CHANGE OF HOSPITAL CONTACT FORM

The following named individual will be responsible for communication with Ohio Department of Medicaid, or their contractual designee, KEPRO, regarding the hospital utilization review program. The following named person(s) will also be responsible for communicating information regarding the program to my organization's internal utilization/quality review Committee(s):

Organization Name: _____
NPI: _____
CEO Name: _____
Physical Address: _____
(No PO Boxes) _____

☐UR Contact (To receive 1st level denial letters and appeal decisions)

Name of Designee: _____
Title: _____
Telephone: _____
Fax: _____
Email Address: _____

☐ Medical Records Request Contact

Name of Designee: _____
Title: _____
Telephone: _____
Fax: _____
Email Address: _____

☐ Quality Concern Contact

Name of Designee: _____
Title: _____
Telephone: _____
Fax: _____
Email Address: _____

Organization Representative Signature: _____ Date: _____
Printed Name: _____ Title: _____

Please return form to:

Fax line: 844.262.8990

Email: OHMedicaid@KEPRO.com