Ohio Department of Medicaid

MEDICAID PROVIDER FINAL SETTLEMENT

Covering the period from _____ to _____

Provider Name:	Provider Number:
Street Address:	Federal ID Number:
City, State & Zip:	Date Submitted to OFS:

Programs From Which Amount is Due to Medicaid/(Provider)	Services Period	SFY Final Settlement
1. Title XIX	From: To:	
2. Title V	From: To:	
3. Total	From: To:	

Note: Title XIX
If the amount shown for Title XIX is due Medicaid and is unpaid, interest will be assessed. This is in addition to the amount shown and is assessed in accordance with Section 5111.03(D) of the Ohio Revised Code and Ohio Administrative Rule 5101:3-1-59.

If there is a balance "due provider" on line 1, a warrant will be issued by the Ohio Department of Medicaid. If there is a balance "due provider" on line 2, a separate warrant will be issued by the Ohio Department of Health. Warrants will be sent under separate cover from the issuing department.

For Department of Health Use Only		
Warrant Number	Date of Warrant	Amount of Warrant

Distribution: Ohio Department of Health

Originator: Bureau of Health Plan Policy – Financial Management Unit

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