



Department of  
Medicaid

The Ohio Department of Medicaid

## Permedion Referral for Focused Review

Date:

Referred by (Name and Agency):

Individual's Demographics:

Name		
Address		
Date of Birth	Recipient ID Number	Date of Death <i>(if applicable)</i>

Past Medical History/ Diagnosis:

Primary Concern:



**Please review hospital records from the following hospitals:** *(include provider # and address)*

MITS Claim number(s):
Facility #1 Name:
Provider ID Number:
Facility City/state:
Admit Date:
Discharge Date:

MITS Claim number(s):
Facility #1 Name:
Provider ID Number:
Facility City/state:
Admit Date:
Discharge Date: