permedion
an HMS company

Ohio Department of Medicaid
Utilization Management Program for Hospital Services

The following named individual will be responsible for communication with Ohio Department of Medicaid, or their contractual designee, Permedion, 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: _____

Medicaid Provider ID#: _____ CEO Name: _____

Physical Address: (No PO Boxes) _____

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

Name of Designee: _____ Title: _____

Physical Address: _____

Telephone: _____ Fax: _____

Email Address: _____

☐ **Medical Records Request Contact**

Name of Designee: _____ Title: _____

Physical Address: _____

Telephone: _____ Fax: _____

Email Address: _____

☐ **Quality Concern Contact**

Name of Designee: _____ Title: _____

Physical Address: _____

Telephone: _____ Fax: _____

Email Address: _____

Organization Representative Signature: _____ Date: _____

Printed Name: _____ Title: _____

Please return form to:
Carol O'Kane, Project Specialist
Permedion, 350 Worthington Road, Suite H,
Westerville, OH 43082
Fax 614-895-6784 *Email: carol.o'kane@hms.com*