

The cover features a central collage of medical and technology-related images, including a hand with a stethoscope, a smartphone displaying a padlock, and various medical icons like a heart, pills, and a microscope. This central image is framed by large, overlapping geometric shapes in shades of blue and purple.

USER MANUAL

Long-Term Care Facility Provider Enrollment Applications

Facility Provider

Ohio | Department of
Medicaid

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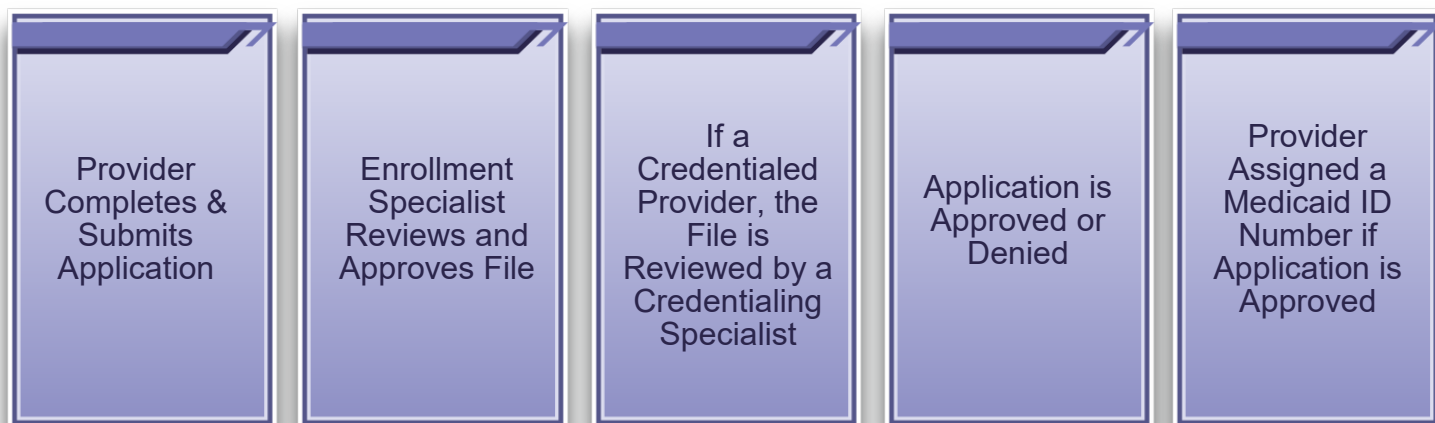
Revalidation/Re-Enrollment Steps 61

Introduction

This desk reference provides the steps and functions of entering a new Provider application to enroll in the Ohio Department of Medicaid (ODM) program. Once submitted, your application will be processed by the Medicaid Enrollment team and then sent to Credentialing, if Credentialing is required for your Provider type. When all the necessary steps are completed for Enrollment and Credentialing (if necessary), you will receive a 'Welcome Letter' notice and a Medicaid Identification Number will be assigned to the Provider.

This document also contains the steps required when the application is returned to Provider for additional information. Additionally, the process for completing Provider updates and revalidation is included in this document.

The steps listed below are for Provider Type 86 – Nursing Facility, Provider Type 88 – State Operated ICF-MR, Provider Type 89 – Non-State Operated ICF-MR.



Provider Administrator Initial Login

In this section of the user manual we will review the initial steps of logging into PNM. All users will log into the PNM system by using IOP (Innovate Ohio Platform).

Step 1: Visit the PNM web address: https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx

Step 2: Click 'Log in with OH|ID'

Log in
All users must log in on the OH|ID portal using their single sign on ID.

2 Log in with OH|ID

Latest News

When creating a new account, you will be required to create an OH|ID.

OH|ID is a secured web portal designed for Ohioans to access information and conduct business with a variety of state agencies, including Medicaid, all in one place.

Why use OH|ID?

In terms of digital identity and cybersecurity, OH|ID is Best-of-Breed. It meets all federal and state digital security guidelines and is regularly audited to ensure your data and personal information remain private and secured.

OH|ID is powered by the [InnovateOhio Platform](#), a key component of Governor Mike DeWine and Lt. Governor Jon Husted InnovateOhio vision to improve citizen interactions with the state by making them more dynamic, data-driven, and customer-centered.

Be sure to register your OH|ID account with **non-work email address**. Your OH|ID account is your personal account and will remain yours, regardless of where you work in the future

ODM Trading Partners, [Click here](#)

***** Provider Revalidation Update: In response to the COVID-19 pandemic, the Ohio Department of Medicaid (ODM) has been granted flexibility from the Centers of Medicare and Medicaid Services (CMS) to suspend provider revalidations for the duration of the national emergency. The revalidation process will resume once the national emergency is lifted. Further information can be found in our Provider Revalidation Waiver Transmittal [Provider Revalidation Waiver Transmittal](#)

Step 3: The system will prompt you to enter your username and password on the IOP login screen illustrated below. Once entered, click 'Log in'

OH|ID

Ohio's Digital Identity. One State. One Account.

Register once, use across many State of Ohio websites

Create Account

Log In

3

OH|ID

Password

Log in

[Forgot OH|ID?](#) | [Forgot password?](#)

Step 4: You will be redirected to the PNM system. Read the Terms of Use and click "Yes, I have read the agreement" to proceed into PNM

Terms

Whoever knowingly, or intentionally accesses a computer or computer system without authorization or exceeds the access to which that person is authorized, and by means of such access, obtains, alters, damages, destroys, or discloses information, or prevents authorized use of the information operated by the State of Ohio, shall be subject to such penalties allowed by law. All activities on this system may be recorded and/or monitored. Individuals using this system expressly consent to such monitoring and evidence of possible misconduct or abuse may be provided to appropriate officials. Users who access this system consent to the provisions of confidentiality of the information being accessed, but have no expectation of privacy while using this system.

In the event that an unauthorized user is able to access information to which they are not entitled, the user should immediately contact the site administrator.

4 ☐ Yes, I have read the agreement

Cancel

Provider Home Page

When you first login to the PNM system you will see a variety of buttons to help with administering your providers.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
154	Provider Trainer	All Complete Approved Return to Provider Not Submitted	Physician/Osteop Individual			Dual Licensed Dentist and Licensed MD/DO.			45069 - 1234	09/29/21	09/09/21	09/29/24

Menu: The menu can be accessed by clicking on the three bars in the top left corner of the screen. The Menu provides a variety of key topics to choose from such as the Provider Directory, Learning Resources, Provider Financials, My Profile, and Contact Us

Pending Agent Requests: This button allows you to approve Agent Requests for access to functions such as Submit Claims and Run Reports with Provider records when needed

Account Administration: This button allows you to set up Agent users, assign them actions/roles, and also transfer the Provider to another Account Administrator

New Provider?: This button is used to start a New Enrollment Application for any New Ohio Medicaid Provider that you will be responsible for administering

Page Navigation

Throughout each page on the application, you will have access to buttons to 'Save', 'Cancel' and 'Next' to proceed through the application.

Save: Saves the current page and remains on the page.

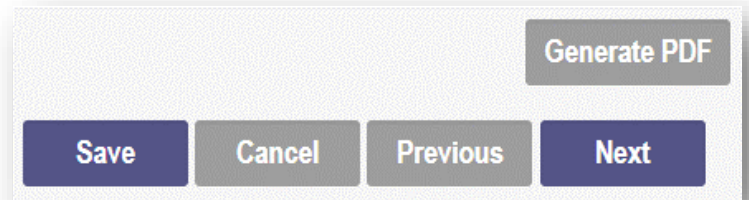
Cancel: Clears the work entered and does not save the page.

Previous: Returns to the previous page.

Next: Saves the current page while advancing to the next page in the application.

Generate PDF: Creates a file with all the application information to be saved to your records.

A workflow at the top of the page shows the progress made throughout your application. Click the icon to review a specific page and jump to other pages for entry into the application.

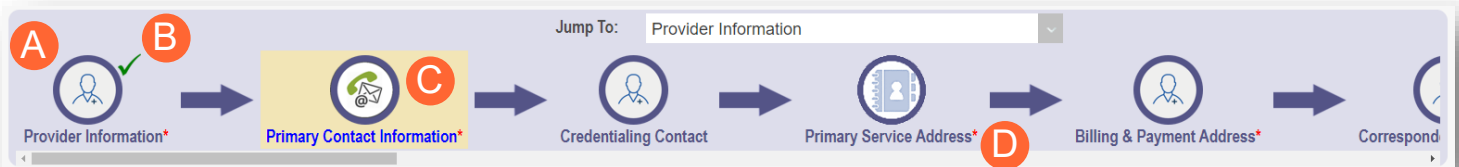


Navigational Bar: A workflow at the top of the page that shows the progress made throughout your application. Click the icon to review a specific page and jump to other pages for entry into the application (A).

Green Checkmark: A green checkmark on any page indicates that you have completed the necessary information on that page and can continue through the subsequent pages (B).

Highlighted Box: The highlighted section indicates the page you are actively working or viewing (C).

Red Asterisk: A red asterisk on a page indicates the page is required to be completed. Help text will also appear in red text on each page to indicate whether or not it is required to be completed (D).



Primary Contact Information
This is a required section.

Pages that do not have a red asterisk are optional to be completed.

Credentialing Contact

This is not a required section. To skip this section click on Next button.

Facility Provider - New Provider Entry

This section displays the necessary steps for creating an Initial Application for an Organization Provider.

Step 1: Click 'New Provider'

<div> My Providers Select Provider Pending Agent Requests Account Administration </div> <div>1 New Provider ?</div>												
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	All	<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
162	Training WheelChair Van	Complete	WHEELCHAIR VAN			Wheelchair Van			43214 - 1564	09/15/21	09/10/21	09/10/26
190	Vicki J Trainer	Approved	PHYSICIAN ASSISTANT			PHYSICIAN ASSISTANT			43231 - 7605		10/20/21	
195	Training J Pharmacist	Complete	Pharmacist			PHARMACIST			43231 - 7605	10/18/21	10/18/21	10/18/24
198	Test Pharmacy	Submitted	PHARMACY			Pharmacy			43085 - 4706		10/19/21	

Step 2: Select the button for the application type for your new Provider

"Please note that you have **10 days to complete your application**. After 10 days, your information will be removed and you will have to re-start the process from the beginning of the application."

Standard application Use this application if you are applying to become a new individual, group, facility, or institutional provider to provide fee-for-service for the State Medicaid program. <input type="button" value="Select"/>	Ordering, Referring, Prescribing Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing. <input type="button" value="Select"/>	Change of Operator Use this option if you want to initiate a Change of Operator for Skilled Nursing Facility or Intermediate Care Facility for individuals with intellectual disabilities. <input type="button" value="Select"/>	MCP Single Case Use this application if you are entering into a Single Case agreement with a Managed Care Plan. <input type="button" value="Select"/>
--	--	---	--

[Click here for more application types...](#)

- Additional application types are displayed by selecting the 'Click here for more application types...' button

"Please note that you have 10 days to complete your application. After 10 days, your information will be removed and you will have to re-start the process from the beginning of the application."

Standard application

Use this application if you are applying to become a new individual, group, facility, or institutional provider to provide fee-for-service for the State Medicaid program.

Select

Ordering, Referring, Prescribing

Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing.

Select

Change of Operator

Use this option if you want to initiate a Change of Operator for Skilled Nursing Facility or Intermediate Care Facility for individuals with intellectual disabilities.

Select

MCP Single Case

Use this application if you are entering into a Single Case agreement with a Managed Care Plan.

Select

2

Less...

Medicaid Waiver (ODM)

Use this application if you are applying to become a Waiver Provider with Ohio Department of Medicaid.

Select

Medicaid Waiver (ODA)

Use this application if you are applying to become a Waiver Provider with Ohio Department of Aging or if you are initiating a Change of Ownership or Change of Operator as an ODA Provider.

Select

Medicaid Waiver (DODD)

Use this application if you are applying to become a Waiver Provider with Ohio Department of Developmental Disabilities.

Select

Non-Medicaid DODD

Use this application if you are applying for one or more of the following options; Supported Living Service, Unpaid Support Broker, ICF Operators, or Licensees.

Select

Note: For ODA and DODD Waiver applications, you will enter the Key Identifiers within PNM and then be navigated to the State Sister Agency portals to complete the application process. More details on these processes can be found in the ODA and DODD Provider User Desk Reference Guides.


Step 3: Next, click ‘Facility/Institution’ to begin a Facility Provider application


"Please note that you have 10 days to complete your application. After 10 days, your information will be removed and you will have to re-start the process from the beginning of the application."


Application Type

Standard application


[Change](#)


 Individual

 Group

 Organization

3

 Facility/Institution

 Pharmacy

9

Key Identifier Information

Step 1: Enter key provider information for the Provider

Enter all required fields marked with an asterisk *

- Provider Type
- Name of Business Entity
- EIN (Employer Identification Number) / SSN (Social Security Number)
- Tax ID
- NPI (National Provider Identifier)
- DD Contract Number *(If Applicable, for DODD Providers)*
- Requested Effective Date
- Zip Code
- Zip Code Extension

1

Application Type: Standard application [Change](#)

Category*: Facility/Institution [Change](#)

Provider Type*:

Name of Business Entity*:

Business Name as it appears on your IRS Assignment letter

Tax ID Type*: ☒ EIN ☐ SSN

Tax ID*:

Are you requesting retro coverage? ☐ What is this [?](#)

NPI*:

DD Contract Number (If Applicable):

Requested Effective Date*: 5/6/2022

Zip Code*:

Zip Code Extension*:

2 **Save** **Cancel**

Step 2: Click 'Save' to save the information and advance

Hint - PNM validates the NPI number is a Type 2 NPI number with the National Plan and Provider Enumeration System (NPPES) Registry database. If it is not a Type 2 NPI number, you will get an error before the taxonomy field appears.



The NPI entered is not in the NPPES list.

Step 3: Select the appropriate primary Taxonomy associated with the Provider's NPI and click 'Save'. If you need to update or add taxonomy codes for a Provider, that will be available on the 'Taxonomy' page of the application.

Application Type	Standard application	Change
Category*	Facility/Institution	Change
Provider Type*		
Name of Business Entity*		
	Business Name as it appears on your IRS Assignment letter	
Tax ID Type*	<input checked="" type="radio"/> EIN <input type="radio"/> SSN	
Tax ID*		
Are you requesting retro coverage?	<input type="checkbox"/> What is this ?	
NPI*		
DD Contract Number (If Applicable)		
Requested Effective Date*		
Zip Code*		
Zip Code Extension*		
<div>3</div> Taxonomy*		
<div>Save</div>		<div>Cancel</div>

Document Upload Process (Any Page)

The option to upload documents is available on most pages of the application.

Step 1: To upload a document, click 'Choose File', select the file on your computer, and click 'OK'

Step 2: Give the file a name

Step 3: Enter a Description (Optional)

Step 4: Click 'Upload File'

Step 5: Verify your document was uploaded by reviewing the information in the table

Step 6: Click 'Save' or 'Next'

Uploaded Documents

Name	Description	File Name	Page Name	Username	View	Delete
Primary Contact Information	Contact Information	test.pdf_29.pdf	LicensesClassifications	lisaproadmin		

1 Choose File No file chosen

2 Name

3 Description

4 Upload file

File Uploaded: test.pdf_29.pdf

6 Save Cancel Previous Next

Primary Contact Information (480295)

Provider Information Page

The first page that displays is the Provider Information page. Fill in all fields and click 'Next' to continue with your application. **Note:** Some information will auto-fill from the key identifier page you previously completed.

Step 1: Enter all the information in the required fields marked with an asterisk*

For this page the following fields are required:

- Name of Business Entity
- DBA (Doing Business As)
- Practice Type
- Ownership Type
- Tax ID
- Provider Type

Jump To: Provider Information

Provider Information* → Primary Contact Information* → Credentialing Contact → Primary Service Address* → Billing & Payment Address* → Correspondence

Provider Information
This is a required section.

1

Name of Business Entity* Training Nursing Facility

DBA*

Practice Type*

Ownership Type*

Tax ID* 346534534

NPI 1962735811

NPI Start Date 09/10/2009

Provider Type* 86 - NURSING FACILITY

Revalidation Date Not Set Yet

Enrollment Status Not Set Yet

Enrollment Status Reason Not Set Yet

2

Save Cancel Next

Step 2:

- Click the 'Save' button to save the information on the page or
- Click the 'Next' button to save and move to the next screen

Primary Contact Information Page

The Primary Contact Page is the next page that displays for the Provider. This is the primary contact who will be responsible for managing communications and returning any required information that is needed to process the application for enrollment.

Step 1: Enter the required fields marked with an asterisk *

- Name
- Address
- City
- State
- Zip
- Phone Number
- Email Address

Step 2: Select the applicable radio button (Yes or No) to indicate a cell phone and to sign up to receive text messages regarding important account updates

Step 3:

- Click the 'Save' button to save the information on the page
- Click the 'Next' button to save and move to the next screen

USPS Address Search Pop-Up

To maintain accurate mailing addresses, PNM uses a USPS system search validation for addresses. Enter an address into PNM and click 'Save' or 'Next.' A USPS system search will review the address and return corrections to the address based on the USPS review.

- Confirm the validation and accuracy of the address information
- Click 'Accept' on the USPS confirmation prompt
- Review the changes made to the address
- Click the 'Next' button again on the page to proceed to the next page of the application

Credentialing Contact Page

This screen allows you to add an individual as a contact for Credentialing in case additional information needs to be gathered for Credentialing purposes.

Note: This is not a required section. Click 'Next' to skip the section and proceed in the application

Step 1: To add a new contact, click 'Add New'

Credentialing Contact
This is not a required section. To skip this section click on Next button.

Generate PDF

Save Cancel Previous Next

History

Add Contact

No records found

1 Add New

Step 2: Enter all required fields marked with an asterisk *

Step 3: Enter any comments or instructions for Credentialing in the 'Comments' field

Step 4: Click the 'Save' or 'Next' buttons to save the contact you added to the record and proceed to the next page

Credentialing Contact
This is not a required section. To skip this section click on Next button.

Save Cancel Previous Next

History

Add Contact

No records found

Add New

2 *Contact Name

*Practice Name

*Contact Phone No

Contact Phone Extension

Contact Fax No

*Contact Email

3 Comments

4 Next



Primary Service Address Page

The Primary Service address page provides a place to enter the primary service address for your location along with specific information about your office that will be included in the Provider Directory.

Step 1: Complete the Primary Service Address information.

Required fields include:

- Organization Name
- Primary Service Address
- City
- State
- Zip
- Zip Ext (*will be automatically imputed after USPS database check*)
- Phone Number
- Email Address



1

Organization Name*

Primary Service Address*

Address 2

City*

State*

County

Zip*

Ext Zip*

Border State

No

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

History

Note: Steps 2 – 4 are optional. If you select 'Provider Directory Opt-Out,' Provider information will not be included in the public facing Provider Directory.

☐ Provider Directory Opt-Out

Step 2: Indicate specific operating information about yourself or your office using the drop-down menus/data entry fields

- Hours of Operation
- Whether the location is open 24 hours

Step 3: Indicate specific office information about yourself or your office using the drop-down menus/data entry fields

- Website
- Telephone Coverage
- Electronic Billing
- Cultural Competencies
- Language Spoken
- Specialized Training
- ADA Compliance
- ASL Offered

Step 4: Indicate specific information about the types of patients your office serves

- Accepting new patients
- Accept patients from referral only
- Youngest patient accepted
- Oldest patient accepted
- If they serve or specialize in a particular gender
- Accept newborns
- Accept pregnant women

The screenshot displays a web form titled "Hours of Operation" with a subtitle "Hours providers available for appointments". It is divided into three main sections: "Hours of Operation", "Office Information", and "Patient Information".

Hours of Operation (Step 2): This section contains a table with days of the week (Monday through Sunday) in the first column. The second and third columns are empty text input fields. To the right of the table, there are seven checkboxes, each labeled "Open 24 Hours".

Office Information (Step 3): This section contains several fields:

- "Website": A text input field.
- "24-hour telephone coverage": A dropdown menu with "Yes" selected.
- "Public transportation access": A dropdown menu with "Yes" selected.
- "Electronic billing": A dropdown menu with "Yes" selected.
- "TDD/IDY": A dropdown menu with "Yes" selected.
- "Cultural Competencies": A dropdown menu.
- "Languages Spoken": A dropdown menu.
- "Specialized Training": A dropdown menu.
- "ADA Compliance*": A dropdown menu with "--Select ADA--" selected.
- "ASL Offered*": A dropdown menu with "Yes" selected.
- "Translation Services": Two checkboxes, "Language Line" and "Translation", both of which are unchecked.

Patient Information (Step 4): This section contains several fields:

- "Accept new patients": A dropdown menu with "No" selected.
- "Accept new patients from referral only": A dropdown menu with "No" selected.
- "Youngest patients accepted": A text input field.
- "Oldest patients accepted": A text input field.
- "Gender of patient Accepted": A dropdown menu.
- "Accept newborn*": A dropdown menu with "No" selected.
- "Accept pregnant women": A dropdown menu with "No" selected.

Step 5:

- Click the 'Save' button to save the information on the page or
- Click the 'Next' button to save and move to the next screen

Address Pages

The following table provides samples of the types of address pages that will be required for your application.

<div><div>Billing & Payment Address Page</div><div><p>If the Billing & Payment Address is the same as the Primary Service Address, select the check box to indicate it is the ‘Same as the Practice Location.’ This will pre-populate information that was entered on the previous screen into the fields.</p><p>If a different address, enter the required fields marked with an asterisk *</p><p>Click ‘Save’ or ‘Next’ to save the contact to the record</p></div></div>	<div><div>Billing & Payment Address</div><div><div><div>Save</div><div>Cancel</div><div>Previous</div><div>Next</div></div><div>History</div><div><div>Same as Practice Location</div><div><div>Address Type</div><div><div>Individual</div><div>Organization</div></div></div><div><div>Organization Name*</div><div>Title</div><div>Address 1*</div><div>Address 2</div><div>City*</div><div>State*</div><div>County</div><div>Zip*</div><div>Ext Zip*</div><div>Phone Number 1*</div><div>Phone Ext 1</div><div>Phone Number 2</div><div>Phone Ext 2</div><div>Fax Number 1</div><div>Fax Number 2</div><div>Contact Name</div><div>Email Address 1*</div></div></div></div></div>
<div><div>Correspondence Address Page</div><div><p>If the Correspondence Address is the same as the Primary Service Address, select the check box to indicate it is the ‘Same as the Practice Location.’ This will pre-populate information that was entered on the previous screen into the fields.</p><p>If a different address, enter the required fields marked with an asterisk *</p><p>Click the ‘Save’ or ‘Next’ buttons to save the contact to the record</p></div></div>	<div><div>Correspondence Address</div><div><div><div>Save</div><div>Cancel</div><div>Previous</div><div>Next</div></div><div>History</div><div><div>Same as Practice Location</div><div><div>Address Type</div><div><div>Individual</div><div>Organization</div></div></div><div><div>Organization Name*</div><div>Address 1*</div><div>Address 2</div><div>City*</div><div>State*</div><div>County</div><div>Zip*</div><div>Ext Zip*</div><div>Phone Number 1*</div><div>Phone Ext 1</div><div>Phone Number 2</div><div>Phone Ext 2</div><div>Fax Number 1</div><div>Fax Number 2</div><div>Contact Name</div><div>Email Address 1*</div></div></div></div></div>

1099 Address Page

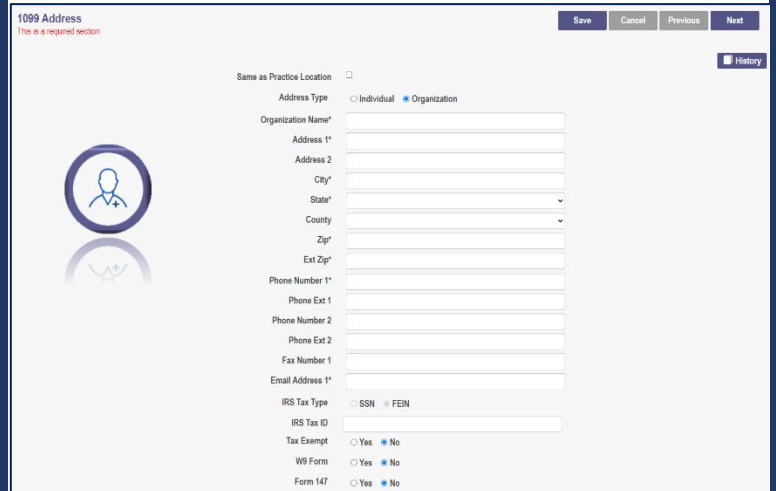
If the 1099 Address is the same as the Primary Service Address, select the check box to indicate it is the 'Same as the Practice Location.' This will pre-populate information that was entered on the previous screen into the fields.

If a different address, enter the required fields marked with an asterisk *

Depending on the original provider entry and provider type, the relevant tax identification information will display automatically.

Select the radio buttons for 'Tax Exempt'; Type of form (W9 or 147)

Click the 'Save' or 'Next' buttons to save the contact to the record



1099 Address
This is a required section

Save Cancel Previous Next History

Same as Practice Location ☐

Address Type ☐ Individual ☒ Organization

Organization Name*

Address 1*

Address 2

City*

State*

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Email Address 1*

IRS Tax Type ☐ SSN ☒ FEIN

IRS Tax ID

Tax Exempt ☐ Yes ☒ No

W9 Form ☐ Yes ☒ No

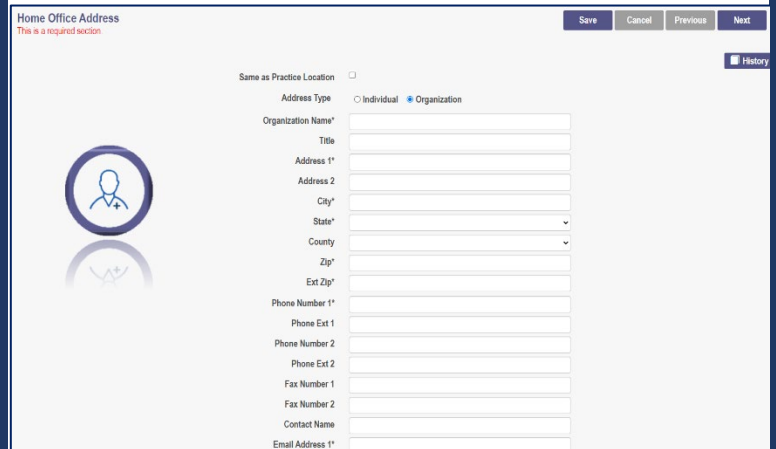
Form 147 ☐ Yes ☒ No

Home Office Address

If the Home Office Address is the same as the Primary Service Address, select the check box to indicate it is the 'Same as the Practice Location.'

This will pre-populate information that was entered on the previous screen into the fields.

If a different address, enter the required fields marked with an asterisk *



Home Office Address
This is a required section

Save Cancel Previous Next History

Same as Practice Location ☐

Address Type ☐ Individual ☒ Organization

Organization Name*

Title

Address 1*

Address 2

City*

State*

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

Long Term Care Addresses Page

Note: Repeat the process below to add more than one location

Step 1: Click 'Add New' to enter details for the Long-Term Care location

Step 2:

- If the Long-Term Care address is the same as the Primary Service Address, click the box at the top of the page to auto-fill the same details from the Primary Service Address page
- If the Long-Term Care address is different than the Primary Service Address, manually input the information on each of the required lines on the page

Step 3: Select a Location Type from the drop-down menu

- Auditors/Preparers Address
- Facility Address
- Change of Operator (CHOP)/Closure Notice Address

Step 4: Click the 'Save' or 'Next' buttons to save the contact to the record and proceed to the next page


Long Term Care Addresses

This is a required section.

Save Cancel Previous Next

4 History

No records found.



2 Same as Practice Location ☐

3 Location Type*

Address Type ☐ Individual ☒ Organization

Organization Name*

Address 1*

Address 2

City*

State*

OH

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

1 Add New

Specialties Page

The specialty page allows you to indicate any specialties

Note: A Primary Specialty must be designated on one Specialty.

Step 1: Click 'Add New' to add a Specialty

- The Specialty drop-down has a variety of specialties that are associated with your Provider type
- If it is your Primary Specialty, select the check box that allows you to 'Designate as Primary Specialty'

The screenshot shows the top navigation bar of the Specialties Page. It includes a 'Jump To:' dropdown menu set to 'Long Term Care Addresses'. Below the navigation bar is a breadcrumb trail with icons and labels: 'dress*', 'Home Office Address*', 'Long Term Care Addresses*', 'Specialties*' (highlighted with a yellow box), 'Taxonomies*', 'Medicare Number*', and 'MCP Affiliation'. To the right of the breadcrumb trail are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', and 'Next'. Below the navigation bar, the section title 'Specialties' is displayed with a red note: 'This is a required section.' Below this, a message states: 'Primary Specialties are not editable by provider after application submission.' Below that, it says 'No records found'. In the bottom right corner, there is a red circle with the number '1' next to an 'Add New' button.

Step 2: Click 'Save' and confirm the New Specialty has been saved by reviewing the table

Step 3: Click 'Add New' and repeat the process to enter any Additional Specialties

The screenshot shows the 'Specialties' form. At the top, there is a 'Save' button highlighted with a red circle with the number '2'. Below the navigation bar, the section title 'Specialties' is displayed with a red note: 'This is a required section.' Below this, a message states: 'Primary Specialties are not editable by provider after application submission.' Below that, it says 'No records found'. In the bottom right corner, there is a red circle with the number '3' next to an 'Add New' button. On the left side, there is a large circular icon containing a DNA helix and a magnifying glass. To the right of the icon, there is a checkbox labeled 'Designate a Primary Specialty' which is checked. Below the checkbox, a red note states: 'Designate a Primary Specialty and save first before secondary specialties can be entered.' Below this, there is a red circle with the number '1' next to a 'Specialty*' dropdown menu. To the right of the dropdown menu are two input fields: 'Start Date*' with the value '5/6/2022' and 'End Date' with the value '12/31/2299'.

Note: The 'Enroll Status' of the Specialties will show as INACTIVE until your Enrollment Application has been fully approved

Step 4: Click 'Next' to Save and proceed to the next page

Specialties

This is a required section.

Generate PDF

4

Save

Cancel

Previous

Next

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status		
860 Dual Certified Skilled Nursing Facility	Yes	05/06/2022	12/31/2299	INACTIVE		

Add New

History

Removing Specialties

- Step 1:** To Remove an added specialty:
- Click the 'x' associated with the applicable specialty line

Specialties

This is a required section.

Generate PDF

Save

Cancel

Previous

Next

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status		
860 Dual Certified Skilled Nursing Facility	Yes	05/06/2022	12/31/2299	INACTIVE		

Add New

History

Taxonomies Page

The Taxonomies page allows you to add, edit, or remove taxonomy codes that are associated in PNM.

Taxonomies associated through NPPES will automatically appear as options within PNM.

Note: If you are missing a taxonomy, you will need to update NPPES first before the taxonomy changes will appear as selections in PNM.

Jump To: Long Term Care Addresses

Office Address*

Long Term Care Addresses*

Specialties*

Taxonomies*

Medicare Number*

MCP Affiliation

Nursing Facility Ventil:

Generate PDF

SaveCancelPreviousNext

Taxonomies

This is a required section.

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
313M00000X	NURSING FACILITY/INTERMEDIATE CARE FACILITY	Yes	05/06/2022	12/31/2299		

Add New

History

If you need to include additional Taxonomy Codes to your record, manually add them by following the process below:

Step 1: Click 'Add New' to add a Taxonomy Code

Step 2: Indicate a Primary Taxonomy by selecting the check box 'Is Primary Taxonomy'

Step 3: Enter the 'Start Date' (This is the date Taxonomy was added to your NPI record)

Step 4: Enter the 'End Date' (This field can be left blank)

Step 5: Click 'Next' to save and proceed to the next page

Taxonomies

This is a required section.

Save

Cancel

Previous

Next

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
313M00000X	NURSING FACILITY/INTERMEDIATE CARE FACILITY	Yes	05/06/2022	12/31/2299		

1

Add New

History

2

Taxonomy*

3

Start Date*

4

End Date

☐ Is Primary Taxonomy

Editing or Changing Primary Taxonomy

Step 1: Click the 'Pencil and Notepad' icon next to the Taxonomy on the list associated with your application

Step 2: Select the appropriate Taxonomy from the drop-down menu and edit start and end dates as needed



Step 3: Select the checkbox for 'Is Primary Taxonomy'

Step 4: Confirm your changes have been adjusted

Step 5: Click 'Next' to save and proceed to the next page

Taxonomies
This is a required section.

Save Cancel Previous **Next**

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
313M00000X	NURSING FACILITY/INTERMEDIATE CARE FACILITY	Yes	05/06/2022	12/31/2299		

1 Add New

History

2 Taxonomy* Nursing Facility/Intermediate Care Facility (313M00000X) ▾

3 Start Date* 05/06/2022

4 End Date 12/31/2299

☒ Is Primary Taxonomy

Medicare Number Page

This may not be a required section to complete. Click 'Next' to skip, if not required.

Step 1: If you need to complete this section, click 'Add New' and enter the relevant information:

- Medicare Number type

If you need further clarification, click 'What is this?' for help

- Medicare number
- Medicare State
- Medicare Enrollment Status (Required)
- Medicare Enrollment Date

Note: System uses Secondary NPI and Medicare State to look up and verify Provider is in PECOS

Step 2: Upload a Medicare Enrollment Certification document by clicking 'Browse'

Step 3: Determine if you need to add Medicaid through another State

- Click 'Add New' to add another State
- Enter all relevant and required information

Step 4: Click 'Save' to save your work

Step 5: Click 'Next' to move to the next screen

4

Medicare Number

This is a required section.

Save

Cancel

Previous

5

Next

MCP Affiliation

This page allows you to confirm your interest with an Ohio Medicaid Managed Care Plan.

Step 1: Indicate if you are interested in contracting with any of the Ohio Medicaid Managed Care Plans by selecting 'Yes' or 'No' radio button

Note: This indication does not ensure a contract with the Ohio Medicaid Managed Care Plans. You must still go through the plan's contracting process, if applicable

Jump To: Medicare Number

Specialties* Taxonomies* Medicare Number* **MCP Affiliation** Nursing Facility Ventilator* Professional Liability Insurance*

Generate PDF

MCP Affiliation
This is not a required section. To skip this section click on Next button.

Save Cancel Previous Next

Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans? ☒ Yes ☐ No

Please Note: This indication does not ensure a contract with the Ohio Medicaid Managed Care Plans. Providers must still go thru the plan's contracting process, if applicable

Confirmed MCP Affiliations

Name	Start Date	End Date	Provider Type	Tracking Number	MITs Specialty
No MCP affiliations found.					

Step 2: If you select 'Yes,' this indicates interest in possible participation with one or more Ohio Medicaid Managed Care Plans. Select the appropriate checkbox(es) for which Managed Care Plans you are interested in participating

Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans? ☒ Yes ☐ No

Indicate your interested in possible participation with one or more Ohio Medicaid Managed Care Plans

2 ☐ AmeriHealth Caritas
☐ Anthem Blue Cross
☐ Aetna
☐ Buckeye
☐ CareSource
☐ Humana
☐ Molina
☐ United Health Care

Please Note: This indication does not ensure a contract with the Ohio Medicaid Managed Care Plans. Providers must still go thru the plan's contracting process, if applicable

Note: Any confirmed MCP Affiliations would appear at the bottom of the page

Confirmed MCP Affiliations

Name	Start Date	End Date	Provider Type	Tracking Number	MITs Specialty
No MCP affiliations found.					

Nursing Facility Ventilator

This page asks you to answer the question “Are you applying as a new nursing facility ventilator provider?”

Note: This page will only appear for Provider Type 86 – Nursing Facility

Step 1: Select the appropriate radio button to answer the question ‘Yes’ or ‘No’

Jump To: Medicare Number

ies* Medicare Number* MCP Affiliation Nursing Facility Ventilator* Professional Liability Insurance* W9 Form* EFT Banking

Generate PDF

Nursing Facility Ventilator
This is a required section.

Save Cancel Previous Next

Are you applying as a new nursing facility ventilator provider? **1** ☐ No ☐ Yes

Yes/No Nursing Facility Ventilator

Step 2: If you select ‘Yes,’ you will be prompted to answer additional Ventilator and Weaning Questions:

Nursing Facility Ventilator
This is a required section.

Save Cancel Previous Next

Are you applying as a new nursing facility ventilator provider? ☐ No ☒ Yes

2 Ventilator Questions

Ventilators are connected to emergency outlets connected to a backup generator in an amount sufficient to meet the needs of ventilator dependent individuals.

☐ No ☐ Yes

Respiratory care professional (RCP) is on-site at least 5 hours per week.

☐ No ☐ Yes

Registered Nurse (RN) with 1-year experience working with ventilator dependent individuals is in the facility at least 5 hours per week.

☐ No ☐ Yes

If ordered by a physician, initial therapy assessments can be done within 48 hours of receipt of order.

☐ No ☐ Yes

If ordered by a physician, therapy is available for up to 2 hours per day, 6 days per week for each ventilator dependent individual.

☐ No ☐ Yes

Stat laboratory services are available 24 hours per day, 7 days per week with results within 4 hours.

☐ No ☐ Yes

For new admissions, pain medications can be administered within two hours from receipt of physician order.

☐ No ☐ Yes

Has not been a special focus facility in past 6 months.

☐ No ☐ Yes

Weaning Questions

A weaning protocol is in place established by a physician trained in pulmonary medicine who is available by phone 24 hours per day 7 days per week while weaning services are provided.

☐ No ☐ Yes

A respiratory care professional (RCP) with training in basic life support is on-site 8 hours per day 7 days per week and available by phone during the remaining hours of the day while weaning services are provided.

☐ No ☐ Yes

A Registered Nurse (RN) with training in basic life support is on-site 24 hours per day 7 days per week while weaning services are provided.

☐ No ☐ Yes

Step 3: If you select 'No,' no further information is necessary

Step 4: Click 'Next' to save and move to the next screen

Nursing Facility Ventilator
This is a required section.

Save

Cancel

Previous

Next

3

Are you applying as a new nursing facility ventilator provider?

☒ No ☐ Yes

4

Professional Liability Insurance Page

This page allows you to enter information about your professional liability insurance

Step 1: To add Professional Liability Insurance, click 'Add New'

Jump To: Medicare Number

Nursing Facility Ventilator* Professional Liability Insurance* W9 Form* EFT Banking Application Fee* Owner Information*

Generate PDF

Professional Liability Insurance
This is a required section.

Save Cancel Previous Next

History

No records found

1 Add New

Yes/No Professional Liability Insurance

Step 2: You must select a 'Yes' or 'No' radio button for the question: "Do you carry malpractice insurance?"

If you select 'Yes,' you will be prompted to enter required corresponding information into the screen:

- Self-Insured?
- Policy Number
- Effective Date
- Original Effective Date
- Expiration Date
- Type of Coverage
- Do you have unlimited coverage?
- Policy includes tail coverage?
- Carrier or Self-Insured Name
- Address
- City
- State
- Zip
- Policy Holder
- Coverage Amount Per Occurrence
- Coverage Amount Per Aggregate

Do you carry malpractice insurance? 2 Yes No

Self Insured? Yes

Policy Number*

Effective Date*

Original Effective Date*

Expiration Date*

Type of Coverage*

Do you have unlimited coverage?

Policy includes tail coverage*

Carrier or Self-Insured Name*

☐ Check here if insurance is through Federal Tort Claims Act (FTCA)

Carrier address 1

Carrier address 2

City*

State* OH

County

Zip*

Policy Holder*

Coverage Amount Per Occurrence*

Coverage Amount Per Aggregate*

Step 3: If you select ‘No,’ you will need to provide an explanation regarding malpractice insurance

Do you carry malpractice insurance?

☐ Yes ☒ No

If No, please provide explanation below.

3

Please provide an explanation regarding malpractice insurance

Step 4: Click ‘Next’ to save and move to the next screen

Professional Liability Insurance

This is a required section.

Get PDF 4

Save Cancel Previous Next

History

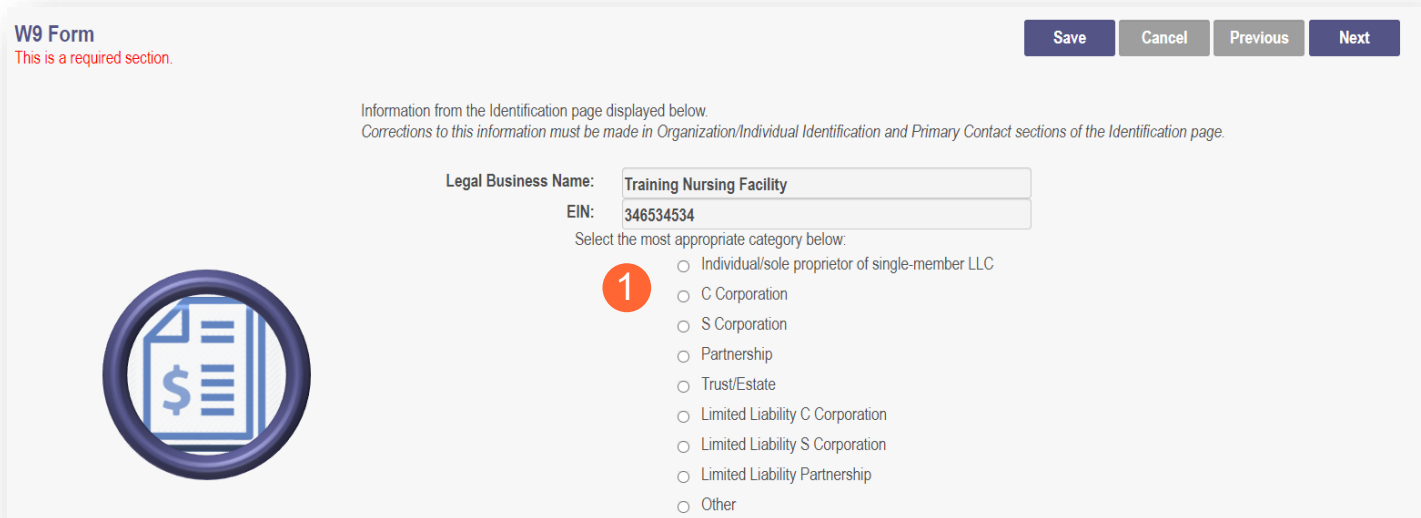
Carrying malpractice insurance?	Policy Number	Effective Date	Expiration Date	Policy Holder	Coverage Account Per Occurrence	Coverage Account Per Aggregate	Explanation regarding malpractice insurance
Yes	4565432113	08/03/2021	08/03/2023	Test Policy Holder	1,000,000	30,000,000	

Add New

W9 Form Page

On this page, indicate which tax filing category and document you complete to provide the correct EIN/TIN

Step 1: Select the most appropriate organization type by clicking on the appropriate radio button category



W9 Form
This is a required section.

Information from the Identification page displayed below.
Corrections to this information must be made in Organization/Individual Identification and Primary Contact sections of the Identification page.

Legal Business Name: Training Nursing Facility
EIN: 346534534

Select the most appropriate category below:

1

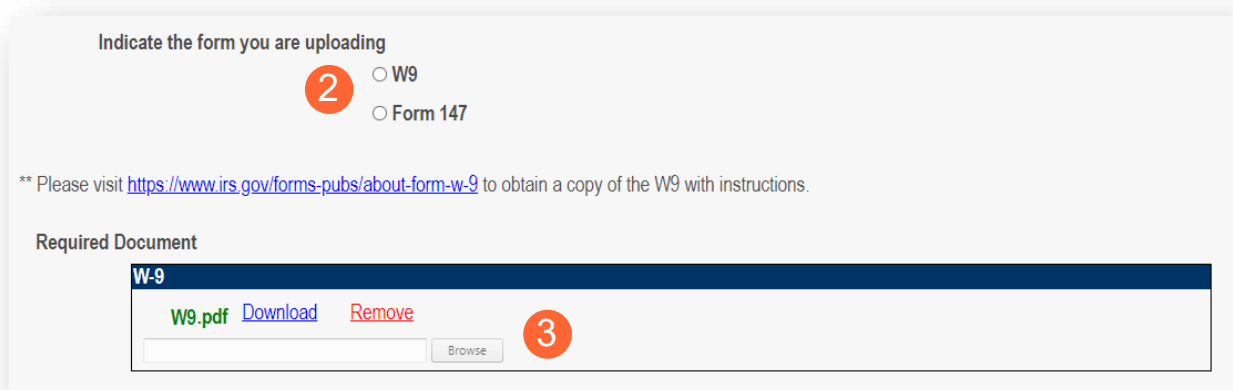
- ☐ Individual/sole proprietor of single-member LLC
- ☐ C Corporation
- ☐ S Corporation
- ☐ Partnership
- ☐ Trust/Estate
- ☐ Limited Liability C Corporation
- ☐ Limited Liability S Corporation
- ☐ Limited Liability Partnership
- ☐ Other

Save Cancel Previous Next

Step 2: Indicate the type of form you are uploading by selecting the radio button for 'W9' or 'Form 147'

Step 3: Under the Required Document section, use the 'Browse' option at the bottom of the screen to upload your W9 or Form 147

- The file name will appear in green text when it has uploaded



Indicate the form you are uploading

2

☐ W9
☐ Form 147

** Please visit <https://www.irs.gov/forms-pubs/about-form-w-9> to obtain a copy of the W9 with instructions.

Required Document

W-9

W9.pdf Download Remove

Browse

3

Step 4: Click 'Next' to save the information and move to the next page

EFT Banking Information Page

This page requires to you indicate enrollment of Electric Fund Transfer (EFT), which is required to enroll with the State Medicaid Program. However, if 'No' is answered to the first question, no additional details need to be entered.

Step 1: Select the 'Yes' or 'No' radio button to answer the question at the top of the page

Step 2: Read the instructions section before proceeding to Step 3

Note: If your bank is outside of the United States, click the checkbox at the end of the 'Instructions' section

Step 3: To enter your Bank Account information, click 'Add New' under the Banking Information Section

Generate PDF

EFT Banking Information

This is a required section.

Save Cancel Previous Next

Do you expect to receive payments directly from the State Medicaid Program (For example: Fee-for-Service Claims, Medicare Crossover Claims, Supplemental Pool Payments, Electronic Health Records Payments, etc.) as opposed to only payments from the Managed Care Contractors?

1 ☐ Yes ☐ No

Instructions

2 READ INSTRUCTIONS BEFORE COMPLETING

- Electronic Fund Transfer (EFT) enrollment is required for a provider to enroll with the State Medicaid Program.
- Medicaid providers must submit this form to receive payment via EFT (Electronic Fund Transfer). It is also the responsibility of the Medicaid provider to ensure this information is updated, as necessary.
- The State Medicaid Program transmits the EFT via the NACHA standard CCD + format.
- It is the responsibility of the Provider to contact their financial institution to request the receipt of all data contained within the ACH information field (including the RTN Reassociation Trace Number) of the CCD + Addenda Record. This Trace Number uniquely identifies the transaction set and aids in reassociating payments and remittance advices.

☐ Check here if the bank is outside of the United States. Per 1902(a)(80) of the Social Security Act, the State shall not provide any payment to any financial institution or entity located outside the United States.

Please enter your banking information below.

Banking Information

No banking information found.

3 Add New

EFT Contact

No EFT contact found.

Add New

Confirm

By selecting the confirmation box below, the submitting individual is attesting and acknowledging on behalf of the Medicaid Provider listed above that:

- He or she is authorized to complete and submit this Enrollment Form.
- The information provided is accurate and true.

☐ I confirm the information provided is true and accurate.

Step 4: Complete the required information

- Financial Institution Name
- Financial Routing Number
- Confirm the Routing Number
- Account Number
- Confirm the Account Number
- Account Type: Checking or Savings

Step 5: Click 'Save'

Banking Information

4

Financial Institution Name*

Training Bank

Financial Institution Routing Number*

041215537

Confirm Financial Institution Routing Number*

041215537

Account Number*

25435345443

Confirm Account Number*

25435345443

Account Type*

☒ Checking ☐ Savings


5

Save

Cancel

Step 6: Click 'Add New' to enter information for the EFT Contact

Banking Information

Financial Institution Name	Account Number	Account Type	
Training Bank	*****	Checking	

EFT Contact

No EFT contact found.

6

Add New

Confirm

By selecting the confirmation box below, the submitting individual is attesting and acknowledging on behalf of the Medicaid Provider listed above that:

- He or she is authorized to complete and submit this Enrollment Form.
- The information provided is accurate and true.

☐ I confirm the information provided is true and accurate.

Step 7: Enter the following contact information for the person who will handle the Electric Funds Transfer account

Required

- Contact First Name
- Last Name
- Phone Number
- Email Address

Optional

- Middle Name
- Phone Extension
- Fax Number

The form is titled "EFT Contact Information" and has a blue header bar with a red circle containing the number 7. The form contains the following fields: "Provider Contact First Name*", "Middle Name", "Last Name*", "Phone Number*" (with a format of () - -), "Extension", "Email Address*", and "Fax Number" (with a format of () - -). At the bottom right, there are two buttons: "Save" (blue) and "Cancel" (gray). A red circle with the number 8 is positioned above the "Save" button.

Step 8: Click 'Save'

Step 9: Review the statement under the Confirm section. Select the checkbox if the information provided is true and accurate

Confirm

By selecting the confirmation box below, the submitting individual is attesting and acknowledging on behalf of the Medicaid Provider listed above that:

- 9
- He or she is authorized to complete and submit this Enrollment Form.
 - The information provided is accurate and true.

☒ I confirm the information provided is true and accurate.

Step 10: Click 'Next' to save the information and move to the next page

The form is titled "EFT Banking Information" and has a blue header bar. Below the title, it says "This is a required section." in red. At the bottom right, there are four buttons: "Save" (blue), "Cancel" (gray), "Previous" (gray), and "Next" (blue). A red circle with the number 10 is positioned above the "Next" button. In the top right corner, there is a button labeled "Generate PDF" with a red circle containing the number 10.

Application Fee

An application fee is required to be paid to be enrolled in the State Medicaid program. The fee can be paid through PNM via credit card, or if you have already paid the fee (within the past 5 years or in another state) you can request a fee waiver.

Paying The Fee

Step 1: Select the 'Credit Card' radio button

Step 2: Click 'Select Payment'

Application Fee

This is a required section.

Save

Cancel

Previous

Next

Application Fee

All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$595.00

You may also request a waiver of the fee if you have paid within the past 5 years.

Fee Amount

\$595.00

Fee Status

Pending

Payment Type

1

☒ Credit Card

☐ Request Waiver of Application Fee

2

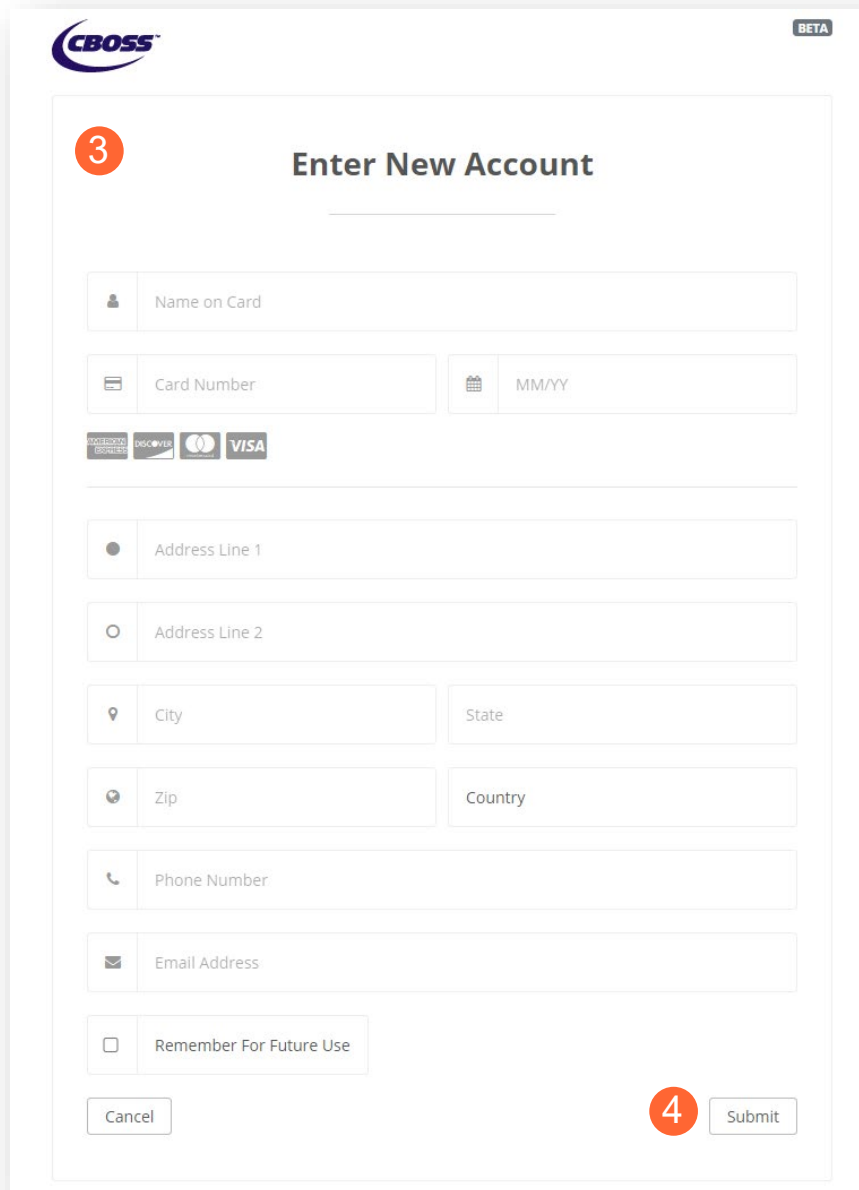
Authorize Payment

Select Payment

Step 3: Enter your credit card information in the secure CBOSS system

- You can select the checkbox to remember your information for future use

Step 4: When all the information has been entered, click 'Submit'



The screenshot shows a web form titled "Enter New Account" with a red circle containing the number "3" in the top left corner. The form is part of the CBOSS system, as indicated by the logo in the top left and a "BETA" label in the top right. The form contains several input fields: "Name on Card", "Card Number", "MM/YY", "Address Line 1", "Address Line 2", "City", "State", "Zip", "Country", "Phone Number", and "Email Address". Below these fields is a checkbox labeled "Remember For Future Use". At the bottom of the form are two buttons: "Cancel" and "Submit". A red circle containing the number "4" is positioned next to the "Submit" button.

3 Enter New Account

NAME ON CARD

CARD NUMBER

MM/YY

DISCOVER

VISA

ADDRESS LINE 1

ADDRESS LINE 2

CITY

STATE

ZIP

COUNTRY

PHONE NUMBER

EMAIL ADDRESS



☐ Remember For Future Use

Cancel **4** Submit

Step 5: Once returned to the Application Fee screen, click ‘Authorize Payment’

Application Fee
This is a required section.

SaveCancelPreviousNext



Application Fee

All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$595.00

You may also request a waiver of the fee if you have paid within the past 5 years.

Fee Amount

\$595.00

Fee Status

Waived

Payment Type

☒ Credit Card

☐ Request Waiver of Application Fee

5

Authorize Payment

Select Payment

Please note your Registration ID on the check.

Amount*

\$595.00

Waiver Reason

Comments

Waiving the Fee

Step 1: Select the 'Request Waiver of Application Fee' radio button

Application Fee
This is a required section.

SaveCancelPreviousNext

Application Fee

All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$595.00

You may also request a waiver of the fee if you have paid within the past 5 years.

Fee Amount

\$595.00

Fee Status

Pending

Payment Type

1

☐ Credit Card

☒ Request Waiver of Application Fee

Authorize Payment

Select Payment

Step 2: From the drop-down menu, choose the appropriate reason you are seeking a waiver

Please note your Registration ID on the check.

Amount*

\$595.00

2

Waiver Reason

Medicare Enrolled

Paid in Another State

Paid in the past 5 years

Medicare Enrollment Pending

Comments

Fee Payment History

Step 3: If needed, type comments in the box

Please note your Registration ID on the check.

Amount*

\$595.00

Waiver Reason

Paid in the past 5 years

3

Comments

Paid 1/2/2021

Step 4: If the fee has been paid in another state or paid previously, a document must be uploaded, including the proof of payment for waiver reasons, by clicking 'Browse' and locating the document on your computer

Proof of fee payment (if Paid in another State as a waiver reason)

Browse

4

Step 5: Click 'Next' to proceed to the next page

Proof of fee payment (if Paid in another State as a waiver reason)

Proof of Payment_2.pdf

Download

Remove

Browse

Owner Information

Step 1: There are several sections on the Owner Information page. Each section page and be expanded by click '+' or reduced by clicking '-'

Step 2: The two areas that are required to be completed are the 'Owner, Managing Employee and Controlling Interest Information' and 'Questions' sections

- **Note:** If additional sections such as 'Real Estate Owners' or 'Additional Disclosure' apply to you, please complete those sections as well

Step 3: To add Owner Information, click 'Add New'


The screenshot shows the 'Owner Information' form interface. At the top right, there are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', and 'Next'. The form title is 'Owner Information' with a note 'This is a required section.' Below the title, a instruction says 'Click on the section header to expand or collapse the panel.' The form is divided into several sections, each with a '+' icon to expand and a '-' icon to collapse. Section 1 is 'Instructions'. Section 2 is 'Definitions & Requirements'. Section 3 is 'Owner, Managing Employee and Controlling Interest Information', which is currently expanded and shows a message 'No owner information found.' with an 'Add New' button. Below this are sections for 'Real Estate Owners', 'Additional Disclosure', and 'Questions'. The 'Questions' section is also expanded and contains several yes/no questions. The questions are: 1. 'Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling?' 2. 'Does any person who has an ownership or control interest in this provider entity also have an ownership or control interest with another provider entity?' 3. 'Have you or any individuals or organizations having a direct or indirect ownership or controlling interest of 5 percent or more in the professional association or practice, any managing employees or other employees been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?' 4. 'Have you as the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?' 5. 'Have any of the individual owners been a resident outside the state of Ohio in the past 5 years?' 6. 'Have you the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, Entity or Practice ever been, sanctioned by the Medicare Program?' 7. 'Does your provider entity have any transactions totaling more than \$25,000 during the past 12 month period with any subcontractor?' 8. 'Have you had any significant business transactions between your provider entity and any subcontractor, or wholly owned supplier, during the 5-year period ending on the date of the request?'


Step 4: Enter the detailed Owner Information for any Individuals, Managing Employees, or Organizations who have ownership interests in your Facility


Step 5: Click 'Save'

Owner Information

4

Owner Type* 


Owner Title 


Affiliation Type 

Address 1*

Address 2

City*

State* 

County 

Zip*

Percentage of Ownership*



Owner End Date 12/31/2299


5 Save Cancel

Step 6: Confirm all owners, managing partners, and individuals with controlling interest, have been added

- Owner, Managing Employee and Controlling Interest Information

6

Type	Name	Title	Percentage		
Individual	Travis Trainer	President	100.00		

Add New 

List the name, home address (no P.O. Box addresses), Date of Birth (DOB), Social Security Number (SSN) and percentage owned for each person with a direct or indirect ownership or control interest of 5 percent or more in the provider entity. In addition, list the same information for any subcontractor in which the provider entity has direct or indirect ownership or control interest of 5 percent or more. If you are an individual AND you are a solo practitioner and you own 100 percent of your practice then you would just list yourself as 100% owner.

Step 7: Once all necessary sections have been completed, answer the Questions listed by either indicating 'Yes' or 'No'

Note: If 'Yes' is answered on any questions, additional information may need to be provided

- Questions

7

Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling?

☐ Yes

☐ No

Does any person who has an ownership or control interest in this provider entity also have an ownership or control interest with another provider entity?

☐ Yes

☐ No

Have you or any individuals or organizations having a direct or indirect ownership or controlling interest of 5 percent or more in the professional association or practice, any managing employees or other employees been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ Yes

☐ No

Have you as the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?

☐ Yes

☐ No

Have any of the individual owners been a resident outside the state of Ohio in the past 5 years?

☐ Yes

☐ No

Have you the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, Entity or Practice ever been, sanctioned by the Medicare Program?

☐ Yes

☐ No

Does your provider entity have any transactions totaling more than \$25,000 during the past 12 month period with any subcontractor?

☐ Yes

☐ No

Have you had any significant business transactions between your provider entity and any subcontractor, or wholly owned supplier, during the 5-year period ending on the date of the request?

☐ Yes

☐ No

Step 8: When all items are completed on the Owner Information page, click 'Next' to proceed to the next page

Jump To: Owner Information

Professional Liability Insurance* → W9 Form* → EFT Banking* → Application Fee* → **Owner Information*** → Required Documents* → Agreements*

Owner Information
This is a required section.

Save Cancel Previous **Next**

Gr 8 DF

Required Documents Page


The required documents page allows you to upload required or optional supporting documentation

Step 1: If you have additional documentation not uploaded on other pages, you can upload it here

Required Documents

This is a required section.

SaveCancelPreviousNext



If you have additional documentation to provide that were not available for upload on other pages, upload those here. You may upload multiple documents and you will be able to view and delete documents after uploading.

You may also mail in additional documentation, which may result in a delay to process your application.
Mailing Address:
Ohio Department of Medicaid
Provider Enrollment Unit
PO Box 1461
Columbus, OH 43216-1461

Required Document

ODI (Ohio Department of Insurance) Attestation

Browse

Optional Document

Site Visit/Accreditation

Browse

Required Document

ODH issued Certificate of Need - CON

Browse

Optional Document

ODH Nursing Home License

Browse

Step 2: If you are required to upload documents, blue upload boxes will be displayed under the Required Documents section

- To upload a document, click 'Browse,' then select the file and open

Step 3: If you want to upload a document not required by any previous page, click 'Choose File'

- Select the file and open
- Name the file
- Add a Description of the file
- Select 'Upload File'
- Confirm your document is attached

Required Document

ODI (Ohio Department of Insurance) Attestation

2

Optional Document

Site Visit/Accreditation

Required Document

ODH issued Certificate of Need - CON

2


Optional Document

ODH Nursing Home License

Required Documents
This is a required section.

If you have additional documentation to provide that were not available for upload on other pages, upload those here. You may upload multiple documents and you will be able to view and delete documents after uploading.

You may also mail in additional documentation, which may result in a delay to process your application.
Mailing Address:
Ohio Department of Medicaid
Provider Enrollment Unit
PO Box 1461
Columbus, OH 43216-1461



Uploaded Documents

Please note that you will not be able to delete uploaded documents once your application has been submitted.

No uploaded documents found.

3 No file chosen

Name

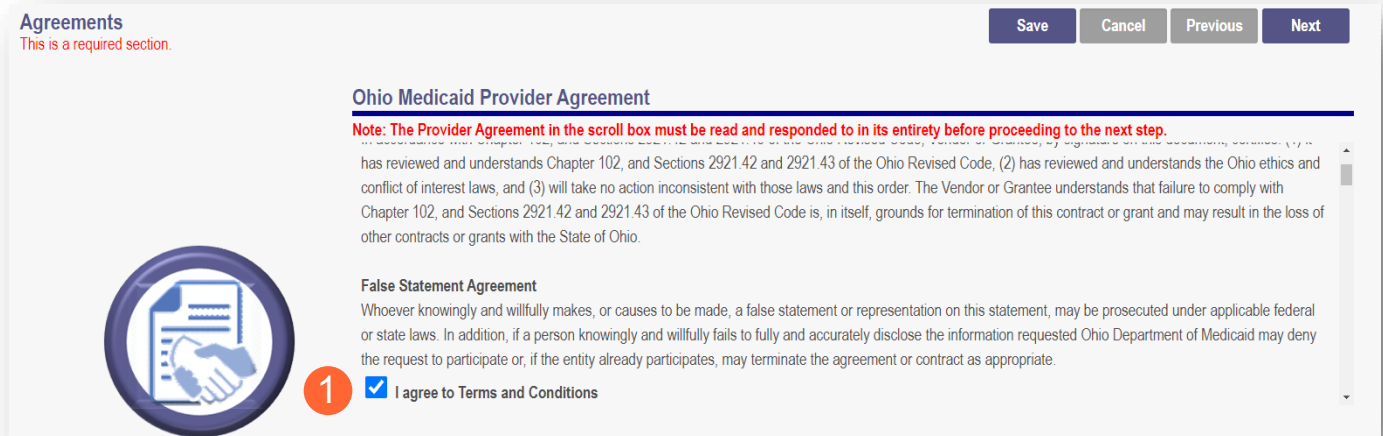
Description

Agreements Page

The Agreements page will ask for you to agree and attest to information that you have provided on your application

Step 1: Complete the Ohio Medicaid Provider Agreement attestation. The agreement must be viewed in its entirety before the 'I Agree' box will be available for selection.

- Click 'I agree to Terms and Conditions'



Agreements
This is a required section.

Ohio Medicaid Provider Agreement

Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step.

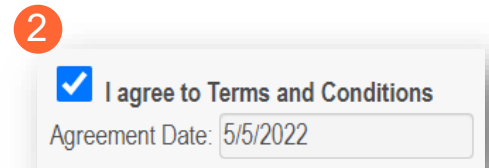
has reviewed and understands Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

False Statement Agreement
Whoever knowingly and willfully makes, or causes to be made, a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, if a person knowingly and willfully fails to fully and accurately disclose the information requested Ohio Department of Medicaid may deny the request to participate or, if the entity already participates, may terminate the agreement or contract as appropriate.

1 ☒ I agree to Terms and Conditions

Step 2: Read the Non-Credentialed Providers section of the agreements

- Select the check box: "I agree to Terms and Conditions"

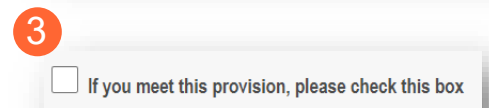


2 ☒ I agree to Terms and Conditions

Agreement Date: 5/5/2022

Step 3: Under the Provision Check section:

- If applicable for requesting retroactive coverage, select the checkbox: 'If you meet this provision, please check this box'



3 ☐ If you meet this provision, please check this box

Step 4: Read the Long-Term Care Facility (LTCF) Agreement and provide a signature either by choosing Option A or Option B

Agreements

This is a required section.

Save

Cancel

Previous

Next

Ohio Medicaid Provider Agreement

Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step.

4 Long Term Care Facility (LTCF) Agreement



Certification Status / Agreement Period The following terms of this agreement are contingent upon continued certification by the Secretary of the U.S. Department of Health and Human Services, or the Ohio Department of Health, which is the state survey agency.

Department Responsibilities This provider agreement is a contract between the Ohio Department of Medicaid (ODM) and the undersigned provider of Medicaid services. ODM shall make payments to the NF provider in accordance with Chapter 5165. of the Ohio Revised Code (ORC) for NF services provided to Medicaid recipients eligible for NF services. Pursuant to its agreement with ODM under ORC section 5124.02, the Ohio Department of Developmental Disabilities (DODD) shall make payments to the ICF-IID provider in accordance with ORC Chapter 5124. for ICF-IID services provided to Medicaid recipients eligible for ICF-IID services.

Provider Signature

☐ Option A **4**

I certify that I am the owner, officer, chief executive officer, general partner, or board member of the business organization entering into this provider agreement to operate this facility in the Medicaid program. I agree to be bound by this agreement and all applicable laws. I certify the information submitted on the application and the information as it appears in this provider agreement is accurate and complete. I agree that our business organization will notify ODM, in writing, of any subsequent changes to the information contained in the application or this agreement.

☐ Option B

By my signature below, I certify that I am signing with agent authority from and on behalf of the owner, officer, chief executive officer, general partner, or board member of the business organization entering into this provider agreement to operate this facility in the Medicaid program and that I have been given the authority to bind the business organization to this agreement and all applicable laws. I certify, on the organization's behalf, that the information submitted on the application and the information as it appears in this provider agreement is accurate and complete. Further, by my signature, I am binding the business organization to notify ODM, in writing, of any subsequent changes to the information contained in the application or this agreement.

Step 5: Complete the Provider Agreement Attestation

- Read the information provided
- Select the check box confirming that you have read the contents of the application and attest it is true, correct, and complete

Provider Agreement Attestation 5

☐ I have read the contents of this application, and the information contained herein is true, correct and complete. I agree to notify Ohio Medicaid of any future changes to the information contained in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Ohio Medicaid may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Ohio Medicaid identification number(s), and/or the imposition of fines, civil damages, and/or imprisonment. My electronic signature legally and financially binds this provider to the laws, regulations, and program instructions of the Ohio Medicaid program. By selecting the signature checkbox and submitting the application, I agree to abide by these terms.

Step 6: Complete the Provider Agreement Signature

- Select or Enter the Name of the Person Attesting

Provider Agreement Signature

6 Name of Person Attesting*:

Provider Name:

User ID:

7

Step 7: Click 'Save'

- A pop-up will appear confirming your application is complete

Step 8: Click 'OK' to review your application prior to submission

Your application is complete and has been saved. Please take time to review your application prior to submission. You will be able to generate your completed application in PDF form prior to submitting your application.

Once your review is complete, **you must click 'Submit for Review' at the top of the Agreements page to submit your application.**

8

Submitting Application

Step 1: When you are satisfied that all information has been entered accurately on the application, click 'Submit for Review' to submit the application

Jump To: Medicare Number

Professional Liability Insurance* → W9 Form* → EFT Banking → Application Fee* → Owner Information* → Required Documents* → Agreements*

Generate PDF

1 Submit for Review

Save Cancel Previous Next

Agreements

This is a required section.

Ohio Medicaid Provider Agreement

Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step.

All Providers must read the statements below and agree to the terms

Ohio Revised Code 2921.42 and 2921.43 Agreement

In accordance with Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

False Statement Agreement

Step 2: You will receive a confirmation message stating that your application has been successfully submitted

Step 3: Click 'Return to Home Page' to go to your dashboard

Menu Ohio Provider Network Management Medicaid Home Learning Contact Fee Schedule Log out

2 Submission Confirmation

You have successfully submitted your application to the Medicaid Program.
Please allow at least 10 days for processing before attempting to submit any changes.

3 Return to Home Page

Resubmitting an Application

If a specialist reviewing your application needs additional information, they will return the file to you with a description of the missing information needed for your application

Step 1: An email will be sent to the address listed on the Primary Contact Information page, indicating the application has been returned to you.

Please log into your account at [Login](#) to view a notice issued by the Ohio Department of Medicaid. You may be required to take action to maintain your Medicaid enrollment.

Step 2: Access your application (in 'Return to Provider' status) by logging into PNM and clicking on the link either under the Reg ID or the Provider heading

Ohio												
Provider Network Management Medicaid Home Learning Contact Fee Schedule trainingprov Log out												
My Providers Select Provider Pending Agent Requests Account Administration New Provider ?												
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
519471	Training Nursing Facility	Return to Provider	86 - NURSING FACILITY	1962735811		Dual Certified Skilled Nursing Facility					05/06/22	

Reviewing Correspondence

Step 1: Under the Manage Application section, click the '+' icon to expand 'Self Service'

Provider Management Home

Registration Information

Provider Name	Medicaid ID	Effective Date	Revalidation Due Date	Term Date
Training Nursing Facility				

Manage Application

Enrollment Actions	+ Enrollment Action Selections:
Programs	+ Program Selections:
Self Service	1 + Self Service Selections:

My Current and Previous Applications

Reg ID	Enrollment Action	Program	Application Id	PNM Application Status	Other Agency Application Status	DD Legal Status	Status Date
519471	Application Flow - Standard - NEW REGISTRATION	Medicaid	608339	NOT PROCESSED			05/06/22

Step 2: Click the 'Provider Correspondence' hyperlink

Manage Application

Enrollment Actions	+ Enrollment Action Selections:
Programs	+ Program Selections:
Self Service	- Self Service Selections:
	2 Provider Correspondence

Step 3: To locate correspondence, complete the following

- Select 'Enrollment Notifications' from the Correspondence Type drop-down menu
- Enter a data range for the search
- Click 'Search'

Step 4: Locate the search results at the bottom of the page and select the one with the subject of 'Send Additional Information (RTP Notice)'

CORRESPONDENCE SEARCH RESULT				
Correspondence Search Results				
Correspondence Subject	Correspondence Type	Date Sent	Date Viewed	Printed
Send Additional Information (RTP Notice)	ENROLLMENT	03/21/2022		✓
Ohio Medicaid Provider Application Received	ENROLLMENT	03/21/2022		

Step 5: Review the correspondence to understand the reason for the return. Once you have viewed, you can click the 'X' in the top-right corner to close

Completing Return to Provider (RTP) Process

Step 1: Under the Manage Application section, click the '+' icon to expand 'Enrollment Actions'

Provider Management Home

Registration Information

Provider Name	Medicaid ID	Effective Date	Revalidation Due Date	Term Date
Sharon Aaron				

Manage Application

Enrollment Actions	1 + Enrollment Action Selections:
Programs	+ Program Selections:
Self Service	+ Self Service Selections:

My Current and Previous Applications

Reg ID	Enrollment Action	Program	Application Id	PNM Application Status	Other Agency Application Status	DD Legal Status	Status Date
519468	Application Flow - Standard - NEW REGISTRATION	Medicaid	608334	NOT PROCESSED			05/05/22

Step 2: Click the 'Continue Registration' hyperlink

Enrollment Actions

2

Enrollment Action Selections:

[Continue Registration](#)
[Cancel New Registration](#)
[Edit Key Provider Identifiers](#)

Programs

+

Program Selections:

Self Service

+

Self Service Selections:

Step 3: The application will open to the page that was rejected during the review

- Rejected pages are marked with a yellow exclamation point
- Messaging will appear at the top of the page indicating the reason the application was rejected

Step 4: Correct or update the information of the page

Proper paperwork not attached (P032)
- Uploaded W9 page is blank. Please upload a copy of the W9 document

3

Jump To: W9 Form

Nursing Facility Ventilator* Professional Liability Insurance* W9 Form* EFT Banking Application Fee* Owner Information*

W9 Form
This is a required section.

Generate PDF

Save Cancel Previous Next

Information from the Identification page displayed below.
Corrections to this information must be made in Organization/Individual Identification and Primary Contact sections of the Identification page.

4 Legal Business Name: Training Nursing Facility
EIN: 346534534
Select the most appropriate category below.

Step 5: Click 'Save' to save the new information

- You will receive a message stating the application has been saved. Click 'OK'

Your application is complete and has been saved. Please take time to review your application prior to submission. You will be able to generate your completed application in PDF form prior to submitting your application.

Once your review is complete, **you must click 'Submit for Review' at the top of the Agreements page to submit your application.**

5 OK

Step 6: To resubmit your application for review, click the 'Submit for Review' button

Step 7: You will receive a message indicating your application has been resubmitted

Step 8: To access your dashboard, click 'Return to Home Page'

Review the Final Decision for Provider Submission

Step 1: Once the entire review process has been approved, you will be assigned a Medicaid ID number

- Use number timeline at the bottom to navigate to the last page
- Locate your newly assigned Medicaid ID number next to your application in the table

Ohio													
Provider Network Management Medicaid Home Learning Contact Fee Schedule Log out													
My Providers Select Provider Pending Agent Requests Account Administration New Provider ?													
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date	
169	Donald Trainer	Complete	Physician/Oste Individual		0000134	Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706	09/29/21	09/16/21	09/29/24	
170	Training Clinic	Complete	CLINIC		0000122	Primary Care Clinic			43085 - 4706	09/16/21	09/16/21	09/16/26	
171	Kim Trainer	Complete	Chiropractor Individual		0000135	Chiropractic Services			43085 - 4706	09/29/21	09/16/21	09/29/24	

Page size: 10 101 items in 11 pages

Step 2: Click the link under the Reg ID or Provider heading to review the file

- Here you can view communications, view Provider file, begin revalidation, and access other Provider self service functions.

Ohio													
Provider Network Management Medicaid Home Learning Contact Fee Schedule Log out													
My Providers Select Provider Pending Agent Requests Account Administration													
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID								
169	Donald Trainer	Complete	Physician/Oste Individual		0000134								
170	Training Clinic	Complete	CLINIC		0000122								
171	Kim Trainer	Complete	Chiropractor Individual		0000135								

Completing an Update

Step 1: Access the file in your dashboard by clicking on link listed under Reg ID or Provider

My Providers Select Provider Pending Agent Requests Account Administration New Provider ?												
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
519471	Training Nursing Facility	Complete	86 - NURSING FACILITY	1962735811	0000401	Dual Certified Skilled Nursing Facility				05/06/22	05/06/22	05/06/25

Step 2: Under the Manage Application section, click the '+' icon to expand 'Enrollment Actions'

Step 3: Click the 'Begin ODM Enrollment Profile Update' hyperlink

Provider Management Home
Registration Information

Provider Name
Medicaid ID
Effective Date
Revalidation Due Date
Term Date

Training Nursing Facility
0000401
05/06/2022
05/06/2025

Manage Application

Enrollment Actions
+

Enrollment Action Selections:

Programs
+

Program Selections:

Self Service
+

Self Service Selections:

Enrollment Actions

-
- 3
- Enrollment Action Selections:**
[Begin ODM Enrollment Profile Update](#)
[Edit Key Provider Identifiers](#)
[Request Disenrollment](#)

Step 4: Choose which element on the file you wish to update from the provided list and click 'Update'

Provider Update - Lets keep your information current !

Please click Update button to update your provider information. Once you have completed all your updates, you will be able to submit your changes from this screen.

4



Address Information

Update

Billing & Payment Address

Update

Correspondence Address

Update

Other Service Locations

Update

1099 Address

Update

Home Office Address



Financial Information

Update

W9 Form

Update

Application Fee



Owner Information

Update

Owner Information

Step 5: Update the file page that you selected and click 'Save' once finished

Note: A red dot will display on the updated page once it is saved (A) (see screenshot below Step 7)

Step 6: If there are other pages that need to be updated, click 'Return to Summary' and select 'Update' for that section

Jump To: Owner Information

Professional Liability Insurance* → W9 Form* → EFT Banking → Application Fee* → **Owner Information*** → Required Documents* → Agreements*

6 Return to Summary
Generate PDF
Save Cancel

Owner Information
This is a required section.

Click on the section header to expand or collapse the panel.

+ Instructions
+ Definitions & Requirements
+ Owner, Managing Employee and Controlling Interest Information

5

Type	Name	Title	Percentage		
Individual	Tim Trainer	President	100.00		

Add New

List the name, home address (no P.O. Box addresses), Date of Birth (DOB), Social Security Number (SSN) and percentage owned for each person with a direct or indirect ownership or control interest of 5 percent or more in the provider entity. In addition, list the same information for any subcontractor in which the provider entity has direct or indirect ownership or control interest of 5 percent or more. If you are an individual AND you are a solo practitioner and you own 100 percent of your practice then you would just list yourself as 100% owner.

Step 7: Once all pages are updated, click 'Submit for Review'

Jump To: Owner Information

Professional Liability Insurance* → W9 Form* → EFT Banking → Application Fee* → **Owner Information*** → Required Documents* → Agreements*

Return to Summary
Generate PDF
7 Submit for Review
Save Cancel

Owner Information
This is a required section.

Click on the section header to expand or collapse the panel.

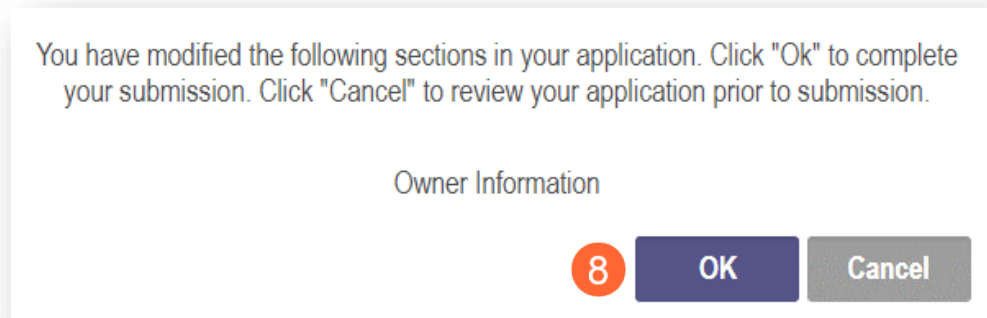
+ Instructions
+ Definitions & Requirements
- Owner, Managing Employee and Controlling Interest Information

Type	Name	Title	Percentage		
Individual	Tim Trainer	President	50.00		
Individual	Tom Trainer	Vice President	50.00		

Add New

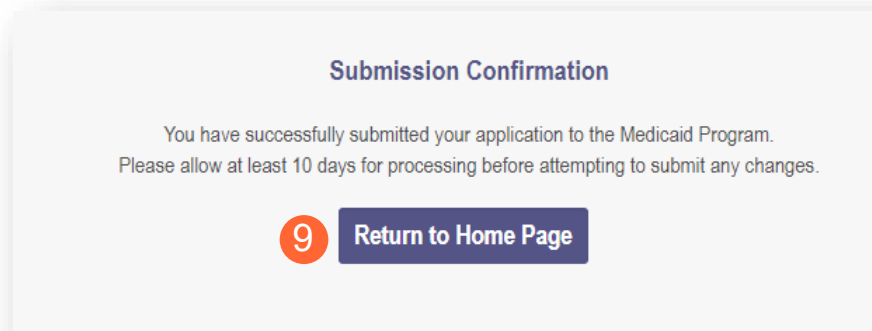
List the name, home address (no P.O. Box addresses), Date of Birth (DOB), Social Security Number (SSN) and percentage owned for each person with a direct or indirect ownership or control interest of 5 percent or more in the provider entity. In addition, list the same information for any subcontractor in which the provider entity has direct or indirect ownership or control interest of 5 percent or more. If you are an individual AND you are a solo practitioner and you own 100 percent of your practice then you would just list yourself as 100% owner.

Step 8: A pop-up window displays confirming which page(s) received an update. Click 'OK' to complete the submission



Step 9: You will receive a confirmation message stating that your application has been successfully submitted

- Click the 'Return to Home Page' button to go to your dashboard



Revalidation/Re-Enrollment Steps

Revalidation/Re-Enrollment is required every three (3) years for Credentialed Providers and every five (5) years for Non-Credentialed Providers. You will receive emailed notices when your application is due for revalidation. You can also view the Revalidation Due Date in the far-right column on the dashboard.

Step 1: Access the application in your dashboard by clicking on link listed under Reg ID or Provider

My Providers Select Provider Pending Agent Requests Account Administration New Provider ?												
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
519471	Training Nursing Facility	Complete	86 - NURSING FACILITY	1962735811	0000401	Dual Certified Skilled Nursing Facility				05/06/22	05/06/22	05/06/25

Step 2: Under the Manage Application section, click the '+' icon to expand 'Enrollment Actions'

Provider Management Home

Registration Information

Provider Name

Training Nursing Facility

Medicaid ID

0000401

Effective Date

05/06/2022

Revalidation Due Date

05/06/2025

Term Date

Manage Application

Enrollment Actions

+

Enrollment Action Selections:

Programs

+

Program Selections:

Self Service

+

Self Service Selections:

Step 3: Click the 'Begin Revalidation' hyperlink

Enrollment Actions

-

Enrollment Action Selections:

[Begin Revalidation](#)
[Edit Key Provider Identifiers](#)
[Request Disenrollment](#)

Step 4: Complete each page of the file. Click 'Next' to save and proceed to the next page

Note: Regardless of whether changes are made, each page needs to be reviewed and saved

Step 5: Confirm that each page has been reviewed, making sure a green checkmark appears for each page. If a green checkmark does not display for a page, review that page, and save the information.

Note: Submission will not be available unless all required pages have a green checkmark

Section Name	Status
Provider Information*	5
Primary Contact Information*	✓
Office Information	✓
Primary Service Address*	✓
Billing & Payment Address*	✓
Correspondence Address*	✓
Other Service Locations	✓
1099 Address*	✓
Home Office Address*	✓
Specialties*	✓
Taxonomies*	✓
Medicare Number	✓
Group, Organizations & Hospital Affiliations	✓
MCP Affiliation	✓
W9 Form*	✓
Owner Information*	✓
Required Documents	✓
Agreements*	✓

Step 5: Once all pages have been completed, click 'Submit for Review' to submit your application for Revalidation