



Ohio Department of Mental Retardation and Developmental Disabilities

Ted Strickland, Governor

John L. Martin, Director

PROVIDER REQUEST FOR ASSOCIATION WITH A BILLING AGENT

MRDD Contract:	Provider Name:
MRDD Billing Agent Number:	Billing Agent Name:
Beginning Effective Date:	
Ending Effective Date: (to rescind authorization only)	

TO ADD A BILLING AGENT

I hereby authorize ODMRDD to accept claims from the ODMRDD billing agent named above, effective for claims submittals beginning on the effective date noted above. This authorization allows the ODMRDD billing agent named above to submit claims on the providers' behalf, access claims files and related information such as reports, and electronic data interchange (EDI) results on the ODMRDD Billing website. This authorization will remain in effect until rescinded by ODMRDD or the provider.

TO RESCIND A BILLING AGENT

I hereby request the association to the billing agent named above be rescinded effective on the date above.

Provider Name:	
Provider Signature:	Date:
(Principal of Provider agency requesting association)	

--ODMRDD Use Only--

Association Made:	Provider Security Affidavit verified:
Association Rescinded:	Billing Agent Affidavit verified: