



USER MANUAL

Behavioral Health Provider Enrollment Applications

Individual Provider



Department of
Medicaid

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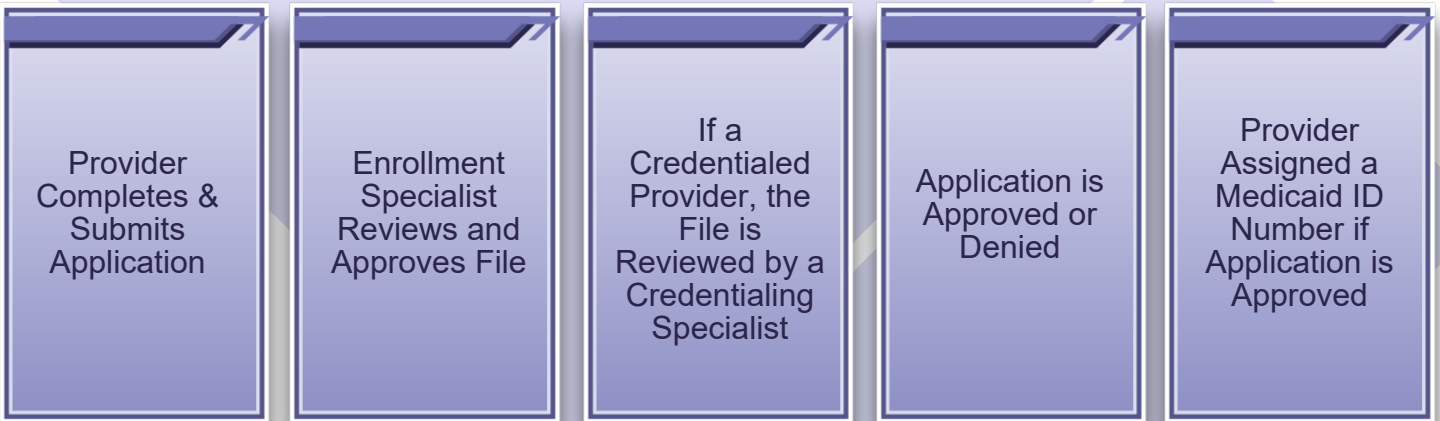
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Introduction

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.



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_PRD/Account/Login.aspx

Step 2: Enter the User ID and click 'Next'

Step 3: Click 'Go to IOP'

Login

Please enter your User ID

2 [Next](#)

[Don't have an Account? Click here](#) [Forgot User 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's 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](#)

Login

Please enter your User ID

3 [Go to IOP](#)

[Don't have an Account? Click here](#) [Forgot User ID?](#)

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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](#)

Step 4: The system will prompt you to enter your username and password on the IOP login screen illustrated below. Click 'Log in'

OH|ID

One state. One Account. Your OH|ID.

OH|ID is a secure way for Ohioans and businesses to interact with multiple State agencies and access a variety of programs and services, with a single user account.

Create Account

Log into OH|ID

4

Forgot OHID?

Forgot Password?

Log in

Step 5: You will be redirected to PNM. The next screen will allow you to 'Accept the Terms' to log into the PNM system by clicking the terms box

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.

5 ☐ 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	Complete	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

Select Provider: This button allows you to search for and move Providers to your OHID account based on identifying information, such as Tax ID, NPI, and Medicaid ID

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 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.

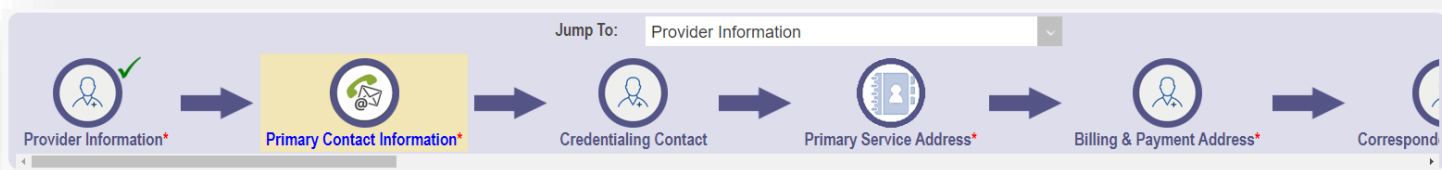
Cancel: Clears the work entered and does not save the page.

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.



A highlighted page indicates the page you are actively working.

A green checkmark on any page indicates that you have completed the necessary information on that page and can continue through the subsequent pages.

Pages marked with a red asterisk are required to be completed.

Primary Contact Information
This is a required section.

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

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

Individual Provider - New Provider Entry

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

Step 1: Click 'New Provider'

My Providers

Select Provider

Pending Agent Requests

Account Administration

1

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
		All	All			All						
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	Ordering, Referring, Prescribing	Change of Operator	MCP Single Case
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.	Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing.	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.	Use this application if you are entering into a Single Case agreement with a Managed Care Plan.
2 Select	Select	Select	Select ⓘ

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

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

“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	Ordering, Referring, Prescribing	Change of Operator	MCP Single Case
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.	Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing.	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.	Use this application if you are entering into a Single Case agreement with a Managed Care Plan.
Select	Select	Select	Select 

Less... **2**

Medicaid Waiver (ODM)	Medicaid Waiver (ODA)	Medicaid Waiver (DODD)	Non-Medicaid DODD
Use this application if you are applying to become a Waiver Provider with Ohio Department of Medicaid.	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.	Use this application if you are applying to become a Waiver Provider with Ohio Department of Developmental Disabilities.	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	Select	Select	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 ‘Individual’ to begin an Individual 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.”

3 Application Type [Change](#)

 Individual	 Group	 Organization	 Facility/Institution	 Pharmacy
--	---	--	---	--

Key Identifier Information

Step 1: Enter key provider information for the Provider

Enter all required fields marked with an asterisk *

- Provider Type
- First Name
- Last Name
- EIN (Employer Identification Number) / SSN (Social Security Number)
- NPI (National Provider Identifier)
- Requested Effective Date
- Gender
- Date of Birth
- Zip Code
- Zip Code Extension

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

Hint - PNM validates the NPI number with the individual name and gender listed in the National Plan and Provider Enumeration System (NPPES) Registry database. If the NPI doesn't match the name and gender, you will get an error before the taxonomy field appears.



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 an Individual Provider, that will be available on the 'Taxonomy' page of the application.

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' to advance to the next page

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 (Individual)

The first page that displays is the Provider Information page. Fill in all fields and click 'Next' to continue with your application.

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

For this page the following fields are required:

- Name (Business and First and Last)
- Tax ID
- Gender
- Date of Birth
- Practice Type
- Ownership Type
- Select the applicable radio button (Yes or No) for residency

Additional fields for optional entry:

- Birth Country
- Birth State
- Birth City
- CAQH # (Council for Affordable, Quality Healthcare)

The screenshot displays the 'Provider Information' form for an individual provider. The form is titled 'Provider Information' with a sub-note 'This is a required section.' A red circle with the number '1' highlights the 'Name of Business Entity*' field. A red circle with the number '2' highlights the 'Next' button. The form includes the following fields:

- Name of Business Entity*** (Text field)
- DBA** (Text field)
- Practice Type*** (Dropdown menu)
- Ownership Type*** (Dropdown menu)
- First Name*** (Text field)
- Middle Initial** (Text field)
- Last Name*** (Text field)
- Title** (Dropdown menu)
- Tax ID*** (Text field)
- NPI** (Text field)
- NPI Start Date** (Text field, pre-filled with 09/20/2005)
- Gender*** (Radio buttons: Female, Male, Unknown)
- Date of Birth*** (Text field)
- Provider Type*** (Dropdown menu, pre-filled with Physician/Osteopath Individual)
- Revalidation Date** (Text field, pre-filled with Not Set Yet)
- Enrollment Status** (Text field, pre-filled with Not Set Yet)
- Enrollment Status Reason** (Text field, pre-filled with Not Set Yet)
- Birth Country** (Dropdown menu)
- Birth State** (Text field)
- Birth City** (Text field)
- CAQH #** (Text field)

At the bottom of the form, there is a question: 'Have you been a resident of the state OHIO for the last 5 years?' with radio buttons for 'Yes' and 'No' (selected).

Step 2: Click 'Save' or 'Next' 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.

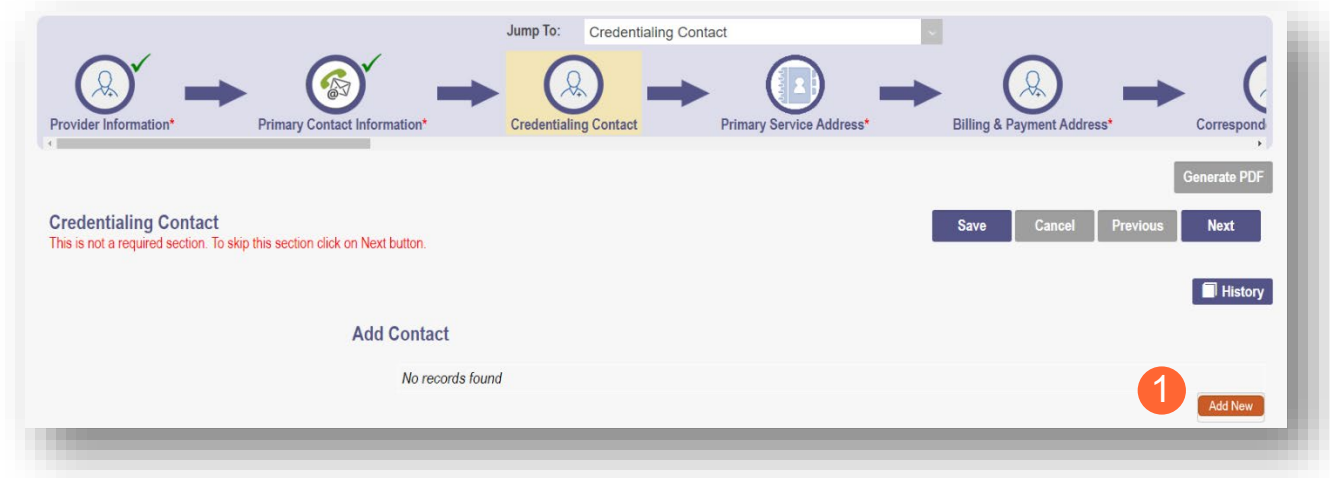
- Confirm the validation and accuracy of the address information
- Click 'Accept' on the USPS confirmation prompt
- Review the changes made to the address
- Click the 'Next' button again to proceed to the next page of the application
- **Note:** If 'Cancel' is selected, you will be taken back to the previous page. A correct address will need to be entered as a valid postal address is required to proceed.

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 page is not required for Behavioral Health Paraprofessionals and will not appear.

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

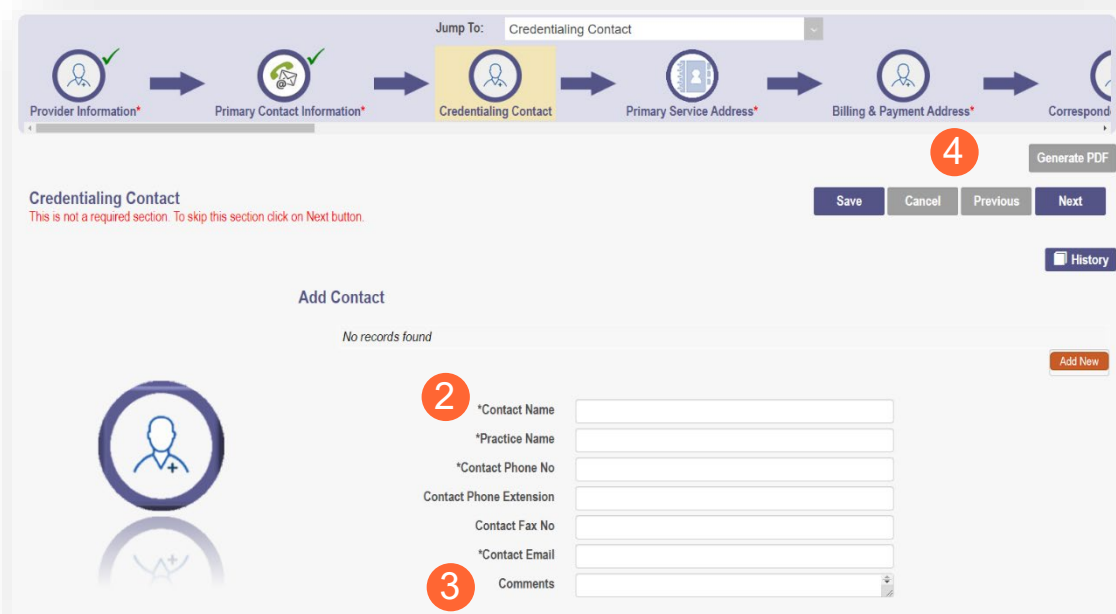


The screenshot shows the 'Credentialing Contact' page. At the top, there is a navigation bar with a 'Jump To:' dropdown set to 'Credentialing Contact'. Below the navigation bar, a series of icons represent different sections: Provider Information*, Primary Contact Information*, Credentialing Contact (highlighted), Primary Service Address*, Billing & Payment Address*, and Correspondence*. Below the navigation bar, the 'Credentialing Contact' section is active, displaying the message 'This is not a required section. To skip this section click on Next button.' and a 'Generate PDF' button. Below this, there are 'Save', 'Cancel', 'Previous', and 'Next' buttons. A 'History' button is also present. The main content area shows 'Add Contact' with 'No records found'. A red circle with the number '1' highlights the 'Add New' button in the bottom right corner.

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



The screenshot shows the 'Credentialing Contact' page with the form fields for adding a new contact. The navigation bar is the same as in the previous screenshot. The 'Add Contact' section shows 'No records found'. A red circle with the number '2' highlights the 'Add New' button in the bottom right corner. A red circle with the number '3' highlights the 'Comments' field. A red circle with the number '4' highlights the 'Next' button. The form fields are as follows:

- *Contact Name
- *Practice Name
- *Contact Phone No
- Contact Phone Extension
- Contact Fax No
- *Contact Email
- Comments

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.

If you select 'Provider Directory Opt-Out,' Provider information will not be included in the public facing Provider Directory.

☐ **Provider Directory Opt-Out**

Step 1: Complete the Primary Service Address information.

Required fields include:

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




1

Provider Name

Primary Service Address*

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*

Step 2: Indicate specific about yourself using the drop-down menus/data entry fields

- Cultural Competencies
- Languages Spoken
- Specialized Training

Step 3: 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 4: 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 5: 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

Step 6: Click the 'Save' or 'Next' buttons to save the contact to the record and proceed to the next page

☐ Provider Directory Opt-Out

Provider Information *Only required for Individual registrations

2

Cultural Competencies

Languages Spoken

Specialized Training

Hours of Operation *Hours providers available for appointments

3

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours

Office Information

4

Website

24-hour telephone coverage

Public transportation access

Electronic billing

TDD/IDY

Cultural Competencies

Languages Spoken

Specialized Training

ADA Compliance*

ASL Offered*

Translation Services

Yes

Yes

Yes

Yes

--Select ADA--

Yes

☐ Language Line
 ☐ Translation

Patient Information

5

Accept new patients

Accept new patients from referral only

Youngest patients accepted

Oldest patients accepted

Gender of patient Accepted

Accept newborn*

Accept pregnant women

No

No

No

No

Billing & Payment Address Page

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

Generate PDF

Save

Cancel

Previous

Next

History

Billing & Payment Address

This is a required section.

Same as Practice Location ☐

Address Type ☒ Individual ☐ Organization



Title

First Name*

Middle Name

Last 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

Fax Number 2

Contact Name

Email Address 1*

Correspondence Address Page

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

Correspondence Address
This is a required section.

Generate PDF

Save Cancel Previous Next

History

Same as Practice Location ☐

Address Type ☒ Individual ☐ Organization

First Name*

Middle Name

Last 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*

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.

Generate PDF

Save Cancel Previous Next

History

Same as Practice Location ☐

Address Type ☒ Individual ☐ 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

Email Address 1*

IRS Tax Type ☒ SSN ☐ FEIN

IRS Tax ID 345234534

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.

Generate PDF

Save Cancel Previous Next

History

Same as Practice Location ☐

Address Type ☒ Individual ☐ Organization

Title

First Name*

Middle Name

Last 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*

Other Service Locations

This page allows you to enter any other locations where you provide services.

Note: This page is not required for Behavioral Health Paraprofessionals and will not appear.

Step 1: Click 'Add New' to add a Service Location

Step 2: Complete all line items with an asterisk *

Step 3: Click 'Save' to save the address

- Select 'Add New' to add any additional addresses

Step 4: Indicate additional operating information regarding the service location

- Provider Information
- Hours of Operation
- Office Information
- Patient Information

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

Jump To:
Other Service Locations

Billing & Payment Address*

Correspondence Address*

Other Service Locations

1099 Address*

Home Office Address*

Specialties*

3

5

Save
Cancel
Previous
Next

Other Service Locations

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

*Please enter Other Service locations that bill/will bill under the same Medicaid ID
No additional practice locations found.

1

Add New
History

2

Name

Address 1*

Address 2

City*

State*

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

☐ Provider Directory Opt-Out

4

Provider Information *Only required for Individual registrations

Cultural Competencies	
Languages Spoken	
Specialized Training	

Hours of Operation *Hours providers available for appointments

Monday			☐ Open 24 Hours
Tuesday			☐ Open 24 Hours
Wednesday			☐ Open 24 Hours
Thursday			☐ Open 24 Hours
Friday			☐ Open 24 Hours
Saturday			☐ Open 24 Hours
Sunday			☐ Open 24 Hours

Office Information

Website	
24-hour telephone coverage	Yes
Public transportation access	Yes
Electronic billing	Yes
TDD/TDY	Yes
Cultural Competencies	
Languages Spoken	
Specialized Training	
ADA Compliance*	--Select ADA--
ASL Offered*	Yes
Translation Services	☐ Language Line ☐ Translation

Patient Information

Accept new patients	No
Accept new patients from referral only	No
Youngest patients accepted	
Oldest patients accepted	
Gender of patient Accepted	
Accept newborn*	No
Accept pregnant women	No

Specialties Page

The specialties page allows you to indicate any specialties for the Provider

Note: At least one specialty must be designated as primary.

The screenshot shows the top navigation bar of the Specialties Page. It includes a 'Jump To:' dropdown menu set to 'Specialties'. Below the navigation bar is a breadcrumb trail with icons and labels: 'My Service Locations', '1099 Address*', 'Home Office Address*', 'Specialties*' (highlighted), 'Taxonomies*', 'Professional Licenses*', and 'CLIA Certifications'. To the right of the breadcrumb trail are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', and 'Next'. Below the navigation bar, the page title 'Specialties' is displayed with a red note: 'This is a required section.' Below the title, a message states: 'Primary Specialties are not editable by provider after application submission.' Below this message, it says 'No records found'. At the bottom right, there is a red circle with the number '1' and an 'Add New' button.

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'

Step 2: Click 'Save' and confirm the new specialty has been saved by reviewing the table *(if specialty is not saved prior to clicking 'Add New' the specialty previously entered will be reset)*

Step 3: Click 'Add New' and repeat the process to enter any additional specialties

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

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.

Get PDF 4

Save
Cancel
Previous
Next

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status		
471 LICENSED PROFESSIONAL COUNSELOR	Yes	05/05/2022	12/31/2299	INACTIVE		
474 LICENSED PROFESSIONAL CLINICAL COUNSELOR	No	05/05/2022	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		
471 LICENSED PROFESSIONAL COUNSELOR	Yes	05/05/2022	12/31/2299	INACTIVE		
474 LICENSED PROFESSIONAL CLINICAL COUNSELOR	No	05/05/2022	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.

Taxonomies

This is a required section.

Generate PDF

SaveCancelPreviousNext

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
1041C0700X	SOCIAL WORKER - CLINICAL	Yes	05/05/2022	12/31/2299		

Add New

History

INDIVIDUAL PROVIDER

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.

Generate PDF

SaveCancelPreviousNext

Taxonomy	Taxonomy Description	Primary	Start Date	End Date	
1041C0700X	SOCIAL WORKER - CLINICAL	Yes	05/05/2022	12/31/2299	1 Add New

2

Taxonomy*

☐ Is Primary Taxonomy

3

Start Date*

4

End Date

History

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 'Save' to save your work

Step 6: Click 'Next' to save your work and move to the next screen

Taxonomies

This is a required section.

5 Save Cancel Prev 6 Next

Taxonomy	Taxonomy Description	Primary	Start Date	End Date	1
1041C0700X	SOCIAL WORKER - CLINICAL	Yes	05/05/2022	12/31/2299	 

Add New

History



Taxonomy* Social Worker Clinical (1041C0700X) 2

3 ☒ Is Primary Taxonomy

4 Start Date* 05/05/2022

End Date 12/31/2299

Professional Licenses

Note: License information and an upload of a copy of a valid license are required to complete the page. This page is not required for Behavioral Health Paraprofessionals and will not appear.

This page allows you to enter and upload information related to your Professional Licenses.

Step 1: To add a Professional License, click ‘Add New’

Professional Licenses

This is a required section.

Generate PDF

SaveCancelPreviousNext

A copy of each license must be uploaded to this page.

History

1Add New

Step 2: Complete the required fields marked with an asterisk*

Note: Most fields will auto-populate if the license is active and in Ohio with the e-license check.

Step 3: Upload a copy of your Professional License by click 'Browse' under the Upload Documents section

- Locate, on your computer, the file you wish to upload then click 'Open'
- The file name will appear in green text to indicate a successful upload

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

Professional Licenses
This is a required section.

Get PDF

Save Cancel Previous Next

History

Add New

A copy of each license must be uploaded to this page.

Results from eLicense verification are read only. After your application is submitted, the only editable field is Expiration Date.

2

State*

License Board Name*

If Other, enter Board Name:

License Number*

Effective Date*

Expiration Date*

License Status

Address 1

Address 2

City

State OH

County

Zip

Endorsement Number

Endorsement Status

Endorsement Focus

Endorsement Specialty

Certifying Organization

Certificate Date

Certificate Expiration

3

Professional License

Optional Document

Browse

Board Certification Page

The Board Certification page allows you to add any recognized board certifications.

Step 1: To add a Board Certification, click 'Add New'

Jump To: Board Certification

Specialties*Taxonomies*Professional Licenses*Board CertificationCLIA CertificationsMedicare NumberGroup, Facility &

Generate PDF

SaveCancelPreviousNext

Board Certification

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

No Board Certification found

1Add New

Step 2: Click the 'radio' button to identify if you are Board Certified (Yes or No)

Board Certification

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

SaveCancelPreviousNext

No Board Certification found

Add New

Are you Board Certified?

2☐ No ☐ Yes

If Yes, Please enter board certification information requested or confirm previously entered information is correct

Step 3: If 'Yes' is chosen, enter the required fields marked with an asterisk *

- Board Certification
- Board Specialty
- Certificate Number (This is not a required field, but certification identification can be included here)
- Effective Date (Date when certification was received)
- Expiration Date (Date the certification expires)

Note: It is important that this information is accurate and matches what is on file with our CAQH

Step 4: Click 'Save' to save your work and then click 'Add New' to add additional certifications

OR click 'Next' to save and move to the next screen

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

No Board Certification found

Are you Board Certified? ☐ No ☒ Yes

If Yes, Please enter board certification information requested or confirm previously entered information is correct

3 Board Certification*

Board Specialty*

Certification Number

Effective Date*

Expiration Date*

4 Save Cancel Previous Next

4 Add New

Uploaded Documents

American Board of Allergy and Immunology
American Board of Anesthesiology
American Board of Colon and Rectal Surgery
American Board of Dermatology
American Board of Emergency Medicine
American Board of Family Medicine
American Board of Internal Medicine
American Board of Medical Genetics and Genomics
American Board of Neurological Surgery
American Board of Nuclear Medicine
American Board of Obstetrics and Gynecology
American Board of Ophthalmology
American Board of Orthopaedic Surgery
American Board of Otolaryngology – Head and Neck Surgery
American Board of Pathology
American Board of Pediatrics

Medicare Number Page

Depending on your Provider type, this may not be a required section

- To move past this screen, click 'Next'

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

The screenshot shows the 'Medicare Number' form. At the top right, there is a red circle with the number '1' next to an 'Add New' button. The form contains several fields: 'Medicare Number Type' with radio buttons for 'CCN (CMS Certification Number)' and 'PTAN (Provider Transaction Access Number)', each with a 'What is this?' link; 'Medicare Number' (text input); 'Secondary NPI' (text input); 'Medicare State' (dropdown menu); 'Medicare Enrollment Status*' (dropdown menu); and 'Medicare Enrollment Date' (text input). Below these fields is an 'Optional Document' section with a blue header 'Medicare Enrollment Certification Required for Dialysis Facilities (Only if approved)' and a 'Browse' button. A red circle with the number '2' is placed over the 'Browse' button.

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

The screenshot shows the 'Medicaid' form. At the top right, there is a red circle with the number '3' next to an 'Add New' button. The form contains two dropdown menus: 'Other State Medicaid Enrollment Status' and 'State'.

Step 4: Click 'Save' to save your work

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

Medicare Number

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

4

Save

Cancel

Prev

5

Next

Group, Facility & Hospital Affiliations (Individual) Page

If you select a Specialty that is an Assistant, Intern, or Trainee, you will need to complete this page. This page will allow you to indicate any group, facility, or hospital affiliations you/your Provider may have.

Adding a Group Affiliation

Step 1: To add a Group Affiliation:

- Click 'Add New' under the Pending Group Affiliations section

Jump To: Group, Facility & Hospital Affiliations (Individual)

CLIA Certifications Medicare Number **Group, Facility & Hospital Affiliations (Individual)** MCP Affiliation State CDS Number Federal ID Number

Generate PDF

Save Cancel Previous Next

Group, Facility & Hospital Affiliations (Individual)
This is not a required section. To skip this section click on Next button.

Pending Group Affiliations
Deleting your affiliation entry in this section will not delete your confirmed group affiliation.

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address
No pending affiliations found.						

1 Add New

Confirmed Group Affiliations
The grid above shows Groups where you are currently confirmed as a Group member (or have in the past been confirmed as a Group member)

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address
No confirmed affiliations found.						

Hospital Affiliations

Facility Name	Staff Category	Status of Privileges	Primary Facility	Start Date	End Date
No hospital affiliations found.					

Add New

Medicaid Pop-Up

Step 2: Enter the Medicaid ID

- Click outside of the field and the NPI field will automatically update

Step 3: Click 'Save' to continue

Group Affiliation

2 Medicaid ID 0000046

NPI

3 Save Cancel

Step 4: Confirm the affiliation is listed on the screen (Repeat the process to add additional affiliations)

Generate PDF

Group, Facility & Hospital Affiliations (Individual)

This is a required section.

Save Cancel Previous Next

Pending Group Affiliations

Deleting your affiliation entry in this section will not delete your confirmed group affiliation.

4

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address		
Training Clinic	1568718724	0000276	05/05/2022	12/31/2299	Pending Approval	1000 N HIGH ST COLUMBUS, OH 43201- 2410		
Training Clinic	1568718724	0000276	05/05/2022	12/31/2299	Pending Approval	2400 CORPORATE EXCHANGE DR COLUMBUS, OH 43231- 7605		

Add New

Step 5: When the 'Pending Group Affiliations' are approved by the Group or Facility, they will move to the 'Confirmed Group Affiliations' section

Generate PDF

Group, Facility & Hospital Affiliations (Individual)

This is a required section.

Save Cancel Previous Next

Pending Group Affiliations

Deleting your affiliation entry in this section will not delete your confirmed group affiliation.

5

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address		
Training Clinic	1568718724	0000276	05/05/2022	12/31/2299	Pending Approval	1000 N HIGH ST COLUMBUS, OH 43201- 2410		
Training Clinic	1568718724	0000276	05/05/2022	12/31/2299	Pending Approval	2400 CORPORATE EXCHANGE DR COLUMBUS, OH 43231- 7605		

Add New

Confirmed Group Affiliations

The grid above shows Groups where you are currently confirmed as a Group member (or have in the past been confirmed as a Group member)

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address
No confirmed affiliations found.						

Adding a Hospital Affiliation

Step 1: Click 'Add New' under the Hospital Affiliations category. Enter all relevant and required information:

- Is this your primary facility?
 - If yes, click the 'check box' next to "This is my Primary Facility"
- Enter an Ohio Medicaid ID, this will populate the Facility name
- Select Status of Privileges from the drop-down menu
- Select Staff Category from the drop-down menu
- Select the Start Date
- Select the applicable 'Yes' or 'No' radio button for: "Any past or present restrictions of privileges?"
 - If 'Yes' is selected, complete the box stating "please specify"

Step 2: Click 'Save' to continue

Hospital Affiliation 1

Do you practice exclusively within the Inpatient Setting?* ☐ Yes ☒ No

Do you have hospital privileges?* ☐ Yes ☒ No

If 'No', please specify

This is my Primary Facility ☐

Ohio Medicaid ID*

Facility Name*

Status of Privileges*

Staff Category*

Start Date*

End Date 12/31/2299

Any past or present restriction of privileges?* ☐ Yes ☒ No

If 'Yes', please specify

2 Save Cancel

Step 3: Confirm Hospital Affiliation has saved (Repeat the process to add additional affiliations)

Step 4: Click 'Save' to save your work

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

Group, Facility & Hospital Affiliations (Individual)

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

Save

Cancel

Previous

Next

4

5

Pending Group Affiliations

Deleting your affiliation entry in this section will not delete your confirmed group affiliation.

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address
No pending affiliations found.						

Add New

3

Confirmed Group Affiliations

The grid above shows Groups where you are currently confirmed as a Group member (or have in the past been confirmed as a Group member)

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address
No confirmed affiliations found.						

Hospital Affiliations

Facility Name	Staff Category	Status of Privileges	Primary Facility	Start Date	End Date		
County General Hospital	Active	Full and Unrestricted	Yes	05/17/2010	12/31/2299		

Add New

Note: 'Delegated Credentialing' will also appear on this screen, if appropriate.

Select the checkbox if you have delegated credentialing that does not display in the table.

This information is maintained by ODM and will auto-populate if credentialing is delegated for this Provider.

Delegated Credentialing

☐ Select this box if you have delegated credentialing that does not display below.
Credentialing delegates are assigned by ODM Credentialing staff.

Assigned Delegates	Delegate Name	Delegate MED ID
No delegates.		

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: MCP Affiliation

Medicare Number → Group, Facility & Hospital Affiliations (Individual) → **MCP Affiliation** → State CDS Number → Federal DEA Registration* → Professional

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

Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans? **1** ☐ 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
No MCP affiliations found.			

Generate PDF Save Cancel Previous Next

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

Confirmed MCP Affiliations

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

Note: Once an MCP Affiliation has been confirmed, it would appear at the bottom of the page

Professional Liability Insurance Page

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

Note: Professional Liability Insurance information is not required for every Provider type.

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

Professional Liability Insurance
This is a required section.

Generate PDF

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*

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	3423423423	01/01/2020	01/01/2025	Test Policy Holder	3,000,000	5,000,000		

Add New

Education Page

On this page, indicate all education and training that you have completed beginning with your undergraduate degree through your professional education and training.

Step 1: To add Education History, click 'Add New'

Step 2: Enter the required fields with an asterisk *

- Education Type
- Name of School
- Start Date
- End Date
- Degree Awarded
- Address
- City
- State
- Zip Code

Note: The Additional Information field can be used to enter other details that may help during the credentialing process. You can provide information such as a Contact Name, Phone Number, Department, or any other information that can help verify your education

Step 3: Click 'Save' to continue

Step 4: Confirm that the Undergraduate School saved

Step 5: To enter additional education, click 'Add New' and follow the same process above

Education
This is a required section.

3 Save Cancel Previous Next

Please enter all education and training you have completed beginning with your undergraduate degree through your professional education and training.

4

School	Education	Specialty	Degree	Start Date	End Date	
UNDERGRADUATE SCHOOL	Undergraduate School		MB	08/01/2000	05/01/2004	

5 Add New

Step 6: Click 'Save' to continue and verify the additional education history as it appears on the screen

Step 7: Click 'Next' once all education has been added

Education
This is a required section.

6 Save Cancel Previous Next 7

Please enter all education and training you have completed beginning with your undergraduate degree through your professional education and training.

6

School	Education	Specialty	Degree	Start Date	End Date	
UNDERGRADUATE SCHOOL	Undergraduate School		MB	08/01/2000	05/01/2004	
PROFESSIONAL SCHOOL	Professional School		MHS	06/01/2004	05/01/2008	
HOSPITAL	Residency		MD	06/01/2008	06/01/2012	

Add New

Malpractice Claims History Page

This page asks the question: “Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?”

Note: This page will only display for required Providers

Step 1: Click ‘Add New’ and then ‘Yes’ or ‘No’ radio button to indicate your answer

Yes/No Malpractice Claims History

- If ‘No’ is indicated, click ‘Next’ to save and proceed to the next page
- If ‘Yes’ is indicated, select ‘Add New’ complete the required information regarding each action

Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?

1
☐ No
 ☒ Yes

No MalpracticeClaim found.

1
Add New

Date of Occurrence*
Date Claim Filed*
Status of the claim*
Open
If settled, the date the claim was settled
Professional liability carrier involved*
Carrier Address Line1*
Carrier Address Line2
City*
State*
Zip*
Phone Number 1*
Phone Ext 1
Policy Number
Method of Resolution
If settled, the amount of settlement
Describe the allegations against you*
Were You*
☐ Primary Defendant
☐ Co-Defendant
No of Other Defendants (if any)
Your role in case*
Describe the alleged injury to the patient
Did the alleged injury result in death?
To the best of your knowledge, is the case included in the NPDB?*
Yes

Step 2: After filling in the required fields, click ‘Save’

Work History Page

A Work History of 5 years (in chronological order) from the start of your licensure, must be provided on your application

Step 1: To add Work History, click the 'Add New' button

- Select the check box for 'Current Employer' for your current employer
- Enter the relevant and required fields
 - Practice Employer Name
 - Start Date
 - End Date
 - Organization Name
 - Address
 - City
 - Zip
 - Phone Number
 - Contact Name: This is a contact for the organization that can verify work history
 - Email Address
 - Additional Information
 - Reason for Departure (if applicable)

Include a chronological work history for the past 5 years.

No records found

1

Add New

1

Current Employer ☐

*Practice/ Employer Name:

* Start Date:

* End Date:

Organization Name*

Address 1*

Address 2

City*

State*

OH

County

Zip*

Phone Number 1

Phone Ext 1

Fax Number 1

Contact Name

Email Address 1*

Email Address 2

Additional Information:

Reason for Departure(If Applicable):

*Are you currently on active military duty or military reserve?

No

Step 2: Click 'Save' to confirm the work history as it appears on the screen

Step 3: Continue adding work history for the past 5 years (in chronological order) by clicking 'Add New' and repeating the process above

Jump To: Work History

Professional Liability Insurance* → Education* → Malpractice Claims History* → **Work History*** → W9 Form* → Required Documents → Agreements*

Work History
This is a required section.

2 Save Cancel Previous Next Generate PDF

Include a chronological work history for the past 5 years.

Practice/ Employer Name	Start Date	End Date
Training Clinic	01/01/2013	

3 Add New

Gaps in Work History

Please enter and explain any time periods or gaps in work history in the past 5 years or that have occurred since graduation from professional school and are longer than three months in duration.

No records found

4 Add New

Step 4: If there are any gaps in work history during the past 5 years, enter that information by clicking 'Add New' under the Gaps in Work History section

- Complete Information for any gaps in Work History
 - Gap Start Date
 - Gap End Date
 - Reason for Gap

Step 5: Click 'Save' then click 'Next' to continue

Gaps in Work History

Please enter and explain any time periods or gaps in work history in the past 5 years or that have occurred since graduation from professional school and are longer than three months in duration.

No records found

4 Add New

*Gap Start Date:

*Gap End Date:

*Reason For Gap:

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 individual type by clicking on the appropriate radio button category

The screenshot shows the 'W9 Form' page. At the top, a navigation bar includes icons for 'Personal Liability Insurance*', 'Education*', 'Malpractice Claims History*', 'Work History*', 'W9 Form*' (highlighted), 'Required Documents', and 'Agreements*'. A 'Jump To:' dropdown menu is set to 'W9 Form'. Below the navigation bar, there are buttons for 'Save', 'Cancel', 'Previous', and 'Next'. A red circle with the number '4' is next to a 'Get PDF' button. The main section is titled 'W9 Form' with a note 'This is a required section.' Below this, it states: '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.' The 'Individual Name:' field contains 'Training' and the 'SSN:' field is empty. Below these fields, a red circle with the number '1' is next to the text 'Select the most appropriate category below:'. A list of radio button options follows: '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', and 'Other'.

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

The screenshot shows the 'Indicate the form you are uploading' section. It has two radio button options: 'W9' (selected, with a red circle with the number '2' next to it) and 'Form 147'. Below this, a note says: '** Please visit <https://www.irs.gov/forms-pubs/about-form-w-9> to obtain a copy of the W9 with instructions.' The 'Required Document' section shows a table with one row: 'W-9'. Below the table, the text 'W9.pdf' is displayed in green, followed by 'Download' and 'Remove' links. A red circle with the number '3' is next to a 'Browse' button.

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

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

EFT Banking Information

This is a required section.

Generate PDF

Save Cancel Previous Next

1

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?

☐ Yes
 ☐ No

2

Instructions

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

EFT Contact Information
7

Provider Contact First Name*

Middle Name

Last Name*

Phone Number*

Extension

Email Address*

Fax Number

8

Save
Cancel

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

EFT Banking Information

This is a required section.

10
Gen PDF

Save
Cancel
Previous
Next

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

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'
 - Select the file on your computer and open

Required Document

Documentation of Training/Certification

2

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

Jump To: Required Documents

Mal Liability Insurance* Education* Malpractice Claims History* Work History* W9 Form* Required Documents Agreements*

Generate PDF

Save Cancel Previous Next

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

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: Complete the Additional Credentialing Statement questions if your Provider type requires credentialing

Possible 'Additional Credentialing Statement' questions:

- Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered?
- Have your privileges at any hospital, facility, HMO, or health plan been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited or placed on probation?
- Have you ever been placed on probation or asked to resign from an internship, residency, or other training program?
- Has your malpractice insurance ever been cancelled, suspended, restricted, limited, special rated, or not renewed?
- Has information pertaining to you ever been reported to the National Practitioner Data Bank?

Select the 'Yes' or 'No' radio button for the appropriate answer *(If 'Yes' is selected, a comment is required)*

Additional Credentialing Statement

Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered?

4 ☐ No ☐ Yes If 'Yes' a comment is required.

Have your privileges at any hospital, facility, HMO, or health plan been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, or placed on probation?

☐ No ☐ Yes If 'Yes' a comment is required.

Step 5: Complete the Individual Provider Questions

Possible Individual Provider Questions:

- 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 been indicted or convicted of a criminal offense related to the involvement of such persons or organization in any of the programs established by Titles XVIII, XIX, or XX?
- Have you or any of the employees of your professional association or practice ever been indicted or convicted of a criminal offense related to the involvement in such programs established by Titles XVIII, XIX, or XX?
- 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?

Select the 'Yes' or 'No' radio button for the appropriate answer *(If 'Yes' is selected, a comment is required)*

Individual Provider Questions

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 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?

☐ No ☐ Yes

If, 'Yes' a comment is required.

5

Have you or any of the employees of your professional association or practice ever been indicted or convicted of a criminal offense related to the involvement in such programs established by Titles XVIII, XIX, or XX?

☐ No ☐ Yes

If, 'Yes' a comment is required.

Step 6: 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

6

☐ 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 7: Complete the Provider Agreement Signature

- Enter the captcha characters
- Enter your full name as the person attesting

Step 8: Click 'Save'

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

Provider Agreement Signature

7 Name of Person Attesting*: Training ⓘ

Provider Name: Training

User ID: provaccount

8 Save

Step 9: 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.

9 OK

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

The screenshot shows the 'Submitting Application' page. At the top, a progress bar indicates the steps: Personal Liability Insurance*, Education*, Malpractice Claims History*, Work History*, W9 Form*, Required Documents, and Agreements*. The 'Agreements' step is highlighted with a yellow background and a green checkmark. Below the progress bar, there is a 'Jump To:' dropdown menu set to 'Agreements'. On the right side, there are buttons for 'Generate PDF', 'Submit for Review' (with a red circle containing the number 1), 'Save', 'Cancel', 'Previous', and 'Next'. The main content area is titled 'Agreements' and includes a red note: 'This is a required section.' Below this, there is a section titled 'Ohio Medicaid Provider Agreement' with a red note: 'Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step.' A scroll box contains the text: 'All Providers must read the statements below and agree to the terms' and 'Ohio Revised Code 2921.42 and 2921.43 Agreement'. The scroll box also contains the text: '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.' Below the scroll box, there is a section titled '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

The screenshot shows the 'Submission Confirmation' page. At the top, there is a navigation bar with the 'Ohio' logo, a home icon, and links for 'Provider Network Management', 'Medicaid Home', 'Learning', 'Contact', 'Fee Schedule', and a user icon with a 'Log out' link. The main content area has a large red circle containing the number 2 and the title 'Submission Confirmation'. Below this, there is a message: 'You have successfully submitted your application to the Medicaid Program. Please allow at least 10 days for processing before attempting to submit any changes.' At the bottom, there is a red circle containing the number 3 and a button labeled '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

Menu 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
519460	Training Mental Health Provider	Not Submitted	95 - OMHAS CERTIFIED/LI TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program						
519468	Sharon Aaron	Return to Provider	47 - CLINICAL COUNSELING	1073521589		LICENSED PROFESSION COUNSELOR					05/05/22	

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
Sharon Aaron				

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
519468	Application Flow - Standard - NEW REGISTRATION	Medicaid	608334	NOT PROCESSED			05/05/22

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

The license you provided is expired. Please provide a current license. (P042)
 - License provided expired on 12/31/2021. Please provide a copy of an active license

3

Jump To: Professional Licenses

Home Office Address* Specialties* Taxonomies* Professional Licenses* Board Certification Medicare Number Group, Facility

Generate PDF

Professional Licenses
 This is a required section.

Save Cancel Previous Next

History

A copy of each license must be uploaded to this page.

4

License Number	License Board	License State	Effective Date	Expiration Date	Address	Endorsement	
34543543345	Counselor, Social Worker, Marriage And Family Therapist	OH	1/1/2020	1/1/2025			 

Add New

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

The screenshot shows a multi-step application form for an individual provider. The steps are: Home Office Address*, Specialties*, Taxonomies*, Professional Licenses* (highlighted in yellow), Board Certification, Medicare Number, and Group, Facility. A 'Jump To:' dropdown menu is set to 'Professional Licenses'. Below the steps, the 'Professional Licenses' section is titled, with a note 'This is a required section.' in red. On the right side, there are buttons for 'Generate PDF', 'Submit for Review' (with a red circle containing the number 6), 'Save', 'Cancel', 'Previous', 'Next', and 'History'.

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

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

The screenshot shows a 'Submission Confirmation' message. It states: 'You have successfully submitted your application to the Medicaid Program. Please allow at least 10 days for processing before attempting to submit any changes.' Below the message is a button labeled 'Return to Home Page' with a red circle containing the number 8.

Submitting a Plan of Correction

Step 1: If the file is returned to you with a Notice of Operational Deficiency, you will need to provide a Plan of Correction to address the issues

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

Menu 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	Approved	Physician/Oste Individual			Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706		09/16/21		
170	Training Clinic	Submitted	CLINIC			Primary Care Clinic			43085 - 4706		09/16/21		
171	Kim Trainer	Return to Provider	Chiropractor Individual			Chiropractic Services			43085 - 4706		09/16/21		
10 Page size: 10 93 items in 10 pages													

Step 3: 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	3 + Enrollment Action Selections:
Programs	+ Program Selections:
Self Service	+ Self Service Selections:

Step 4: Click the 'Continue Registration' hyperlink

The screenshot shows a sidebar menu on the left with three items: 'Enrollment Actions', 'Programs', and 'Self Service'. To the right of the 'Enrollment Actions' item is a grey box containing the text 'Enrollment Action Selections:' followed by three blue hyperlinks: 'Continue Registration', 'Cancel New Registration', and 'Edit Key Provider Identifiers'. A red circle with the number '4' is placed to the left of the 'Continue Registration' link. To the right of the 'Programs' item is a grey box containing the text 'Program Selections:' preceded by a blue plus sign. To the right of the 'Self Service' item is a grey box containing the text 'Self Service Selections:' preceded by a blue plus sign.

Step 5: You will be redirected to the 'Site Visit Screening' page where you will find the Notice of Operational Deficiency issued by the Compliance Specialist. To view the Deficiency, click 'Download'

Step 6: To resolve the issue or issues, create a 'Plan of Correction' and once developed, upload the plan by clicking 'Browse' and choosing the file from your computer

The screenshot shows the 'Site Visit Screening' page. At the top, it says 'Original Screening Complete Date 09/20/2021'. On the left is a circular icon with a person silhouette and a plus sign. To the right of the icon is a red circle with the number '5'. Below the icon is a section titled 'Notice Of Deficiency' with a blue header bar. Inside this section, there is a text input field containing 'Notice of Deficiency.jpg', a blue 'Download' link, and a grey 'Browse' button. Below this is a section titled 'Plan Of Correction' with a blue header bar. Inside this section, there is a text input field containing 'Date of Plan of Correction 9/20/21', a red circle with the number '6', a text input field containing 'Plan of Correction.jpg', a blue 'Download' link, and a grey 'Browse' button. At the bottom left, it says 'Uploaded Documents'.

Step 7: Once uploaded, click 'Plan of Correction'. This will send the file back to the Compliance Specialist

Jump To: Site Visit Screening

Education* Malpractice Claims History* Work History* W9 Form* Required Documents* Agreements* Site Visit Screening*

Generate PDF

7 Plan of Correction

Cancel

Site Visit Screening
This is a required section.

Original Screening Complete Date 09/20/2021

Notice Of Deficiency

Notice of Deficiency.jpg [Download](#)

Browse

Plan Of Correction

Note: If additional Notice of Operations Deficiency requests are submitted, you will need to click 'Choose File' under the Uploaded Documents section at the bottom of the page to add additional Plan of Corrections to address the issue(s)

Uploaded Documents

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

No uploaded documents found.

	Choose File	No file chosen
Name		
Description		

Upload file

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. Click the '+' icon to expand the Selections.

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	

Provider Management Home

Registration Information

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

Manage Application

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

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
		All				All						
519460	Training Mental Health Provider	Not Submitted	95 - OMHAS CERTIFIED/LI TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program						
519468	Sharon Aaron	Complete	47 - CLINICAL COUNSELING	1073521589	0000394	LICENSED PROFESSION COUNSELOR				05/05/22	05/05/22	05/05/27

Step 2: 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 **2** + Enrollment Action Selections:

Programs + Program Selections:

Self Service + Self Service Selections:

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

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



Most Common Updates

- [Update](#) Primary Contact Information
- [Update](#) Primary Service Address
- [Update](#) Professional Licenses
- [Update](#) Group, Facility & Hospital Affiliations (Individual)
- [Update](#) Required Documents



Credentialing Information

- [Update](#) Credentialing Contact
- [Update](#) State CDS Number
- [Update](#) Professional Liability Insurance
- [Update](#) Malpractice Claims History



Address Information

- [Update](#) Office Information
- [Update](#) Billing & Payment Address
- [Update](#) Correspondence Address
- [Update](#) Other Service Locations
- [Update](#) 1099 Address
- [Update](#) Home Office Address

INDIVIDUAL PROVIDER

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: Specialties

Correspondence Address* → 1099 Address* → Home Office Address* → **Specialties*** → Taxonomies* → W9 Form* → EFT Banking* → Requirements*

6 Return to Summary
5 Generate PDF
Save Cancel

Specialties
This is a required section.

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status		
471 LICENSED PROFESSIONAL COUNSELOR	Yes	05/05/2022	12/31/2299	ACTIVE		

Add New
History

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

Jump To: Specialties

→ Billing & Payment Address* → Correspondence Address* → 1099 Address* → Home Office Address* → **Specialties*** → Taxonomies*

Return to Summary
Generate PDF
7 Submit for Review
Save Cancel

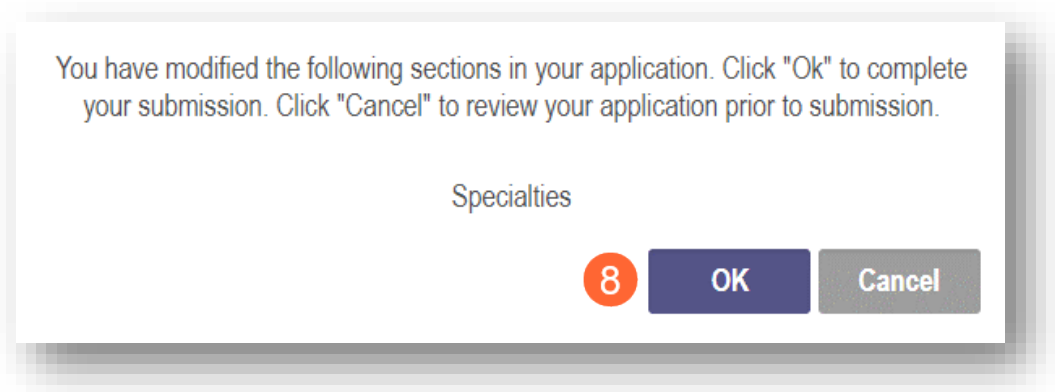
Specialties
This is a required section.

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status		
471 LICENSED PROFESSIONAL COUNSELOR	Yes	05/05/2022	12/31/2299	ACTIVE		

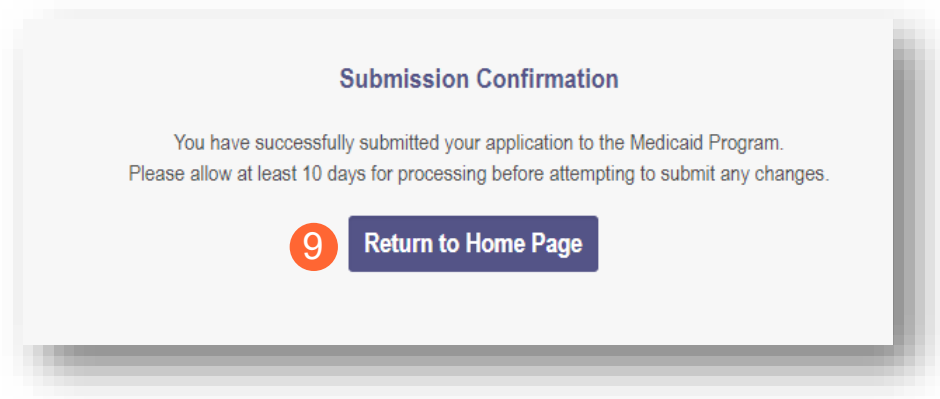
Add New
History

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
		All				All						
519460	Training Mental Health Provider	Not Submitted	95 - OMHAS CERTIFIED/LI TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program						
519468 1	Sharon Aaron	Complete	47 - CLINICAL COUNSELING	1073521589	0000394	LICENSED PROFESSION COUNSELOR				05/05/17	05/05/17	05/05/22

Step 2: 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 2 +	Enrollment Action Selections:
Programs +	Program Selections:
Self Service +	Self Service Selections:

Step 3: Click the 'Begin Revalidation' hyperlink

Enrollment Actions

3 -

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

Jump To: Agreements

Section Name	Status
Provider Information*	✓
Primary Contact Information*	5
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*	✓

Agreements
This is a required section.

Ohio Medicaid Provider Agreement
Note: The Provider Agreement in the scroll box.
All Providers must read the statements below.

Ohio Revised Code 2921.42 and 2921.43 Agreements
In accordance with Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code, I, the undersigned, understand Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code and this order is, in itself, grounds for termination of this contract.

by signature on this document, certifies: (1) it 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 is, in itself, grounds for termination of this contract.

Thank you for your information.

Generate PDF
Submit for Review
Save Cancel Previous Next

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

Generate PDF

5 Submit for Review

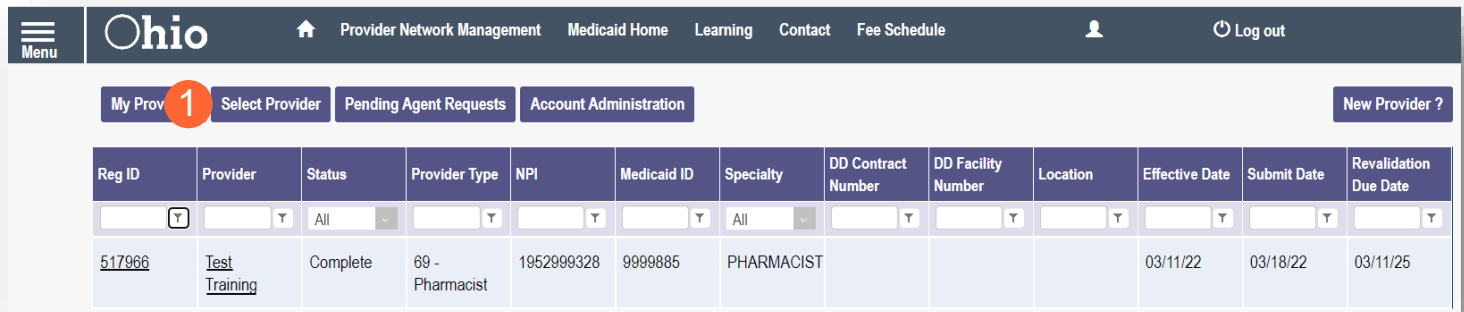
Save Cancel Previous Next

Select and Transfer Providers

The selection and transfer of Providers allows you to move Providers to your OHID account based on identifying information, such as Tax ID, NPI and Medicaid ID.

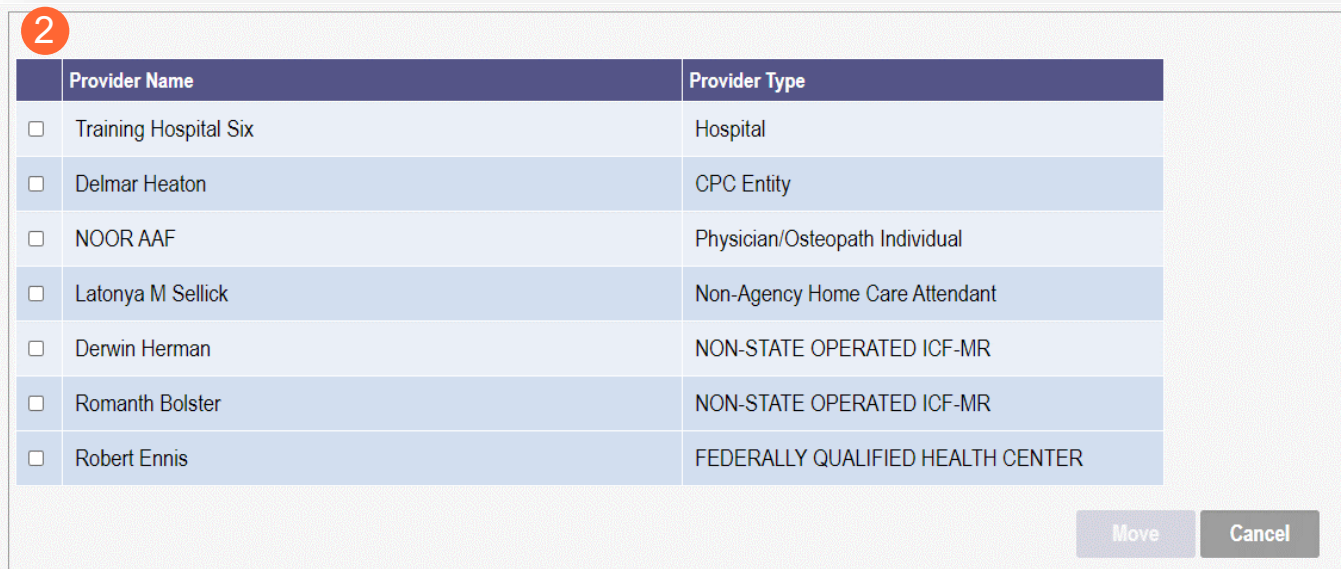
If you would like to transfer Providers to another OHIO ID account, first click 'Select Provider' button at the top of the homepage. This will display a list of Providers associated with your email account.

Step 1: Click the 'Select Provider' button from your dashboard



The screenshot shows the Ohio Provider Network Management dashboard. The top navigation bar includes links for Provider Network Management, Medicaid Home, Learning, Contact, Fee Schedule, and a Log out button. Below the navigation bar, there are four tabs: My Prov, Select Provider (highlighted with a red circle and the number 1), Pending Agent Requests, and Account Administration. A 'New Provider ?' button is also present. Below the tabs is a table with 13 columns: Reg ID, Provider, Status, Provider Type, NPI, Medicaid ID, Specialty, DD Contract Number, DD Facility Number, Location, Effective Date, Submit Date, and Revalidation Due Date. The table contains one row of data for a provider with Reg ID 517966, Provider Test Training, Status Complete, Provider Type 69 - Pharmacist, NPI 1952999328, Medicaid ID 9999885, Specialty PHARMACIST, and various dates.

Step 2: You can select any Providers whom you want to transfer to your OHID account by clicking the check box in the grid at the bottom of the page



The screenshot shows a modal window for selecting providers. It features a table with two columns: Provider Name and Provider Type. There are seven rows of providers, each with a checkbox in the first column. At the bottom right of the modal, there are two buttons: Move and Cancel.

	Provider Name	Provider Type
☐	Training Hospital Six	Hospital
☐	Delmar Heaton	CPC Entity
☐	NOOR AAF	Physician/Osteopath Individual
☐	Latonya M Sellick	Non-Agency Home Care Attendant
☐	Derwin Herman	NON-STATE OPERATED ICF-MR
☐	Romanth Bolster	NON-STATE OPERATED ICF-MR
☐	Robert Ennis	FEDERALLY QUALIFIED HEALTH CENTER

INDIVIDUAL PROVIDER

Step 3: Enter the Medicaid ID and Tax ID associated with the Provider record you are trying to move and click 'Save'

Provider Information

3 Medicaid ID* 0000179

Tax ID* 565453434

Save

Cancel

Step 4: The system returns to the grid with the selected Provider, click 'Move' to confirm your choice

	Provider Name	Provider Type
☒	Training Hospital Six	Hospital
☐	Delmar Heaton	CPC Entity
☐	NOOR AAF	Physician/Osteopath Individual
☐	Latonya M Sellick	Non-Agency Home Care Attendant
☐	Derwin Herman	NON-STATE OPERATED ICF-MR
☐	Romanth Bolster	NON-STATE OPERATED ICF-MR
☐	Robert Ennis	FEDERALLY QUALIFIED HEALTH CENTER

Move

Cancel

Step 5: Click the 'home icon' at the top of the page to refresh the screen and see the newly added Provider in your Provider list

Version and Revision History:

Revision:	Description of Changes and Pages Affected:	Effective Date:	Author:
1.0	Initial Release to client	5/6/2022	Jon Wulf

Approval:

Accepted By	Signature	Date:
ODM Contract Manager		
ODM Project Sponsor		
Approval Comments		