

Ohio Department of Medicaid  
**BASIC BILLING TRAINING REGISTRATION**

**Thank you for your interest in participating in a Medicaid basic billing training session.**

Seven-digit Ohio Medicaid Legacy Provider Number(s)
Name of provider or Billing Agency
Type of Provider (e.g.: <i>physician, dentist</i> )

**CONTACT PERSON**

Name ( <i>First, Last</i> )		
Mailing Address		
City	State	Zip Code
Telephone #	Fax #	

**1st Choice** (If the training is full for this date, you may be scheduled for the training noted as your 2nd choice)

Training Date	Session #
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Name of Attendee(s) ( <i>First, Last</i> )	Position ( <i>Billor, Office Manager</i> )

**2nd Choice**

Training Date	Session #
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Name of Attendee(s) ( <i>First, Last</i> )	Position ( <i>Billor, Office Manager</i> )

**Please provide us with the following information.**

1. Can you access Ohio Medicaid's website for electronic provider manuals? The website address is:  
<http://emanuals.odjfs.state.oh.us/emanuals>  
 Yes     No
  
2. Do you or your agency offer billing services to more than one Ohio Medicaid provider?  
 Yes     No
  
3. Is your agency a Medicaid provider or a billing agent?  
*(If your agency is a Medicaid provider, please indicate your Medicaid number(s) on the top of the previous page)*  
 Medicaid Provider     Billing Agent
  
4. How did you hear about this training?  
 Provider Enrollment  
 Provider Assistance  
 External Business Relations Staff  
 Ohio Medicaid Provider Newsletter  
 The Medicaid Website  
 Your Provider Association  
 Another Provider  
 Other \_\_\_\_\_

Complete a registration form for **each** basic billing training session requested. For example, a training request for a Hospital provider training **and** a request for a Physician provider training must be on two separate registration requests. We must receive the completed registration form at least 30 days prior to the training session. If you are approved for the requested session, we will mail you a confirmation letter stating the date of your training, along with directions to our facility.

**Please bring the confirmation letter with you to the training.**

Mail your registration to:  
Ohio Department Medicaid  
External Business Relations  
P.O. Box 1461  
Columbus, Ohio 43216-1461  
Attn: Medicaid Billing Training Session

**For questions, please call External Business Relations at 614-644-1399**