# INTERESTED PRACTITIONER 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. Please make sure your CAQH has been updated. All correspondence will be send to the email address on this form. The process takes approximately 60-90 days.

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

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Full Name (First/Last/MI) / Degree (MD, DO, etc.)

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Group Name

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Primary Service Location Address

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Primary Service Phone # Fax #

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Credentialing Contact Name

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Credentialing Contact Email Address & Phone Number

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Specialty/Title

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Hospitals where Hospital Privileges are maintained

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Tax ID # Individual NPI # CAQH#