REQUEST FOR CPT REIMBURSEMENT AMOUNTS

Please submit required information to Ohio Health Choice using one of these methods:

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

Using any submission method or format, please provide:

Tax ID #: _____
Provider Name: _____
Requestor Name: _____
Requestor Email: _____ Phone: _____

Preferred submission format:

Please email an Excel spreadsheet with the columns described below:

CPTCode	Modifier	POS	Billed Charges
(Required)	(If applicable)	(11 will be used if not specified)	(Required)

Alternative submission format:

CPT Code (Required)	Modifier	POS	Billed Charges (Required)