

## ELECTRONIC MEDIA NOTIFICATION

JFS 06301(ODMRDD 1/2007)

Please complete this form and submit with your Ohio Medicaid application to:

Ohio Department of MRDD  
 Provider Certification Unit  
 35 East Chestnut 5th Floor  
 Columbus, OH 43215

Ohio Medicaid Provider Number	
Provider Name	
Street Address	
City, State and Zip Code	Telephone Number (Include Area Code)

The Medicaid provider is ultimately responsible for the accuracy and validity reporting of all Medicaid claims submitted for payment. A provider using an electronic media claim submitter should ensure through a legal contract that the electronic media claim submitter reports claim information only as directed by the provider. A copy of all contracts between the provider and electronic media claim submitter must be made available to ODJFS upon request. Both the individual and the electronic media claim submitter must maintain a record of all Medicaid claims submitted for payment.

Claim Type:  Clinic  Inpatient Hospital  Pharmacy  Transportation  Dental  
 Laboratory  Physician  Home Health  Outpatient Hospital  Vision  
 Medical Supply  Medicare Crossover  Waiver Services

Billing agency authorized to submit claims for provider listed above is:

Agent's Name	Provider Number
OHIO DEPARTMENT OF MRDD	0000957
Agent's Authorized Signature	

Previous agent no longer submitting claims for provider listed is:

Agent's Name	Provider Number
Agent's Authorized Signature	

Provider's Authorized Signature (signature must be that of the provider or an officer of the organization whose billing number is on this form)

Name and Title of Person Signing This Form  
(please print this information)

Effective Date

**Rule 5101:3-18-06 of the Ohio Administrative Code requires to provide this information. Should you fail to complete this form and not provide the required information to ODJFS, your Medicaid Claims will be delayed or rejected.**