



USER MANUAL

# CHOP Reference Guide

Change of Operator (CHOP)



**Department of  
Medicaid**

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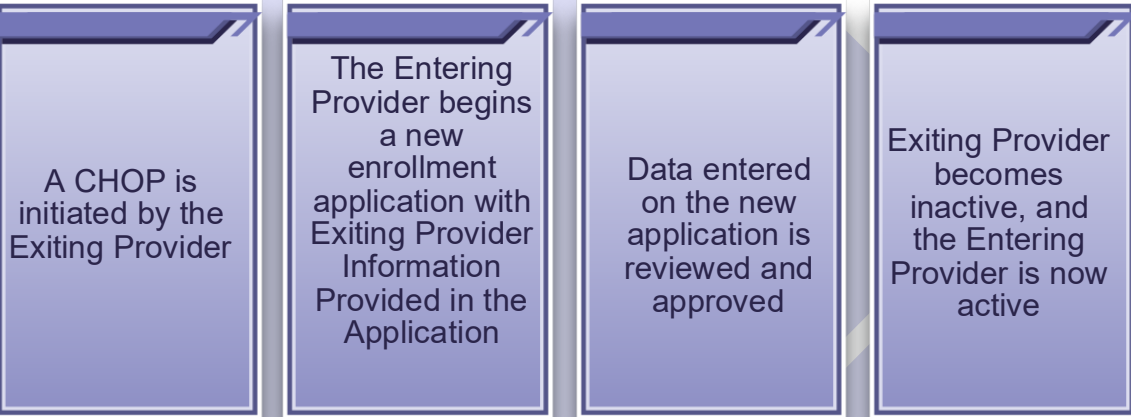
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## Introduction

This document discusses the steps and functions of initiating a Change of Operator (CHOP) in PNM. In the overall process, files will be initiated by the Exiting Provider when a Change of Operator is requested. Once the Change of Operator (CHOP) is initiated by the exiting provider, the entering provider will complete a new enrollment application.

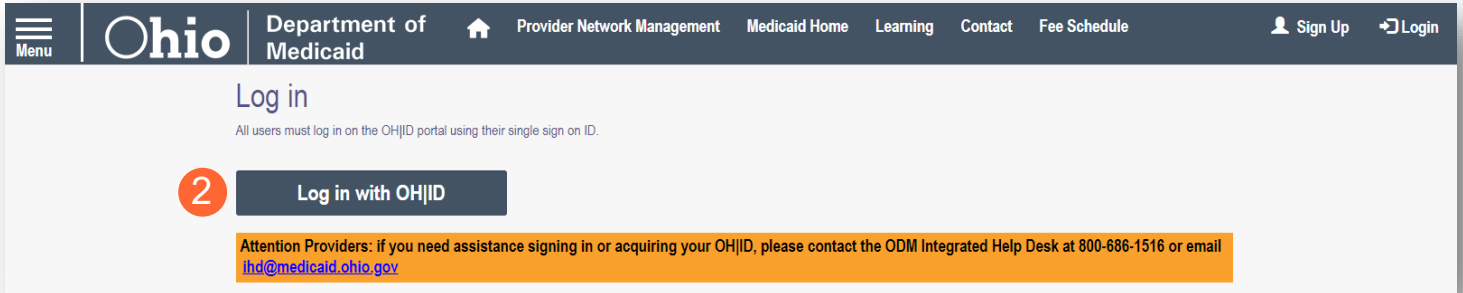


## Provider User Initial Login

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

**Step 1:** Visit the PNM web address: [https://ohpnm.omes.maximus.com/OH\\_PNM\\_PROD/Account/Login.aspx](https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx).

**Step 2:** Click **Log in with OH|ID**.



## CHANGE OF OPERATOR (PROVIDER)

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

- If you have not created an IOP account previously, you can click **Create Account** and follow the steps to create a new account.

**OHID**  
Ohio's Digital Identity. One State. One Account.  
Register once, use across many State of Ohio websites

Create account

---

**Log In**

3 OHID

Password

Log in

[Forgot your OHID or password?](#) | [Get login help](#)

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

Terms

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

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

Yes, I have read the agreement

4

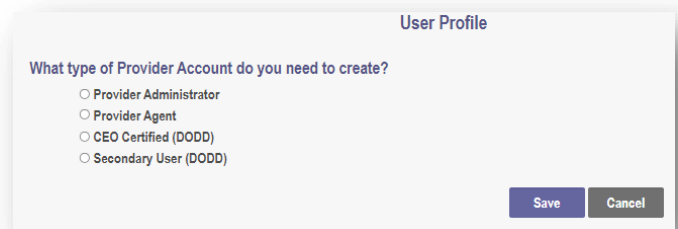
Cancel

### Provider Home Page

There are two provider roles in PNM:

- **Provider Administrator:** (Also known as CEO Certified for DODD) A role assigned to a user in PNM that allows that user to create new enrollment applications, update provider records, and complete revalidations among other tasks. The Administrator role will also be able to grant accesses/actions to other users in PNM, known as Agents.
  - There is one Administrator role per NPI/Medicaid ID. However, a single user with the Administrator role can administer to multiple providers (NPIs/Medicaid IDs).
- **Provider Agent:** (Also known as Secondary User for DODD) A role assigned to a user in PNM that allows that user to complete specific actions such as updating a provider record, revalidation, claims submission, prior authorization, the viewing of reports, etc. These actions are assigned to each Agent by the Administrator for the Medicaid ID.

A user must select a role the first time they log into PNM.



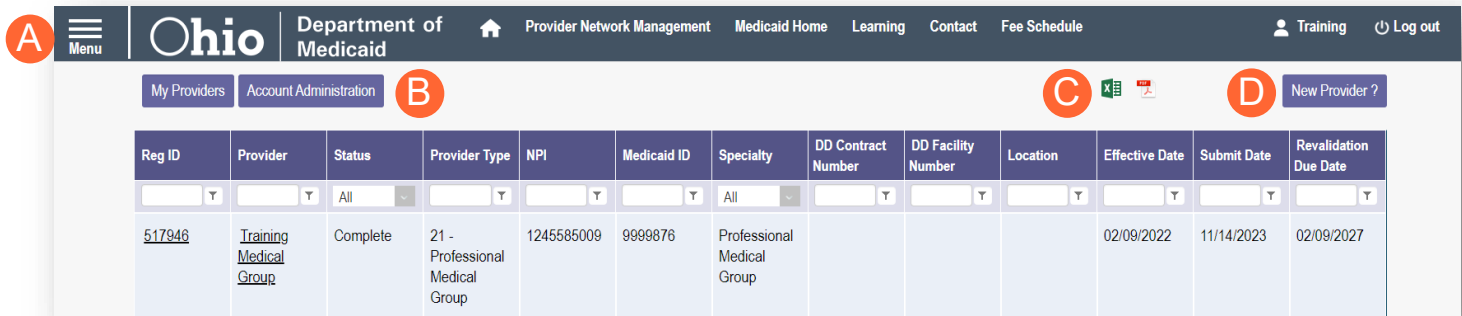
User Profile

What type of Provider Account do you need to create?

- Provider Administrator
- Provider Agent
- CEO Certified (DODD)
- Secondary User (DODD)

Save Cancel

When you first login to the PNM system you will see a variety of buttons to help with administering providers. Some of the buttons, as indicated below, are only accessible to certain user roles.



The screenshot shows the Ohio Medicaid Provider Network Management dashboard. At the top left, a 'Menu' button is marked with a red circle 'A'. Below the navigation bar, 'Account Administration' is marked with a red circle 'B'. In the top right, 'Excel' and 'PDF' export icons are marked with a red circle 'C', and a 'New Provider?' button is marked with a red circle 'D'. Below these are several filters and a table of 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
517946	Training Medical Group	Complete	21 - Professional Medical Group	1245585009	9999876	Professional Medical Group				02/09/2022	11/14/2023	02/09/2027

**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, and Contact Us (A).

**Account Administration:** This button allows a Provider Administrator to set up Agent users, assign them actions/roles, or transfer the Provider to another Provider Administrator user (*button only displays for users holding the Provider Administrator or CEO Certified role*) (B).

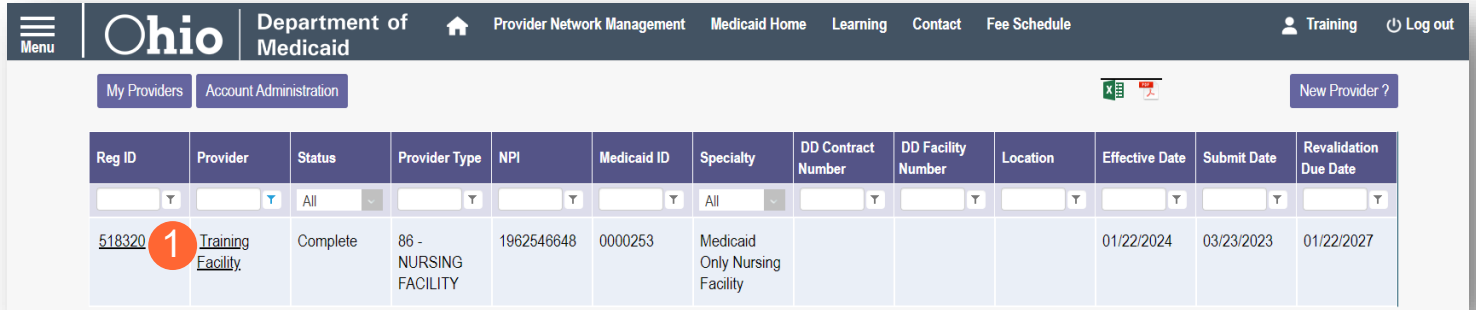
**Excel and PDF Icons:** These buttons allow you to export the list of providers appearing on your dashboard. Click the 'green' icon to export the list in an Excel format or the 'red' icon to export the list in a PDF format (C).

**New Provider?:** This button is used to start a New Enrollment Application (first time enrolling with ODM, ODA, or DODD) for any new Ohio Medicaid provider that you will be responsible for administering (*button only displays for users holding the Provider Administrator or CEO Certified role*) (D).

## Initiating a CHOP (Exiting Provider)

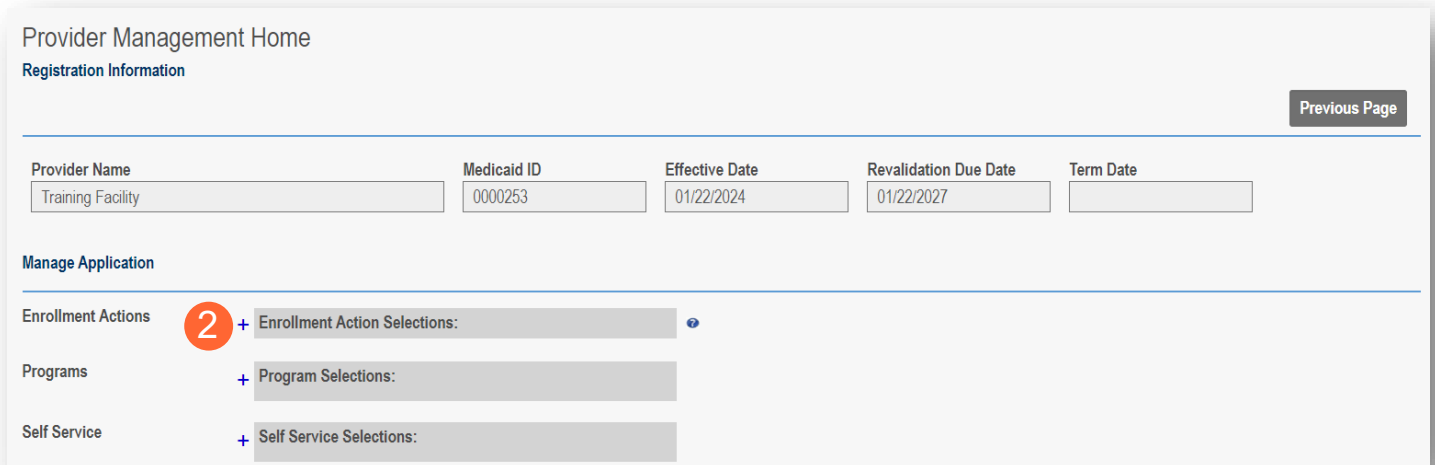
This section demonstrates the CHOP (Change of Operator) process when initiated by the exiting provider.

**Step 1:** From the list of providers on the Homepage/Dashboard, click on the link under Reg ID or Provider for the provider that will be the 'Exiting Provider' for the CHOP.



Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
518320	Training Facility	Complete	86 - NURSING FACILITY	1962546648	0000253	Medicaid Only Nursing Facility				01/22/2024	03/23/2023	01/22/2027

**Step 2:** On the Provider Management Home page, under the Manage Application section, click the '+' icon to expand the Enrollment Actions.



Provider Management Home

Registration Information

Previous Page

Provider Name	Medicaid ID	Effective Date	Revalidation Due Date	Term Date
Training Facility	0000253	01/22/2024	01/22/2027	

Manage Application

Enrollment Actions **2** + Enrollment Action Selections: [dropdown]

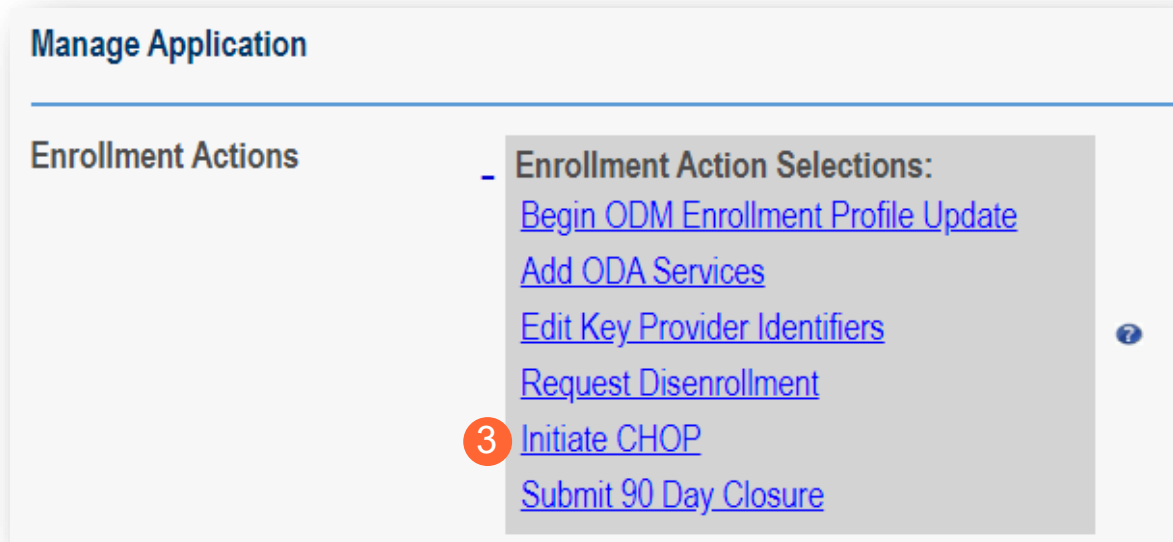
Programs + Program Selections: [dropdown]

Self Service + Self Service Selections: [dropdown]



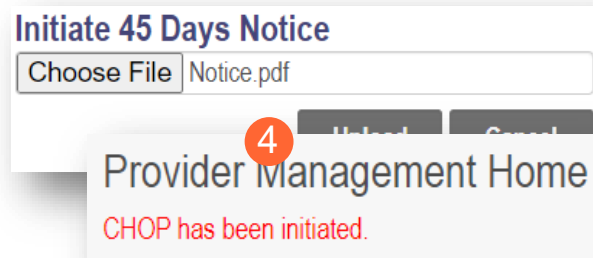
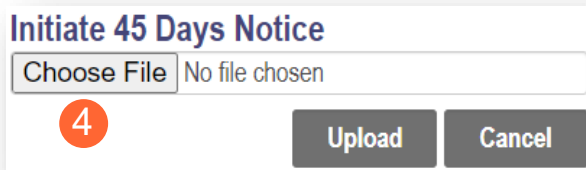
## CHANGE OF OPERATOR (PROVIDER)

**Step 3:** Under the Enrollment Actions, click the hyperlink labeled 'Initiate CHOP'.



**Step 4:** A pop-up appears requesting a 45-day notice.

- Click **Choose File** to locate the document on your computer.
- Once located, select the document, and click **Open**.
- When the file has been selected, click **Upload**.



Uploading the '45 Days' Notice' begins the CHOP process. PNM will display a message stating that the CHOP has been initiated.

## Entering a New Provider (Entering Provider)

Now the Entering Provider needs to provide their records to continue the CHOP process. This section demonstrates the entering of the new provider.

**Step 1:** From the Homepage/Dashboard, click **New Provider?** to begin a new application.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
518125	Training Nursing Facility Two	Approved	86 - NURSING FACILITY	1972517738	0000053	Medicaid Only Nursing Facility				08/15/2022	08/15/2022	08/15/2025

**Step 2:** Under Application Type, click 'Select' for the Change of Operator option.


"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."

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

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

**Step 3:** Click **Facility/Institution**.

Application Type  [Change](#)

**3**  **Facility/Institution**

## CHANGE OF OPERATOR (PROVIDER)

### Key Identifiers Information Page

Note: Previous selections made (application type, category) can be changed by clicking on the “Change” link.

**Step 1:** Enter key provider information for the provider.

Enter all required fields marked with an asterisk (\*).

- Provider Type
- Name of Business Entity
- Exiting Provider Medicaid ID (*if known*)
- Exiting Provider NPI (*if known*)
- EIN (Employer Identification Number)
- Tax ID
- NPI (National Provider Identifier)
- Requested Effective Date
- Zip Code
- Zip Code Extension

1 Application Type: Change of Operator [Change](#)

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

Provider Type\*: 86 - NURSING FACILITY

Name of Business Entity\*: Training Nursing Facility New

Exiting Provider Medicaid ID: 0000253

Exiting Provider NPI: 1962546648

Exiting Provider Name: Training Facility

Business Name as it appears on your IRS Assignment letter

Tax ID Type\*:  EIN  SSN

Tax ID\*: 132665223

NPI\*: 1326652231

Requested Effective Date\*: 1/22/2024

Zip Code\*: 43231

Zip Code Extension\*: 7605

2 Save Cancel

**Step 2:** Click **Save** to save the information and advance.

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



The NPI entered is not in the NPPES list.

The NPI entered must be a Type 2 NPI.

**Step 3:** Select the appropriate primary Taxonomy associated with the provider’s NPI and click **Save** again.

The available taxonomy choices listed are pulled from the NPPES registry database. If you need to update taxonomy information, please contact NPPES.

If multiple taxonomies need to be listed, additional taxonomies can be added on the on the ‘Taxonomies’ page of the application.

Application Type: Change of Operator [Change](#)

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

Provider Type\*: 86 - NURSING FACILITY

Name of Business Entity\*: Training Nursing Facility New

Exiting Provider Medicaid ID: 0000253

Exiting Provider NPI: 1962546648

Exiting Provider Name: Training Facility

Business Name as it appears on your IRS Assignment letter

Tax ID Type\*:  EIN  SSN

Tax ID\*: 132665223

NPI\*: 1326652231

Requested Effective Date\*: 1/22/2024

Zip Code\*: 43231

Zip Code Extension\*: 7605

Taxonomy\*:

3 Save Cancel

## CHANGE OF OPERATOR (PROVIDER)

### Continuing an 'In Progress' Application

If an application has been initiated, but has not been submitted, you can pick up the 'in progress' application to continue adding information. The steps below show how to access an application that has been initiated but not submitted.

Note: Applications that have been initiated, but not submitted will display a Status of "Not Submitted."

**Step 1:** Click the Reg ID or Provider hyperlink for the provider for which you wish to continue the application.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
518421	Training Nursing Facility	Not Submitted	86 - NURSING FACILITY	1013959857								

**Step 2:** Expand the Enrollment Action Selections by clicking the '+' icon.

### Manage Application

---

Enrollment Actions **2** + Enrollment Action Selections: ?

Programs + Program Selections:

Self Service + Self Service Selections:

**Step 3:** Click the hyperlink "Continue Registration."

### Manage Application

---

Enrollment Actions - **3** Enrollment Action Selections: ?

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

Note: PNM will open to the first 'unsaved' page of the application.

### Document Upload Process (Any Page)

The option to upload documents is available on most pages of the application. Some pages have a box asking for a specific document and uploads can be completed there. For all other uploads, the steps below can be followed.

**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	Deletes
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

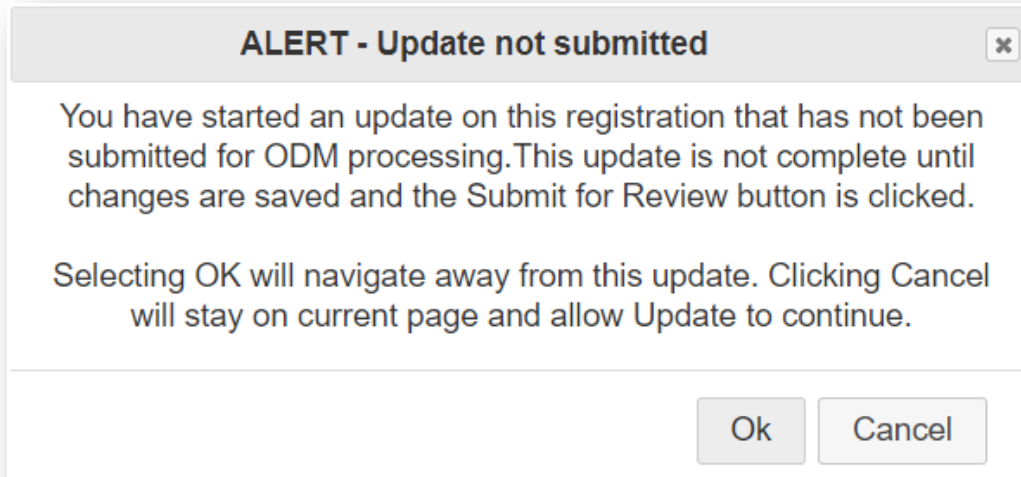
6 Save Cancel Previous Next

Primary Contact Information (480295)

### Page Save Warning Message

While the application pages can be completed in any order, PNM is set up to present the pages in an order that user-friendly to complete. To change to different pages, you can click the icon in the navigation bar or choose the page name from the drop-down menu.

If you leave a page where information has not been saved, PNM displays a pop-up window.



To advance to the page selected, click **Ok**.

To remain on the current page, click **Cancel**.

### Provider Information Page

The first page that displays is the Provider Information page. Fill in all fields and click **Next** to continue with the application. (Clicking 'Next' saves the information on the page and advance to the next page of the application.)

Note: Some information will auto-fill from the key identifiers page you previously completed.

**Step 1:** Enter all the information in the required fields marked with an asterisk (\*).

For this page, the following fields are required:

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

**Provider Information**  
This is a required section.

An asterisk \* indicates a required field

1 Name of Business Entity\* Training Nursing Facility New

DBA\*

Practice Type\*

Ownership Type\*

Tax ID\* 132665223

NPI 1326652231

NPI Start Date 09/08/2020

Provider Type\* 86 - NURSING FACILITY

Revalidation Date Not Set Yet

Enrollment Status Not Set Yet

Enrollment Status Reason Not Set Yet

2 Save Cancel Next

**Step 2:**

- Click the **Save** button to save the information on the page *OR*
- Click the **Next** button to save and move to the next screen.

### Primary Contact Information Page

The Primary Contact Page is the next page that displays on the application. This is the primary contact who will receive communications from PNM and be responsible for managing those communications as well as 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 1 (*can enter multiple*)
- Email Address 1 (*can enter multiple*)

**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 *OR*
- Click the **Next** button to save and move to the next screen.

Primary Contact Information  
This is a required section

An asterisk \* indicates a required field

Override Address Validation

1 Name\* Tom Trainer

The primary contact is the main person responsible for the information submitted

Title

Address 1\* 2400 Corporate Exchange Drive

Address 2

City\* Columbus

State\* OH

County

Zip\* 43233

Ext Zip

Phone Number 1\* (614) 555-4321

Phone Ext 1

2  Yes  No Indicate this is a cell phone if you wish to receive text message. Standard text messaging and data rates may apply.

Phone Number 2

Phone Ext 2

Yes  No Indicate this is a cell phone if you wish to receive text message. Standard text messaging and data rates may apply.

Fax Number 1

Fax Number 2

Email Address 1\* trainer@lesstraining.com

Email Address 2

Office Manager

History

### 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 after clicking 'Save' or 'Next', a USPS system search will review the address and return corrections to the address based on the USPS review.

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

*If the address listed cannot be validated by USPS, select the 'Override Address Validation' box to proceed forward.*

Override Address Validation

According to the USPS database, the address entered is inaccurate. The following address was found:

2400 CORPORATE EXCHANGE DR  
FRANKLIN  
COLUMBUS, OH 43231-7605

Click on 'Accept' to accept the corrections.

Accept Cancel



## CHANGE OF OPERATOR (PROVIDER)

### 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: Depending on the provider type selected, this page may not appear on the application. If it does, PNM indicates, that this is not a required section. Click **Next** to skip the section and proceed in the application.

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

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

Generate PDF

Save Cancel Previous Next

History

Add Contact

No records found

1 Add New

**Step 2:** Enter all required fields marked with an asterisk (\*).

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

**Step 4:**

- Click the **Save** button to save the information on the page *OR*
- Click the **Next** button to save and move to Primary Service Address Page

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

4 Save Cancel Previous Next

History

Add Contact

No records found

Add New

An asterisk \* indicates a required field

2 \*Contact Name

\*Practice Name

\*Contact Phone No

Contact Phone Extension

Contact Fax No

\*Contact Email

3 Comments

### Primary Service Address Page

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

**Step 1:** Complete the Primary Service Address information.

Required fields include:

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

**5** Save Cancel Previous Next

### Primary Service Address

This is a required section.

An asterisk \* indicates a required field

Override Address Validation

**1** Organization Name\* Training Facility

Primary Service Address\* 2400 Corporate Exchange Drive

Address 2

City\* Columbus

State\* OH

County\*

Zip\* 43231

Ext Zip\* 7605

Phone Number 1\* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1\* test@test.com

History

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

Provider Directory Opt-Out

## CHANGE OF OPERATOR (PROVIDER)

**Step 2:** Indicate specific operating information about the provider or provider's office using the drop-down menus/data entry fields:

- Cultural Competencies
- Languages Spoken
- Specialized Training
- Hours of Operation
- Whether the location is open 24 hours

**Step 3:** Indicate specific office information about the provider or provider's office using the drop-down menus/data entry fields:

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

**Step 4:** Indicate specific information about the types of patients the provider's office serves:

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

The screenshot shows a registration form with three numbered callouts:

- 2** **Provider Information** \*Only required for individual registrations. Fields include Cultural Competencies, Languages Spoken, and Specialized Training, each with a dropdown menu.
- 3** **Office Information**. Fields include Website (text), 24-hour telephone coverage (Yes/No dropdown), Public transportation access (Yes/No dropdown), Electronic billing (Yes/No dropdown), TDD/IDY (Yes/No dropdown), Cultural Competencies, Languages Spoken, and Specialized Training (dropdowns), ADA Compliance\* (--Select ADA-- dropdown), ASL Offered\* (Yes/No dropdown), and Translation Services (checkboxes for Language Line and Translation).
- 4** **Patient Information**. Fields include Accept new patients (No dropdown), Accept new patients from referral only (No dropdown), Youngest patients accepted (text), Oldest patients accepted (text), Gender of patient Accepted (dropdown), Accept newborn\* (No dropdown), and Accept pregnant women (No dropdown).

**Step 5:**

- Click the **Save** button to save the information on the page **OR**
- Click the **Next** button to save and move to the next screen.

## Address Pages

The following table provides samples of the types of address pages that will be required for a Change of Operator (CHOP) application.

### Billing & Payment Address Page

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

Same as Practice Location

If a different address, enter the required fields marked with an asterisk (\*).

If the address listed cannot be validated by USPS, click the 'Override Address Validation' box to proceed forward.

Override Address Validation

Click **Next** to save the information to the record and advance to the next page.

### Correspondence Address Page

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

If a different address, enter the required fields marked with an asterisk (\*).

If the address listed cannot be validated by USPS, click the 'Override Address Validation' box to proceed forward.

Click **Next** to save the information to the record and advance to the next page.

## CHANGE OF OPERATOR (PROVIDER)

### 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 Primary Service Address page into the fields.

If the 1099 Address is the same as the Billing & Payment Address, select the check box to indicate it is the 'Same as Billing Location.' This will pre-populate information that was entered on the Billing & Payment page into the fields.

If a different address, enter the required fields marked with an asterisk (\*).

If the address listed cannot be validated by USPS, click the 'Override Address Validation' box to proceed forward.

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 **Next** to save the information to the record and advance to the next page.

### 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 Primary Service Address page into the fields.

If a different address, enter the required fields marked with an asterisk (\*).

If the address listed cannot be validated by USPS, click the 'Override Address Validation' box to proceed forward.

Click **Next** to save the information to the record and advance to the next page.

## Long Term Care Addresses Page

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

Jump To: Long Term Care Addresses

Address\* → 1099 Address\* → Home Office Address\* → Long Term Care Addresses\* → Specialties\* → Taxonomies\* → Medicare Number\*

Generate PDF

Save Cancel Previous Next

4

History

Long Term Care Addresses

This is a required section.

No records found.

1 Add New

## CHANGE OF OPERATOR (PROVIDER)

### Step 2:

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

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

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

Same as Practice Location  2

Override Address Validation

3 Location Type\*

Address Type  Individual  Organization

2 Organization Name\*

2 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\*

### Step 4: Click the **Next** button to save and move to the next screen.

## Specialties Page

The specialty page allows for an indication of specialties for the group, organization, or pharmacy.

Note: A primary specialty must be designated first, before adding any secondary specialties.

**Step 1:** Click **Add New** to add a specialty.

- The specialty drop-down has a variety of specialties that are associated with the selected provider type.
- If it is the primary specialty, select the check box that allows you to ‘Designate a Primary Specialty.’

This screenshot shows the top portion of the 'Specialties' page. On the left, the word 'Specialties' is displayed in blue, with a red note below it stating 'This is a required section.' On the right, there are four navigation buttons: 'Save', 'Cancel', 'Previous', and 'Next'. In the center, a message reads 'Primary Specialties are not editable by provider after application submission.' In the bottom right corner, there is a red circle with the number '1' next to an 'Add New' button.

This screenshot shows the main form area of the 'Specialties' page. It includes the same 'Specialties' header and 'This is a required section.' note as the previous screenshot. The navigation buttons 'Save', 'Cancel', 'Previous', and 'Next' are also present. The central message 'Primary Specialties are not editable by provider after application submission.' is repeated. In the bottom right, there is an 'Add New' button. Below this, a checkbox labeled 'Designate a Primary Specialty' is checked. A red note below the checkbox says 'Designate a Primary Specialty and save first before secondary specialties can be entered.' A red circle with the number '1' is positioned to the left of the 'Specialty\*' dropdown menu. Below the dropdown are two text input fields: 'Start Date\*' with the value '1/19/2024' and 'End Date' with the value '12/31/2299'.



## CHANGE OF OPERATOR (PROVIDER)

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

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


**Specialties**  
This is a required section.

2 Save Cancel Previous Next 4

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status	Edit	Delete
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	All		
860 Dual Certified Skilled Nursing Facility	Yes	01/19/2024	12/31/2299	INACTIVE		
865 Dual Certified Religious Non-medical Health Care	No	01/19/2024	12/31/2299	INACTIVE		

3 Add New History



**Note:** The 'Enroll Status' of the specialties will show as INACTIVE until the Enrollment Application has been fully approved by the Ohio Department of Medicaid.

**Step 4:** Click **Next** to proceed to the next page.

## Removing Specialties

**Step 1:** To remove an added specialty, click the 'x' associated with the applicable specialty line.


**Specialties**  
This is a required section.

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status	Edit	Delete
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	All		
860 Dual Certified Skilled Nursing Facility	Yes	01/19/2024	12/31/2299	INACTIVE		
865 Dual Certified Religious Non-medical Health Care	No	01/19/2024	12/31/2299	INACTIVE		1

Add New History



## Taxonomies Page

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

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

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

Jump To: Taxonomies

Address\* Long Term Care Addresses\* Specialties\* Taxonomies\* Medicare Number\* MCP Affiliation Nursing Facility V

Generate PDF

Save Cancel Previous Next

### Taxonomies

This is a required section.

Taxonomy	Taxonomy Description	Primary	Start Date	End Date	
282E00000X	LONG TERM CARE HOSPITAL	Yes	01/19/2024	12/31/2299	

Add New History

## CHANGE OF OPERATOR (PROVIDER)

If you need to include additional Taxonomy Codes to the 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 the provider's 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** Save Cancel Previous **Next** 5

This is a required section.

Taxonomy	Taxonomy Description	Primary	Start Date	End Date	
282E00000X	LONG TERM CARE HOSPITAL	Yes	01/19/2024	12/31/2299	<span style="border: 1px solid black; border-radius: 50%; padding: 2px 5px;">1</span>

1 Add New   
 History



Taxonomy\* 2

Is Primary Taxonomy

3 Start Date\*

4 End Date

## Editing or Changing Primary Taxonomy

**Step 1:** Click the 'pencil and paper' 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 and proceed to the next page.


Taxonomies

This is a required section.

Save Cancel Previous Next

Taxonomy	Taxonomy Description	Primary	Start Date	End Date	
282E00000X	LONG TERM CARE HOSPITAL	Yes	01/19/2024	12/31/2299	 

Add New History



2 Taxonomy\* (282E00000X) v

3  Is Primary Taxonomy

4 Start Date\* 01/19/2024

End Date 12/31/2299

5

6

1

### Medicare Number Page

Depending on the provider type, this may not be a required section. Click **Next** to skip, if not required.

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

- Medicare Number type

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

- Medicare Number (based on type selected)
- Medicare State
- Medicare Enrollment Status (Required)
- Medicare Enrollment Date

Medicare Number

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

Medicare Number

No records found

History

1 Add New

Medicare Number Type

CCN (CMS Certification Number) [What is this?](#)

PTAN (Provider Transaction Access Number) [What is this?](#)

Medicare Number\*

Secondary NPI

Medicare State\*

Medicare Enrollment Status\*

Medicare Enrollment Date

Required Document

2 Medicare Enrollment Certification Required for Dialysis Facilities (Only if approved)

Browse

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** and locate the file on your computer.

**Step 3:** Determine if you need to add Medicaid information from another State.

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

Medicaid

No Other State Medicaid Number found

3 Add New

Other State Medicaid Enrollment Status

State

## CHANGE OF OPERATOR (PROVIDER)

---

**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.

## CHANGE OF OPERATOR (PROVIDER)

### MCP Affiliation

This page allows for the ability to enter interest in contracting with an Ohio Medicaid Managed Care Plan.

**Step 1:** Indicate interest 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, Organizations & Hospital Affiliations → **MCP Affiliation** → Federal DEA Registration → W9 Form\* → EFT Banking\*

Generate PDF

Save Cancel Previous Next

### 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?  Yes  No

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

#### Confirmed MCP Affiliations

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

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

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

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

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

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

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

#### Confirmed MCP Affiliations

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

## CHANGE OF OPERATOR (PROVIDER)

### Nursing Facility Ventilator

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

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

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

Jump To: Nursing Facility Ventilator

xonomies\* Medicare Number\* MCP Affiliation Nursing Facility Ventilator\* Professional Liability Insurance\* W9 Form\*

Generate PDF

Save Cancel Previous Next

**Nursing Facility Ventilator**  
This is a required section.

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

### Yes/No Nursing Facility Ventilator

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

**Nursing Facility Ventilator**  
This is a required section.

Save Cancel Previous Next

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

**2 Ventilator Questions**

Ventilators are connected to emergency outlets connected to a backup generator in an amount sufficient to meet the needs of ventilator dependent individuals.  
 No  Yes

Respiratory care professional (RCP) is on-site at least 5 hours per week.  
 No  Yes

Registered Nurse (RN) with 1-year experience working with ventilator dependent individuals is in the facility at least 5 hours per week.  
 No  Yes

If ordered by a physician, initial therapy assessments can be done within 48 hours of receipt of order.  
 No  Yes

If ordered by a physician, therapy is available for up to 2 hours per day, 6 days per week for each ventilator dependent individual.  
 No  Yes

Stat laboratory services are available 24 hours per day, 7 days per week with results within 4 hours.  
 No  Yes

For new admissions, pain medications can be administered within two hours from receipt of physician order.  
 No  Yes

Has not been a special focus facility in past 6 months.  
 No  Yes

**Weaning Questions**

A weaning protocol is in place established by a physician trained in pulmonary medicine who is available by phone 24 hours per day 7 days per week while weaning services are provided.  
 No  Yes

A respiratory care professional (RCP) with training in basic life support is on-site 8 hours per day 7 days per week and available by phone during the remaining hours of the day while weaning services are provided.  
 No  Yes

A Registered Nurse (RN) with training in basic life support is on-site 24 hours per day 7 days per week while weaning services are provided.  
 No  Yes



## CHANGE OF OPERATOR (PROVIDER)

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

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

**Nursing Facility Ventilator**  
This is a required section.

Are you applying as a new nursing facility ventilator provider?

No  Yes

Save Cancel Previous **Next**

3 4

**Note:** A message pop-up appears. Click **OK**.

**Message**

Your facility is approved for the Nursing Facility Chronic Ventilator Program effective 1/22/2024 5:20:06 PM

Your facility is approved for the Nursing Facility Weaning Program effective 1/22/2024 5:20:07 PM

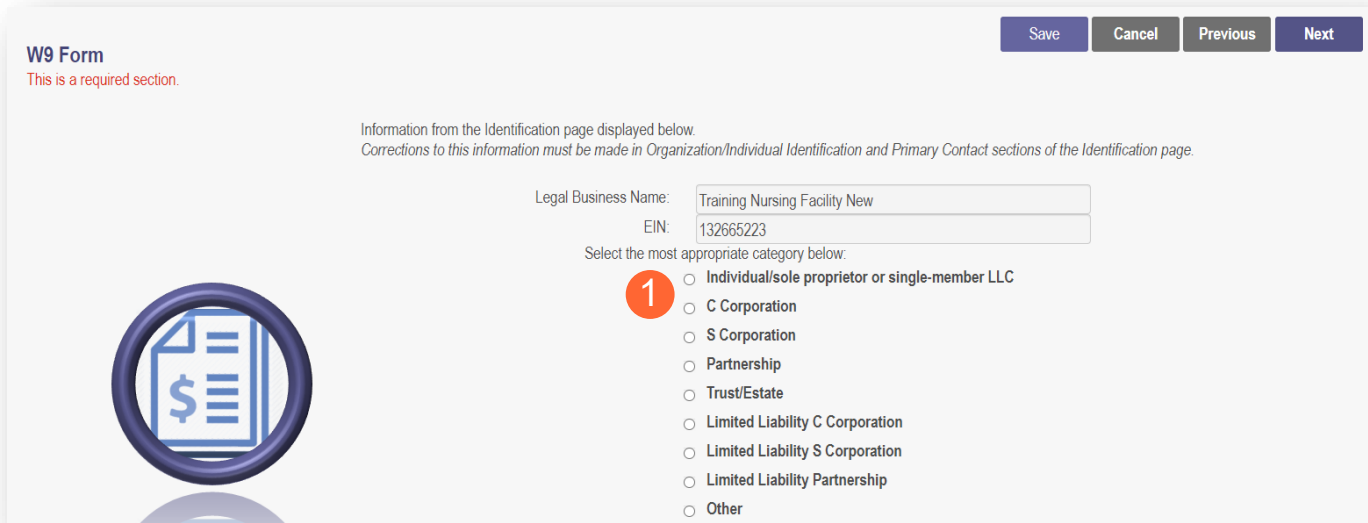
OK

## CHANGE OF OPERATOR (PROVIDER)

### W9 Form Page

On this page, indicate which tax filing category and document the provider completes to provide the correct EIN/TIN information.

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

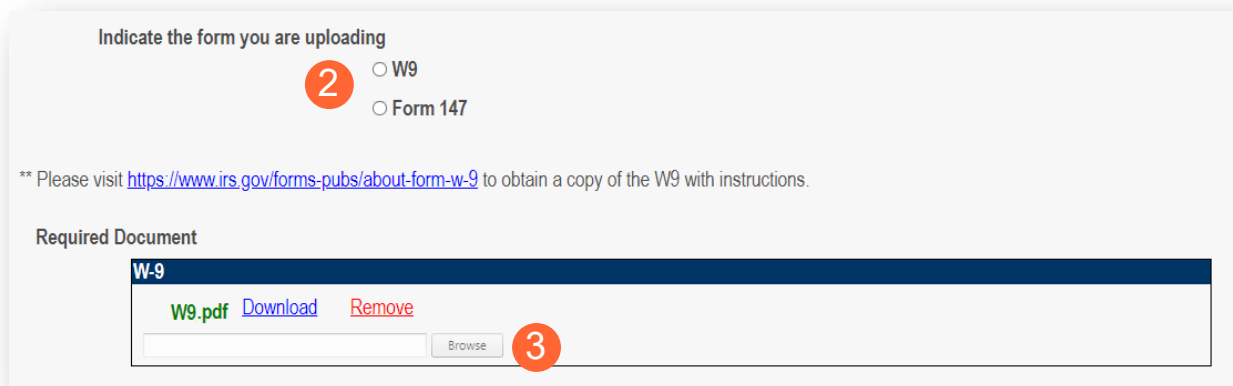


The screenshot shows the 'W9 Form' page with a 'This is a required section.' warning. It displays information from the Identification page: Legal Business Name: Training Nursing Facility New, EIN: 132685223. A red circle with the number '1' highlights the 'Individual/sole proprietor or single-member LLC' radio button option in the 'Select the most appropriate category below:' section. Other options include C Corporation, S Corporation, Partnership, Trust/Estate, Limited Liability C Corporation, Limited Liability S Corporation, Limited Liability Partnership, and Other. A 'W9' icon is visible on the left.

**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 successfully uploaded.



The screenshot shows the 'Indicate the form you are uploading' section with two radio button options: 'W9' (selected, highlighted with a red circle '2') and 'Form 147'. Below this is a note: '\*\* 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 file named 'W9.pdf' with 'Download' and 'Remove' links. A 'Browse' button is highlighted with a red circle '3'.

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

## CHANGE OF OPERATOR (PROVIDER)

### EFT Banking Information Page

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

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

Jump To: EFT Banking

CP Affiliation → Federal DEA Registration → W9 Form\* → **EFT Banking\*** → Application Fee\* → Owner Information\* → Required Docs

Generate PDF

Save Cancel Previous Next

**EFT Banking Information**

This is a required section.

**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

**Step 2:** If 'Yes' is answered, 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.

**Instructions**

**2** READ INSTRUCTIONS BEFORE COMPLETING

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

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

Please enter your banking information below.

**Banking Information**

No banking information found.

**3** Add New

## CHANGE OF OPERATOR (PROVIDER)

**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.

## CHANGE OF OPERATOR (PROVIDER)

**Step 7:** Enter the following contact information for the person who will manage 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*	<input type="text"/>
Middle Name	<input type="text"/>
Last Name*	<input type="text"/>
Phone Number*	<input type="text" value="( ) - -"/>
Extension	<input type="text"/>
Email Address*	<input type="text"/>
Fax Number	<input type="text" value="( ) - -"/>

8

**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

### Application Fee

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

Note: This page will only appear if the provider type being entered is required to pay the application fee.

### Paying The Fee

**Step 1:** Select the 'Credit Card' radio button for Payment Type.

**Step 2:** Click **Select Payment**.

Application Fee Save Cancel Previous Next

This is a required section.

#### Application Fee

All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$688.00

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

Fee Amount	\$688.00
Fee Status	Pending
Payment Type	<input checked="" type="radio"/> Credit Card
	<input type="radio"/> Request Waiver of Application Fee

Authorize Payment Select Payment

## CHANGE OF OPERATOR (PROVIDER)

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

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

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

**CBOSS** BETA

### Enter New Account

**3**

AMERICAN EXPRESS DISCOVER MASTERCARD VISA

Remember For Future Use

**4**

## CHANGE OF OPERATOR (PROVIDER)

**Step 5:** Once returned to the Application Fee screen, click **Authorize Payment**.

Application Fee

This is a required section.

**Application Fee**

All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$688.00

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

Fee Amount \$688.00

Fee Status Pending

Payment Type  Credit Card  Request Waiver of Application Fee

**5** **Authorize Payment** Select Payment MasterCard ... 8767



## Waiving the Fee

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

**Application Fee**  
This is a required section.

**Application Fee**  
All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$688.00

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

Fee Amount \$688.00  
Fee Status Pending

Payment Type  Credit Card  
**1**  Request Waiver of Application Fee

Authorize Payment Select Payment

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

Please note your Registration ID on the check.  
Amount\* \$688.00

**2** Waiver Reason  
Comments Medicare Enrolled  
Paid in Another State  
Paid in the past 5 years  
Medicare Enrollment Pending

Fee Payment History

**Step 3:** If needed, type comments in the box.

Please note your Registration ID on the check.  
Amount\* \$688.00

Waiver Reason Paid in the past 5 years

**3** Comments Paid 1/5/2023

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

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

Browse **4**

**Step 5:** Click **Next** to proceed to the next page.

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

Proof of Payment\_2.pdf Download Remove

Browse

## Owner Information

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

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

- **Note:** If additional sections such as 'Real Estate Owners' or 'Additional Disclosure' apply to the situation of the provider being entered, please complete those sections as well.

**Step 3:** To add Owner Information, click **Add New**.

Jump To: Owner Information

MCP Affiliation → Federal DEA Registration → W9 Form\* → Application Fee\* → **Owner Information\*** → Required Documents → Agreements\*

Generate PDF

Save Cancel Previous Next

Owner Information  
This is a required section.

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

- 1 + Instructions
- 2 + Definitions & Requirements
- 2 - Owner, Managing Employee and Controlling Interest Information
- + Real Estate Owners
- + Additional Disclosure
- 2 - Questions

No owner information found.

3 Add New

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

+ Real Estate Owners

+ Additional Disclosure

2 - Questions

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

Yes  
 No

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

Yes  
 No

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

Yes  
 No

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

Yes  
 No

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

Yes  
 No

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

Yes  
 No

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

Yes  
 No

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

Yes  
 No

## CHANGE OF OPERATOR (PROVIDER)

**Step 4:** Enter the detailed Owner Information for any Individuals, Managing Employees, or Organizations who have direct or indirect ownership or controlling interest of 5 percent or more in the provider entity (Group or Organization).

**Step 5:** Click **Save**.

Owner Information

4

Owner Type\*

Owner Title

Affiliation Type\*

Address 1\*

Address 2

City\*

State\*

County

Zip\*

Percentage of Ownership\*

Owner End Date

5 Save Cancel

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

- Owner, Managing Employee and Controlling Interest Information

6

Type	Name	Title	Percentage	Start Date	End Date		
Individual	Travis Trainer	President	100.00	12/26/2023	12/31/2299		

[Add New](#)

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

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

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

## - Questions **7**

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

- Yes  
 No

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

- Yes  
 No

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

- Yes  
 No

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

- Yes  
 No

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

- Yes  
 No

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

- Yes  
 No

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

- Yes  
 No

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

- Yes  
 No

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

Jump To: Owner Information

MCP Affiliation → Federal DEA Registration → W9 Form\* → Application Fee\* → **Owner Information\*** → Required Documents → Agreements\*

**8** DF

Owner Information  
This is a required section.

Save Cancel Previous Next

## Required Documents Page

The required documents page allows for the ability to upload required or optional supporting documentation that was not indicated on previous pages of the application. Click **Next** to bypass this page if there is nothing to upload.

**Step 1:** If you are required to upload documents, blue upload boxes will be displayed under the Required Documents section.

- To upload a document, click **Browse**, then select the file on your computer and click **Open**.

The screenshot shows two document upload sections. The top section is labeled "Required Document" and contains a blue header bar with the text "ODM 03620 ODM 03620". Below the header is a white input field and a "Browse" button. A red circle with the number "1" is positioned to the right of the "Browse" button. The bottom section is labeled "Optional Document" and contains a blue header bar with the text "Real Estate Documents Real Estate Documents". Below the header is a white input field and a "Browse" button.

## CHANGE OF OPERATOR (PROVIDER)

**Step 2:** If you want to upload a document not listed in PNM, click **Choose File**.

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

Jump To: Required Documents

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

Generate PDF

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

Save Cancel Previous Next

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.

2 Choose File No file chosen

Name

Description

Upload file

## Change of Operator Information page

This page allows for the entry of the information relating to the change of operator.

**Step 1:** Enter Change of Operator information, which could include the following:

- CHOP Type
- Purchase Price
- Sub-lease Amount
- Total Annual Master Lease Amount
- Effective Date of CHOP

**Change of Operator Information**  
This is a required section.

Save Cancel Previous Next

**Change of Operator Information**

1

CHOP Type SALE OR TRANSFER OF OWNERSHIP INTEREST

Exiting Operator Medicaid ID 0000253


Purchase Price \$545,000.00

Sub-lease Amount \$0.00

Total Initial Annual Master Lease Amount \$0.00

Effective Date of CHOP 1/24/2024

2



**Step 2:** When information has been entered, click **Next**.

### Agreements Page

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

Save Cancel Previous Next

### Ohio Medicaid Provider Agreement

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

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.

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."

I agree to Terms and Conditions

Agreement Date: 1/19/2024

**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.'

If you meet this provision, please check this box



## CHANGE OF OPERATOR (PROVIDER)

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

### Agreements

This is a required section.

Save

Cancel

Previous

Next

#### Ohio Medicaid Provider Agreement

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

#### 4 Long Term Care Facility (LTCF) Agreement



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

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

### Provider Signature

Option A **4**

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

Option B **4**

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

## CHANGE OF OPERATOR (PROVIDER)

### **Step 5:** Complete the Provider Agreement Attestation:

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

### Provider Agreement Attestation **5**

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

### **Step 6:** Complete the Provider Agreement Signature:

- Enter the Name of the Person Attesting.
- Confirm Provider Name and User ID auto-filled correctly.

### **Step 7:** Click Save.

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

### Provider Agreement Signature

**6** Name of Person Attesting\*:  ⓘ

Provider Name:

User ID:

**7**

### **Step 8:** Click **OK** to review the application prior to submission.

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

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

**8**

## CHANGE OF OPERATOR (PROVIDER)

### Submitting Application

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

Jump To: Agreements

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

Generate PDF  
Submit for Review

Save Cancel Previous Next

Agreements

This is a required section.

Ohio Medicaid Provider Agreement

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

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

**Step 2:** You will receive a message giving one last opportunity to review the application pages. 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.

2 OK

**Step 3:** When the information on all pages is satisfactory, click **Submit for Review** again.

**Step 4:** You will receive a confirmation message stating that the application has been successfully submitted.

**Step 5:** Click **Return to Home Page** to go to your dashboard.

4 Submission Confirmation

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

5 Return to Home Page

## Resubmitting an Application (Return to Provider – RTP)

If a specialist reviewing the application needs additional information, they will return the file 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.

Provider Name: Training Nursing Facility

Medicaid ID:

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.

REG\_ID: 518421

**Step 2:** Access the application, indicated by the Reg ID in the email, (which will be in ‘Return to Provider’ status) by logging into PNM and clicking on the link under the Reg ID or Provider heading.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
518421	Training Nursing Facility	Return to Provider	86 - NURSING FACILITY	1013959857		Dual Certified Skilled Nursing Facility					01/19/2024	

## Reviewing Correspondence

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

Provider Management Home

Registration Information Previous Page

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

Manage Application

Enrollment Actions + Enrollment Action Selections: ⓘ

Programs + Program Selections:

Self Service + 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	Workflow Complete
518421	Application Flow - Standard - NEW REGISTRATION	Medicaid	606881	Return to Provider			01/19/24	N

**Step 2:** Click the 'Provider Correspondence' hyperlink.

Manage Application

Enrollment Actions + Enrollment Action Selections: ⓘ

Programs + Program Selections:

Self Service - Self Service Selections:

[View Provider File](#)

**2** [Provider Correspondence](#)

## CHANGE OF OPERATOR (PROVIDER)

**Step 3:** To locate correspondence, complete the following:

- Select 'Enrollment Notifications' from the Correspondence Type drop-down menu.
- Enter a date range for the search (optional).
- Click **Search**.

**\* SEARCH CORRESPONDENCE**

An asterisk \* indicates a required field

\*Correspondence TYPE: Enrollment Notifications

Date Available From: MM/DD/YYYY

Date Available To: MM/DD/YYYY

Search Clear

**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 Subject	Correspondence Type	Date Sent	Date Viewed
<a href="#">Send Additional Information (RTP Notice)</a>	ENROLLMENT	12/26/2023	
<a href="#">Ohio Medicaid Provider Application Received</a>	ENROLLMENT	12/26/2023	

**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 or click **Close** at the bottom of the window. Click **Print** to print a physical copy of the correspondence or download

**Provider Communication**

**Subject:** Provider Screening and Enrollment Registration-Action Required

Dear Provider:

Your Ohio Medicaid Provider Application/Agreement could not be processed as submitted. Your provider enrollment application has been returned because the Ohio Medicaid Enrollment requires additional information in order to process the application.

Please see the return reasons below:

P064 - Address does not match what is currently on file, please update information in the module system or application to match.

Within the next 30 days, please log into the Provider Network Management system [http://ohpnm-trn.omes.maximus.com/OH\\_PNM\\_TRN/Account/Login.aspx](http://ohpnm-trn.omes.maximus.com/OH_PNM_TRN/Account/Login.aspx) to complete and resubmit your provider enrollment application request. Failure to do so within 30 days of this communication will result in the closure of the application.

Please note the return reasons listed in this email will also be displayed in the portal identifying the pages that need correction or require additional information. If you have any questions, please contact the Provider Enrollment Customer Service at 1-800-686-1516.

If you are mailing paper copies of required documentation, please send to the following address:

Provider Enrollment Unit  
P.O. Box 1461  
Columbus, Ohio 43216-1461

Sincerely,

Print Close

## Confirmation of Building CHOP

Once the CHOP is completed and the new Entering Provider is approved and enrolled, you can verify that the Exiting Provider's building is associated with the Entering Provider.

**Step 1:** Click on the Reg ID or Provider name hyperlink on the homepage/dashboard.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
518320	<a href="#">Training Facility</a>	Submitted	86 - NURSING FACILITY	1962546648		Medicaid Only Nursing Facility					01/22/2024	

**Step 2:** On the Provider Management Home page, expand the Self-Service section by clicking the '+' icon. Click 'View Provider File.'

**Self Service**

- Self Service Selections:
- [View Provider File](#)
- [Provider Correspondence](#)
- [Remittance Advice](#)
- [Recipient Eligibility](#)
- [Claims](#)
- [Prior Authorization](#)
- [Cost Reports and Rate Setting](#)
- [Hospice](#)
- [Payment Innovation Reports](#)
- [Attachments](#)

## CHANGE OF OPERATOR (PROVIDER)

**Step 3:** You can find the Building Medicaid ID by searching for the Entering Provider- in the header information. Expand the header by clicking the **More...** button.

The screenshot displays the Ohio Medicaid Provider Network Management interface. At the top, the navigation bar includes the Ohio logo, a home icon, and links for Provider Network Management, Medicaid Home, Learning, Contact, and Fee Schedule. The user is logged in as 'lisachop' and can click 'Log out'.

The main content area shows provider details in a dark blue header. A red circle with the number '3' is positioned on the left and right sides of this header. The details include:

Provider Name	Medicaid ID	NPI
Provider Type: NURSING FACILITY	Risk Level: Limited	Effective Date: 08/18/2021
Application Type: Change of Operator	Enrollment Type: New	Revalidation Date: 08/18/2024
Application Status: Complete	Reason Code: ACTIVE	
Enrollment Status: ACTIVE		
Building Medicaid ID: 175117541		

Below the header is a progress bar with six steps: Provider Information\*, Primary Contact Information\*, Credentialing Contact, Office Information, Primary Service Address\*, and Billing & Payment Address\*. The 'Provider Information\*' step is highlighted with a yellow background and a green checkmark. A 'Jump To:' dropdown menu is set to 'Provider Information'. A 'Generate PDF' button is located to the right of the progress bar.

The 'Provider Information' section contains the following fields:

- Name of Business Entity\*: Golden Girls Villa
- DBA\*: GGV

A 'Next' button is located at the bottom right of the section.