VOLUNTARY TERMINATION
OF OHIO MEDICAID PROVIDER AGREEMENT

(Submit this form **only** if you want to terminate your provider agreement)

Date: _____

To: Bureau of Network Management

From: Provider #: _____

Provider Name:

_____
(please print clearly)

Address:

_____

_____

I, (print your name) _____, am voluntarily relinquishing my independent provider number and request that **my provider agreement be terminated effective the date of this notice**. I no longer provide services to consumers on the Ohio Home Care Waiver. I understand that if I voluntarily terminate my provider agreement I must reapply, and be accepted, before providing services in the future.

Signature **Date**

If you are voluntarily terminating your provider agreement, return this form to:

Ohio Department of Medicaid
Attn: BCI Coordinator
P.O. Box 183017
Columbus, OH 43218-3017

TELEPHONE: (800) 922-3042
FAX: (614) 995-5904