

# VOLUNTARY TERMINATION OF OHIO MEDICAID PROVIDER AGREEMENT

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

**Date:** \_\_\_\_\_

**To:** Bureau of Provider Services, Network Management Section

**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.

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**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