practitioner for services rendered to Ohio Medicaid recipients as a part of the group activity.

2. Notification will be provided to the Ohio Department of Job and Family Services of the addition of any practitioner(s) to the group entity or the deletion of any individual practitioner(s) from the entity so named above.

Signature of Authorized Agent	Printed name and title	Date

Return to: Ohio Department of Job and Family Services, Provider Enrollment Unit, P.O. Box 1461, Columbus, Ohio 43216-1461.