Ohio Department of Health

OHIO DEPARTMENT OF HEALTH
CHILDREN WITH MEDICAL HANDICAPS PROGRAM (CMH)
FAX 614-728-3616

NOTIFICATION OF CHANGES IN CHILD/FAMILY STATUS

Person completing the form:	Name of Agency:	Date: mm/dd/yyyy
Phone Number:	Fax Number:	

Client Name:	CMH Case #	Date of Birth: mm/dd/yyyy
New Address:		
Phone of Client/Parent/Guardian:		Effective Date: mm/dd/yyyy
Does this involve a move to a different county of residence? ☐ Yes ☐ No New County:	Does this involve a move to a different Health Department? ☐ Yes ☐ No New Health Dept:	

NEW/CURRENT INSURANCE INFORMATION FOR THE CLIENT

Name of Insurance Company:	Phone Number:
Name of Insured:	Effective Date: mm/dd/yyyy
Policy Number:	Group Number:
Does your plan include prescription benefits: ☐ Yes ☐ No	Does your drug plan require mail order pharmacy: ☐ Yes ☐ No
Name of company that administers prescription benefits:	
Does client have dental insurance: Yes ☐ ☐ No	Does client have vision insurance: ☐ Yes ☐ No
Name of company that administers dental benefit:	
Name of company that administers vision benefit:	

What services are not covered by your insurance? (Examples: Orthodontia, Prescriptions, etc.)

CHANGE IN MEDICAID STATUS (check correct line)

☐ Approved	Case #	Date: mm/dd/yyyy
☐ Denied	Reason:	Date: mm/dd/yyyy
☐ No longer eligibile	Reason:	Date: mm/dd/yyyy
NAME OF MEDICAID HMO INSURANCE (if applicable):		

*** If denied or no longer eligible, please include denial copy or notification from ODJFS.**

CHANGES IN FAMILY STATUS (parent/guardian name change, change in guardianship, etc):

CHILD EXPIRED: ☐ Please attach Obituary or Death Certificate	**Date:** mm/dd/yyyy

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ADDENDUM

Person completing the form (please print):	Name of agency:	Date: mm/dd/yyyy
Phone:	Fax Number:	

Client Name:	**CMH Case #**	**Date of Birth:**
ADDITIONAL CHANGES NEEDED ON LETTER OF APPROVAL (LOA) (extension of Diagnostic services needed, additional diagnoses and CMH physician providing care, etc)		