INTERESTED FACILITY REQUEST

Thank you for your interest in becoming a provider with Ohio Health Choice. Please complete and return all items on this form in order to evaluate our provider needs in your area. Ohio Health Choice Provider Relations will contact you to discuss the request in more detail.

Submit to Ohio Health Choice using one of these methods:

Fax: 330-996-8211
Email: OHCProviderRelations@OhioHealthChoice.com
Address: Ohio Health Choice
PO Box 2090
Akron, OH 44309-2090

Facility Name

Facility Type

Primary Service Location Address

Primary Service Phone # Fax #

Contact Name

Contact Email Address & Phone Number

Tax ID # NPI # CAQH#