

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
 BASIC BILLING TRAINING
 REGISTRATION FORM**

Thank you for your interest in participating in one of the Medicaid basic billing training sessions conducted by the Ombudsman/Medical Assistance Coordinator (MAC) Unit of the Ohio Department of Job and Family Services. Please complete both pages of this registration form, and return it to the Ombudsman/MAC Unit. Refer to the training schedule for details.

Medicaid Provider Number(s): _____

Name of Provider or Billing Agency: _____

Type of Provider (physician, dentist): _____

CONTACT PERSON

Name (first, last): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact's Telephone #: _____

Contact's Fax #: _____

1st Choice

(If the training room is full for this date, you may be scheduled for the training noted as your 2nd choice.)

Training Date: _____

of Session: _____

Name of Attendee(s) (first, last)	Position (biller, office manager)

2nd Choice

Training Date: _____

of Session: _____

Name of Attendee(s) (first, last)	Position (biller, office manager)

Please answer the following questions.

1. Can you access Ohio Medicaid’s website for electronic provider manuals? The website address is (<http://emanuals.odjfs.state.oh.us/emanuals/>).

Yes _____ No _____

2. Do you or your agency offer billing services to more than one Ohio Medicaid provider?

Yes _____ No _____

3. Is your agency a Medicaid provider or a billing agent? If your agency is a Medicaid provider, please indicate your agency’s Medicaid number(s) on the top of the previous page.

Medicaid Provider _____ Billing Agent _____

4. How were you notified of this training?

- Provider Enrollment _____
- Provider Assistance _____
- The Ombudsman/MAC Unit _____
- Ohio Medicaid Provider Newsletter _____
- The Medicaid Website _____
- Your Provider Association _____
- Other Providers _____
- Other _____

NOTE: Please complete the registration form for each type of training requested. For example, training requests for the Hospital providers and Physician (type) providers must be on 2 separate forms. The Ombudsman/MAC Unit must receive the completed registration form 30 days prior to the training session. Mail the form to the following address. Also, you will not be allowed to attend your requested training session without a letter from the Ombudsman/MAC unit confirming your attendance.

Ombudsman/Medical Assistance Coordinator Unit
P.O. Box 1461
Columbus, Ohio 43216-1461
ATTN: Medicaid Billing Training Session

For questions, please call the Ombudsman/Medical Assistance Coordinator Unit at 614-644-1399.