



HEALTH INSURANCE FACT FORM  
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES 06614 INSTRUCTIONS

**PROVIDER INFORMATION**

**PROVIDER NO:** Enter the seven digit Medicaid provider number.

**PROVIDER NAME:** Enter name of the provider to which Medicaid payment is to be made and who is assigned the seven digit provider number.

**ADDRESS:** Enter the mailing address for which correspondence relating to this form is to be sent.

**CONTACT PERSON:** Enter the name of the individual with whom contact is to be made if further information is needed.

**PHONE NUMBER:** Enter the telephone number including area code.

**RECIPIENT INFORMATION**

**PATIENT(S) NAME:** Enter name of the patient for whom services are rendered.

**MEDICAID BILLING NO.:** Enter patients medicaid twelve (12) digit billing number.

**NAME OF INSURANCE CARRIER:** Enter name of third party insurance company or entity liable for payment other than Medicaid or Medicare.

**ADDRESS:** Enter complete mailing address of the liable third party where claims are to be billed.

**PHONE NUMBER:** Enter telephone number including area code, of liable third party for verification and/or claim processing.

**POLICY HOLDER'S NAME:** Enter full name of individual(s) whom the liable third party deems as holder of the policy. This will always be an individual, not a company.

**POLICY NO.:** Enter the policy number for the carrier. **DO NOT ENTER THE MEDICAID OR MEDICARE BILLING NUMBER.** This number can also be the SSN of the policyholder.

**POLICYHOLDER'S SS NO.:** Enter the policyholder's SOCIAL SECURITY NUMBER.

**GROUP NO.:** Enter group and/or employer number of the liable third party if applicable.

**NAME, ADDRESS, PHONE NUMBER OF EMPLOYER (POLICYHOLDER):** Enter policy holders employment information if this is a group policy.

**VERIFIED POLICY TERMINATION DATE:** Enter actual date the policy was terminated if applicable. **YOU NEED TO SUPPLY SUPPORTING DOCUMENTATION WHEN A POLICY HAS BEEN TERMINATED SHOWING THE ACTUAL DATE FROM THE LIABLE THIRD PARTY. (e.g., EOB w/ TERM DATE, CARRIER LETTER).**

**PLEASE NOTE** **FAILURE TO ATTACH DOCUMENTATION TO SUPPORT TERMINATION REQUEST WILL RESULT IN THE TERMINATION NOT BEING COMPLETED.**

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