REQUEST FOR CPT REIMBURSEMENT AMOUNTS

Please fill in all information then submit to Ohio Health Choice using one of these methods:

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

Tax ID #: _____

Provider Name: _____

Requestor Name: _____

Requestor Email: _____ Phone: _____

CPT Code	Billed Charges

Comments:

_____
_____
_____
_____
_____