

Ohio Department of Medicaid
Utilization Management Program & Ohio Mental Health and Substance Abuse
Utilization Review Program for Hospital Services

The following named individual will be responsible for communication with Ohio Department of Medicaid (ODM) or Ohio Mental Health and Substance Abuse Department (OMHA), or their contractual designee, Permedion, regarding the hospital utilization or mental health utilization review programs. 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 & appeal decisions)

ODM **OMHA Onsite** **OMHA Desk Audits**

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

Medical Records Request Contact **ODM** **OMHA Onsite** **OMHA Desk Audits**

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

Quality Concern Contact **ODM ONLY**

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

Organization Representative Signature: _____ Date: _____

Printed Name: _____ Title: _____

*Please return form to: Jilian Braver, Senior Project Specialist
Permedion, 350 Worthington Road, Suite H, Westerville, OH 43082
Fax 614-895-6784 Email: jilian.braver@hms.com*