



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 sent 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: OHCPProviderRelations@OhioHealthChoice.com
Address: Ohio Health Choice
PO Box 2090
Akron, OH 44309-2090

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

Group Name

Primary Service Location Address

Primary Service Phone #

Fax #

Credentialing Contact Name

Credentialing Contact Email Address & Phone Number

Specialty/Title

Hospitals where Hospital Privileges are maintained

Tax ID #

NPI #

CAQH#