

USER MANUAL

Behavioral Health Provider Enrollment Applications

**Behavioral Health
Individual Provider**



**Department of
Medicaid**

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Introduction

This user manual provides the steps and functions of entering a new provider application to enroll in the Ohio Department of Medicaid (ODM) program. An NPI number is required to complete an enrollment. 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.

Applications for enrollment with the Ohio Department of Medicaid (ODM), the Ohio Department of Aging (ODA) and the Ohio Department of Developmental Disabilities (DODD) are initiated through the PNM system.

To obtain a status update on an application submitted and in process, please contact the ODM Integrated Help Desk at 1-800-686-1516.

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 a revalidation is included in this document.

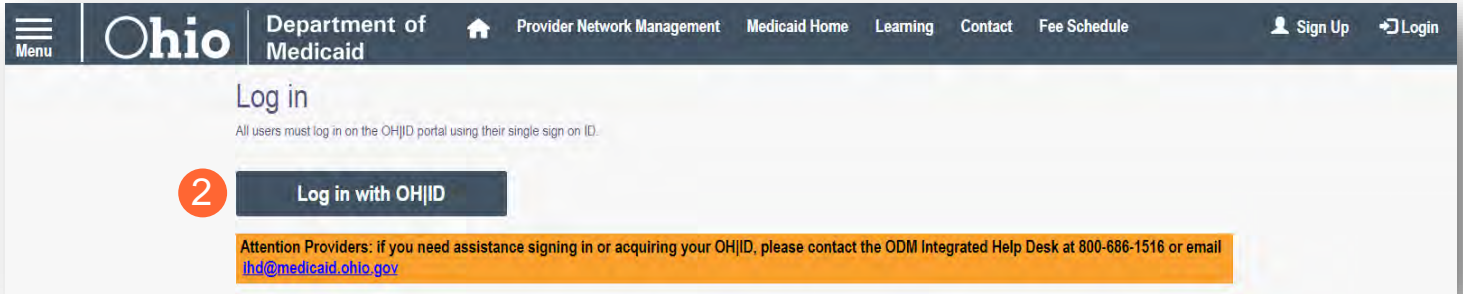


Provider User Initial Login

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.

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



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.

4 Yes, I have read the agreement

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)

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 Department of Medicaid Provider Network Management dashboard. Callout A points to the Menu icon (three horizontal bars) in the top left. Callout B points to the Account Administration button. Callout C points to the Excel and PDF export icons. Callout D points to the New Provider? button.

| Reg ID | Provider | Status | Provider Type | NPI | Medicaid ID | Specialty | DD Contract Number | DD Facility Number | Location | Effective Date | Submit Date | Revalidation Due Date |
|--------|------------------------|----------|---------------------------------|------------|-------------|----------------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 517948 | 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).

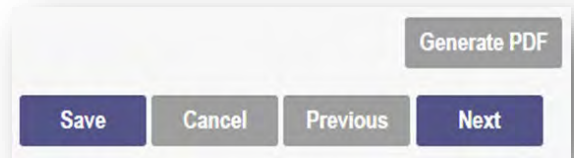
Account Administration: This button allows a Provider Administrator to set up Agent users, assign them actions/roles, or transfer the Provider to another Provider Administrator user (*button only displays for users holding the Provider Administrator or CEO Certified role*) (B).

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).

Page Navigation

Throughout each page on the application, you will have access to buttons to 'Save', 'Cancel', 'Previous' 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.

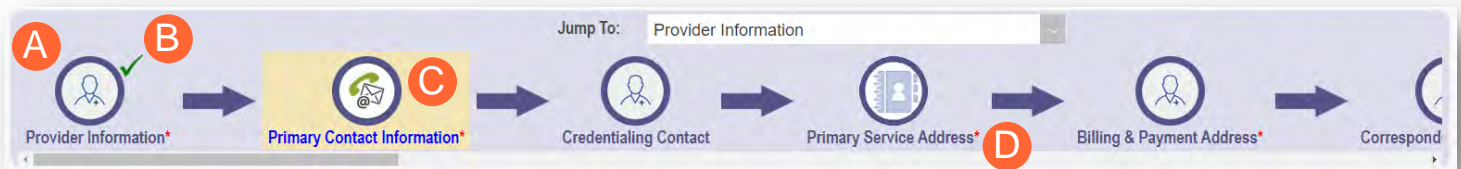
A green checkmark on any page indicates that you have completed the necessary information on that page and can continue through the subsequent pages.

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

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

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

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



Primary Contact Information
This is a required section.

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

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

New Provider Application Entry – Individual Provider

This section displays the necessary steps for creating an initial application (first time enrolling with ODM, ODA or DODD) for an individual provider.

Note: The ‘New Provider?’ button, and the ability to complete new enrollment application, is only available to users holding the Provider Administrator or CEO Certified roles in PNM.

Step 1: Click 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 |
|--------|---------------|----------|--------------------------|------------|-------------|--|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 518287 | Test Training | Complete | 54 - CHEMICAL DEPENDENCY | 1699328021 | 0000177 | LICENSED INDEPENDENT CHEMICAL DEPENDENCY COUNSELOR | | | | 04/13/2023 | 11/15/2023 | 04/13/2026 |

Step 2: Select the button for the appropriate application type for the new provider.

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

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

Standard application

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

2 [Select](#)

Ordering, Referring, Prescribing

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

[Select](#)

Change of Operator

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

[Select](#)

MCP Single Case

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

[Select](#) ⓘ

2 [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 Use this application if you are applying to become a new individual, group, facility, or institutional provider to provide fee-for-service for the State Medicaid program. Select | Ordering, Referring, Prescribing Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing. Select | Change of Operator Use this option if you want to initiate a Change of Operator for Skilled Nursing Facility or Intermediate Care Facility for individuals with intellectual disabilities. Select | MCP Single Case Use this application if you are entering into a Single Case agreement with a Managed Care Plan. Select |
| Medicaid Waiver (ODM) Use this application if you are applying to become a Waiver Provider with Ohio Department of Medicaid. Select | Medicaid Waiver (ODA) Use this application if you are applying to become a Waiver Provider with Ohio Department of Aging or if you are initiating a Change of Ownership or Change of Operator as an ODA Provider. Select | Medicaid Waiver (DODD) Use this application if you are applying to become a Waiver Provider with Ohio Department of Developmental Disabilities. Select | Non-Medicaid DODD Use this application if you are applying for one or more of the following options; Supported Living Service, Unpaid Support Broker, ICF Operators, or Licensees. Select |

2

Less...

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

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
- First Name
- Last Name
- SSN (Social Security Number)
- NPI (National Provider Identifier)
- Requested Effective Date (MM/DD/YYYY)
- Gender
- Date of Birth (MM/DD/YYYY)
- Zip Code
- Zip Code Extension

The screenshot shows a form for entering provider information. A red circle with the number '1' is positioned to the left of the 'Category*' field. The form includes the following fields and options:

- Application Type: Standard application (with a 'Change' link)
- Category*: Individual (with a 'Change' link)
- Provider Type*: (dropdown menu)
- First Name*: (text input)
- Middle Name: (text input)
- Last Name*: (text input)
- Tax ID Type*: EIN SSN
- Tax ID*: (text input)
- Are you requesting retro coverage? What is this?
- NPI*: (text input)
- DD Contract Number (If Applicable): (text input)
- Requested Effective Date*: 1/18/2024
- Gender*: Female Male Unknown
- Date of Birth*: (text input)
- Zip Code*: (text input)
- Zip Code Extension*: (text input)

At the bottom right, there is a red circle with the number '2' next to 'Save' and 'Cancel' buttons.

Note: If requesting a retro coverage date (a start date with Medicaid prior to the date you are entering the application, please indicate that through the appropriate box on the page).

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/or gender, you will get an error before the taxonomy field appears.



There is a name mis-match with NPPES.
There is a gender mis-match with NPPES.

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.

The screenshot shows a web form for a provider application. The fields are as follows:

- Application Type: Standard application (with a [Change](#) link)
- Category*: Individual (with a [Change](#) link)
- Provider Type*: 42 - PSYCHOLOGY (dropdown menu)
- First Name*: John
- Middle Name: (empty)
- Last Name*: Trainer
- Tax ID Type*: EIN SSN
- Tax ID*: 128532364
- Are you requesting retro coverage? What is this ?
- NPI*: 1285323323
- DD Contract Number (If Applicable): (empty)
- Requested Effective Date*: 1/18/2024
- Gender*: Female Male Unknown
- Date of Birth*: 7/4/1976
- Zip Code*: 43231
- Zip Code Extension*: 7605
- Taxonomy*: (empty dropdown menu)

At the bottom right, there is a red circle with the number 3, followed by a blue 'Save' button and a grey 'Cancel' button.

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 |
|--------|-------------------------------|---------------|----------------|------------|-------------|-----------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 518415 | Test Training | Not Submitted | 42 - PSYCHOLOG | 1285323642 | | | | | | | | |

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 - Enrollment Action Selections: ?

3 [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.

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.

The screenshot displays the 'Uploaded Documents' section of the application. At the top, there is a table with the following data:

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

Below the table is a form for uploading a new document. The form includes:

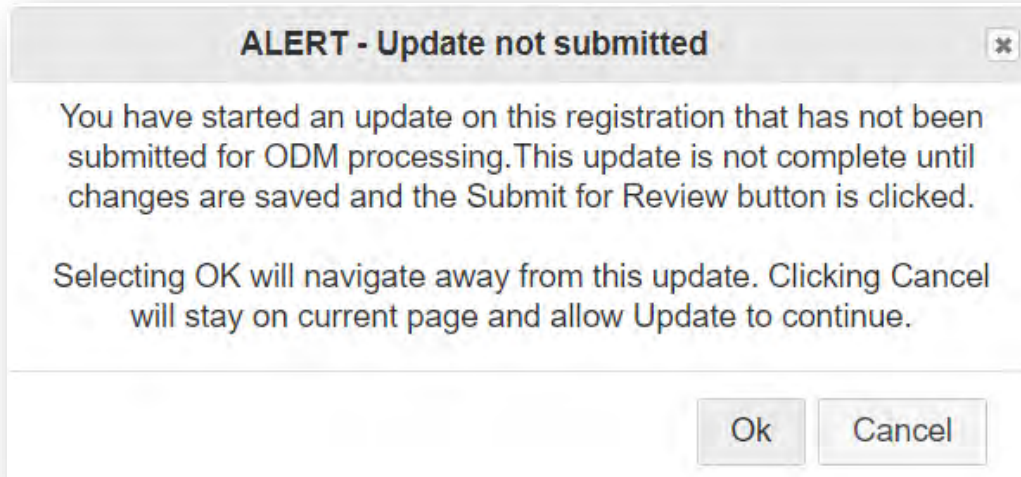
- A 'Choose File' button (labeled 1) with the text 'No file chosen'.
- A 'Name' input field (labeled 2).
- A 'Description' input field (labeled 3).
- An 'Upload file' button (labeled 4) with the text 'File Uploaded: test.pdf_29.pdf' below it.

At the bottom of the form, there are four buttons: 'Save', 'Cancel', 'Previous', and 'Next' (labeled 6). The text 'Primary Contact Information (480295)' is visible at the bottom left of the form area.

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 (Individual)

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 for the required fields marked with an asterisk (*).

For this page the following fields are required:

- Name (Business and First and Last)
- Tax ID
- NPI (National Provider Identifier)
- Gender
- Date of Birth (MM/DD/YYYY)
- 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)

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 *(can enter multiple)*
- Email Address *(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.

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.

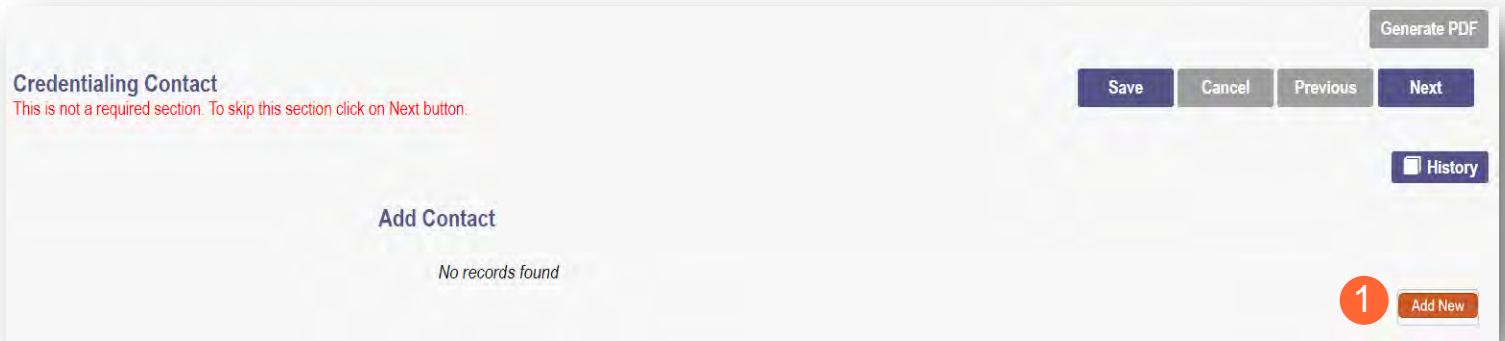
Override Address Validation

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**.

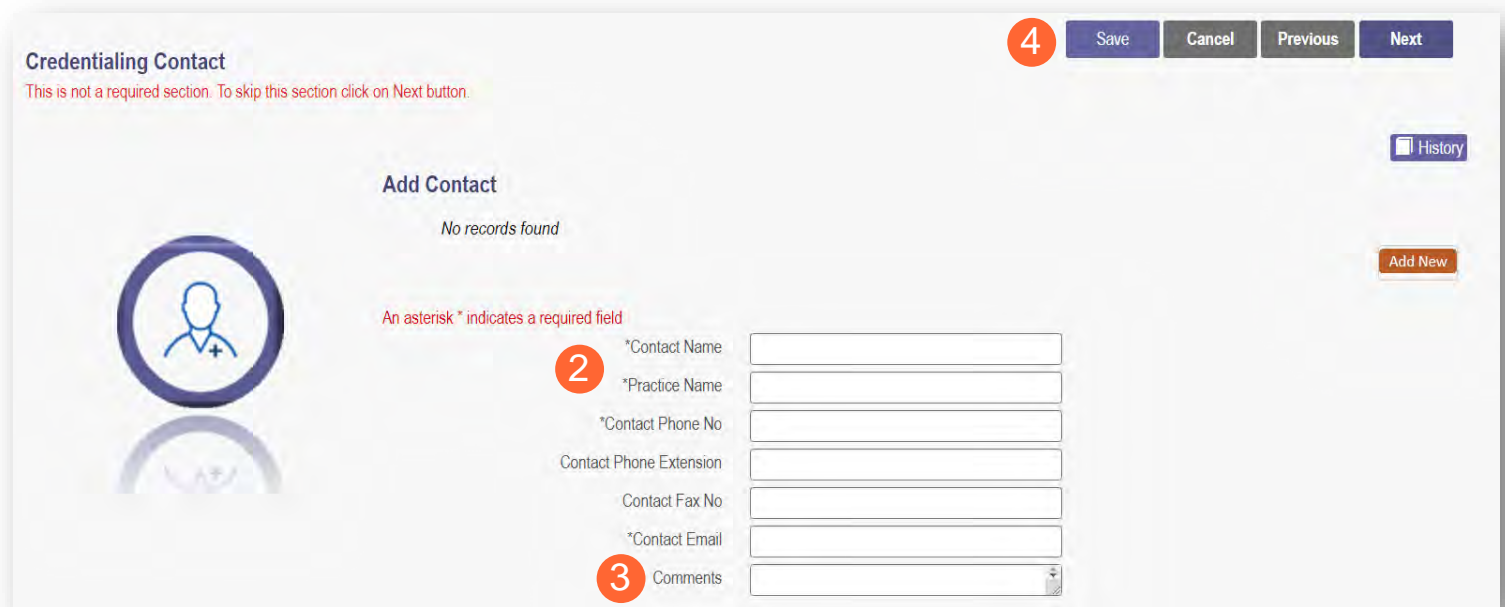


Step 2: Enter all required fields marked with an asterisk (*).

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 the next screen.



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:

- 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 *(XXX-XXX-XXXX)*
- Email Address

Save Cancel Previous Next


Primary Service Address

This is a required section.

History

An asterisk * indicates a required field

Override Address Validation



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*

Note: Steps 2 – 5 are optional. If you select 'Provider Directory Opt-Out,' Provider information will not be included in the public facing Provider Directory.

Provider Directory Opt-Out

Step 2: Indicate specific details about the provider 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** button to save the information on the page *OR*
- Click the **Next** button to save and move to the next screen.

The screenshot shows a web-based registration form for a behavioral health individual provider. At the top, there is a checkbox for "Provider Directory Opt-Out". The form is divided into several sections, each highlighted with a red circle and a number:

- 2 Provider Information** (Only required for individual registrations): Includes dropdown menus for Cultural Competencies, Languages Spoken, and Specialized Training.
- 3 Hours of Operation** (Hours providers available for appointments): A table with days of the week (Monday through Sunday) in the first column, time slots in the second and third columns, and checkboxes for "Open 24 Hours" in the fourth column.
- 4 Office Information**: Includes a text field for Website, dropdown menus for 24 hour telephone coverage, Public transportation access, Electronic billing, and TDD/TTY. Below these are dropdown menus for Cultural Competencies, Languages Spoken, Specialized Training, and ADA Compliance*, and a dropdown for ASL Offered*. At the bottom of this section are checkboxes for "Language" and "Translation" services.
- 5 Patient Information**: Includes dropdown menus for "Accept new patients", "Accept new patients from referral only", "Youngest patients accepted", "Oldest patients accepted", "Gender of patient Accepted", "Accept newborn*", and "Accept pregnant women".

Address Pages

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

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.

Other Service Locations

On this page, enter any other locations where the practitioner provides services. Be sure to enter other service locations that bill (or will bill) under the same Medicaid ID.

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 include additional addresses.

Step 4: If you would like, indicate additional operating information regarding the service location (see [Primary Service Address Page](#) for more details)

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

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.

The screenshot shows the 'Other Service Locations' form. At the top right, there are buttons for 'Save', 'Cancel', 'Previous', and 'Next'. A red circle with the number '3' is placed over the 'Save' button, and another red circle with the number '5' is placed over the 'Next' button. Below the buttons, a red message states: 'This is not a required section. To skip this section click on Next button.' A note in the center reads: '*Please enter Other Service locations that bill/will bill under the same Medicaid ID. No additional practice locations found.' On the right side, there are two buttons: 'Add New' (with a red circle '1' next to it) and 'History'. On the left side, there is a circular icon with a person and a plus sign. In the center, there is a checkbox labeled 'Override Address Validation' with a red circle '2' next to it. Below this are several input fields: 'Name*', 'Address 1*', 'Address 2', 'City*', 'State*', 'County', 'Zip*', 'Ext Zip*', 'Phone Number 1*', 'Phone Ext 1', 'Phone Number 2', 'Phone Ext 2', 'Effective Date*' (with the value '1/18/2024'), and 'End Date' (with the value '12/31/2299').

Note: If an address cannot be validated by USPS, click the 'Override Address Validation' box to proceed.

4

Provider Information *Only required for Individual registrations

| | |
|-----------------------|----------------------|
| Cultural Competencies | <input type="text"/> |
| Languages Spoken | <input type="text"/> |
| Specialized Training | <input type="text"/> |

Hours of Operation *Hours providers available for appointments

| | |
|-----------|----------------------|
| Monday | <input type="text"/> |
| Tuesday | <input type="text"/> |
| Wednesday | <input type="text"/> |
| Thursday | <input type="text"/> |
| Friday | <input type="text"/> |
| Saturday | <input type="text"/> |
| Sunday | <input type="text"/> |

Office Information

| | |
|------------------------------|----------------------------------|
| Website | <input type="text"/> |
| 24-hour telephone coverage | <input type="text" value="Yes"/> |
| Public transportation access | <input type="text" value="Yes"/> |
| Electronic billing | <input type="text" value="Yes"/> |
| TDD/TDY | <input type="text" value="Yes"/> |

| | |
|-----------------------|---|
| Cultural Competencies | <input type="text"/> |
| Languages Spoken | <input type="text"/> |
| Specialized Training | <input type="text"/> |
| ADA Compliance* | <input type="text" value="--Select ADA--"/> |
| ASL Offered* | <input type="text" value="Yes"/> |
| Translation Services | <input type="checkbox"/> Language Line <input type="checkbox"/> Translation |

Patient Information

| | |
|--|---------------------------------|
| Accept new patients | <input type="text" value="No"/> |
| Accept new patients from referral only | <input type="text" value="No"/> |
| Youngest patients accepted | <input type="text"/> |
| Oldest patients accepted | <input type="text"/> |
| Gender of patient Accepted | <input type="text"/> |
| Accept newborn* | <input type="text" value="No"/> |
| Accept pregnant women | <input type="text" value="No"/> |

Specialties Page

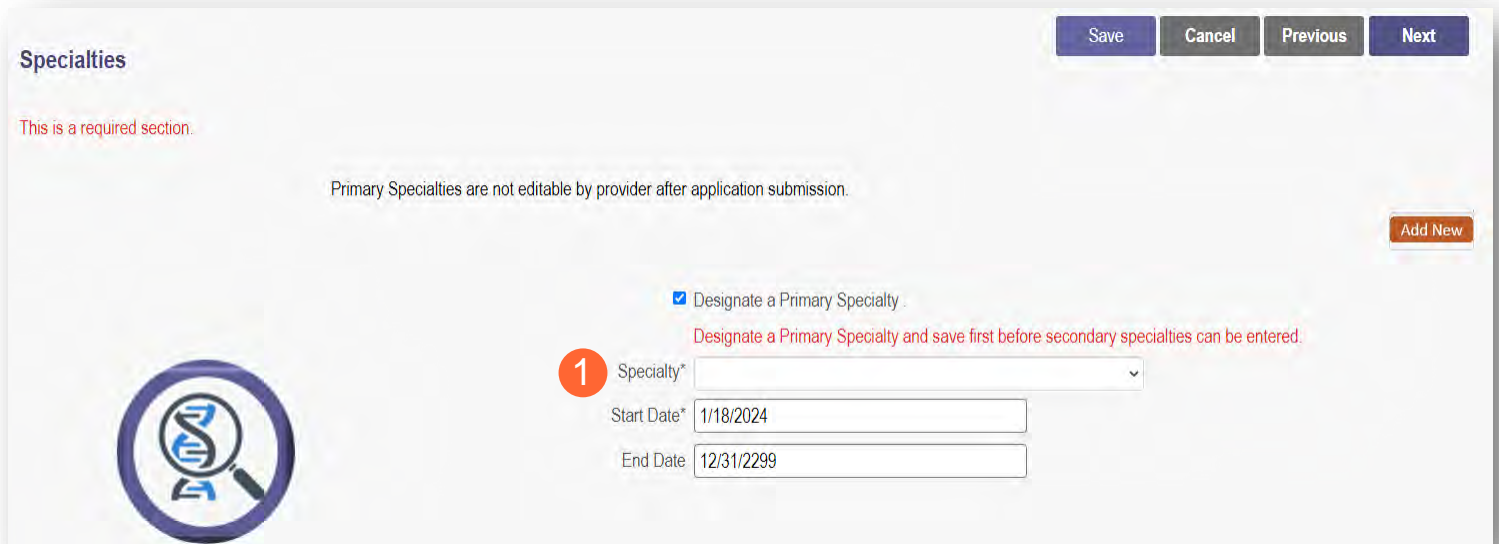
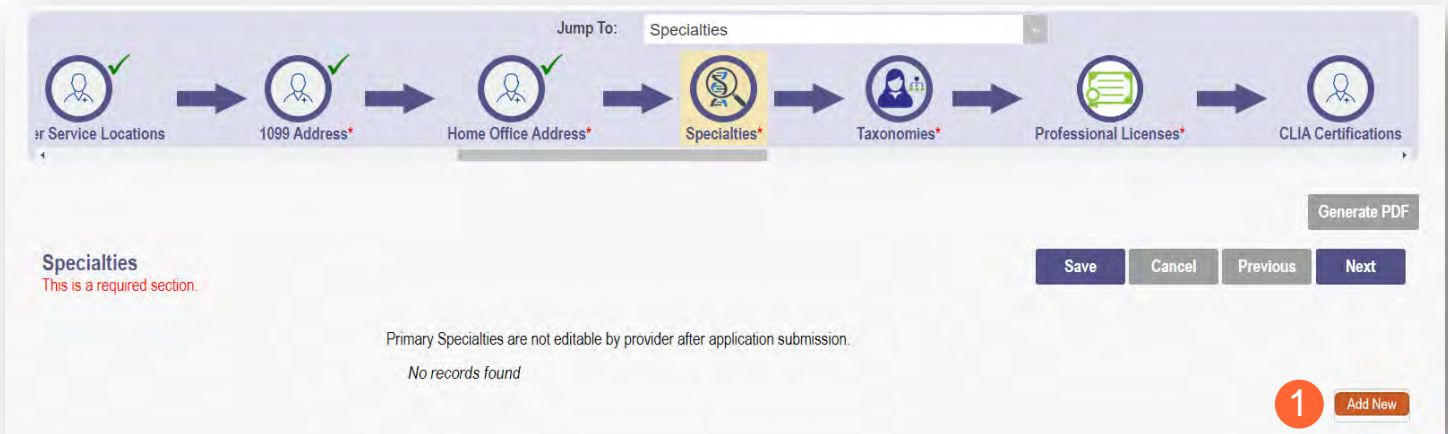
The specialty page allows for an indication of specialties for the individual practitioner.

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

Note: If a specialty needs to be added, but the specialty is in a different scope (not linked in PNM to this provider type) and does not display in the drop-down menu, please send an email to Medicaid_Provider_Update@medicaid.ohio.gov, after submitting the application. Be sure to include the Reg ID or NPI for the practitioner that needs to be updated and indicate the specialty that needs to be added.

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.’
- The Start Date field (MM/DD/YYYY) will default to the date that you are entering the information.
 - This can be backdated but cannot be prior to the provider’s effective date with Ohio Medicaid.
- The End Date field will default to an infinite date of 12/31/2299.



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.

Jump To: Specialties

2 Save Cancel Previous Next 4 PDF

Specialties
This is a required section.

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 | | |
| 420 LICENSED PSYCHOLOGIST | Yes | 01/18/2024 | 12/31/2299 | INACTIVE | | |
| 421 BOARD LICENSED SCHOOL PSYCHOLOGIST | No | 01/18/2024 | 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.

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 | | |
| 420 LICENSED PSYCHOLOGIST | Yes | 01/18/2024 | 12/31/2299 | INACTIVE | | |
| 421 BOARD LICENSED SCHOOL PSYCHOLOGIST | No | 01/18/2024 | 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

1099 Address* Home Office Address* Specialties* Taxonomies* Professional Licenses* Board Certification Medicare

Generate PDF

Save Cancel Previous Next

Taxonomies

This is a required section

| Taxonomy | Taxonomy Description | Primary | Start Date | End Date | |
|------------|---------------------------|---------|------------|------------|--|
| 101YM0800X | COUNSELOR - MENTAL HEALTH | Yes | 01/18/2024 | 12/31/2299 | |

Add New

History

BEHAVIORAL HEALTH INDIVIDUAL 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

This is a required section.

| Taxonomy | Taxonomy Description | Primary | Start Date | End Date | |
|------------|---------------------------|---------|------------|------------|---|
| 101YM0800X | COUNSELOR - MENTAL HEALTH | Yes | 01/18/2024 | 12/31/2299 |   |

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 your work and move to the next screen.


Taxonomies

This is a required section.

Save Cancel Previous Next

| Taxonomy | Taxonomy Description | Primary | Start Date | End Date | |
|------------|---------------------------|---------|------------|------------|---|
| 101YM0800X | COUNSELOR - MENTAL HEALTH | Yes | 01/18/2024 | 12/31/2299 |  |

Add New History



2 Taxonomy* Counselor, Mental Health (101YM0800X)

3 Is Primary Taxonomy

4 Start Date* 01/18/2024

End Date 12/31/2299

5 6 1

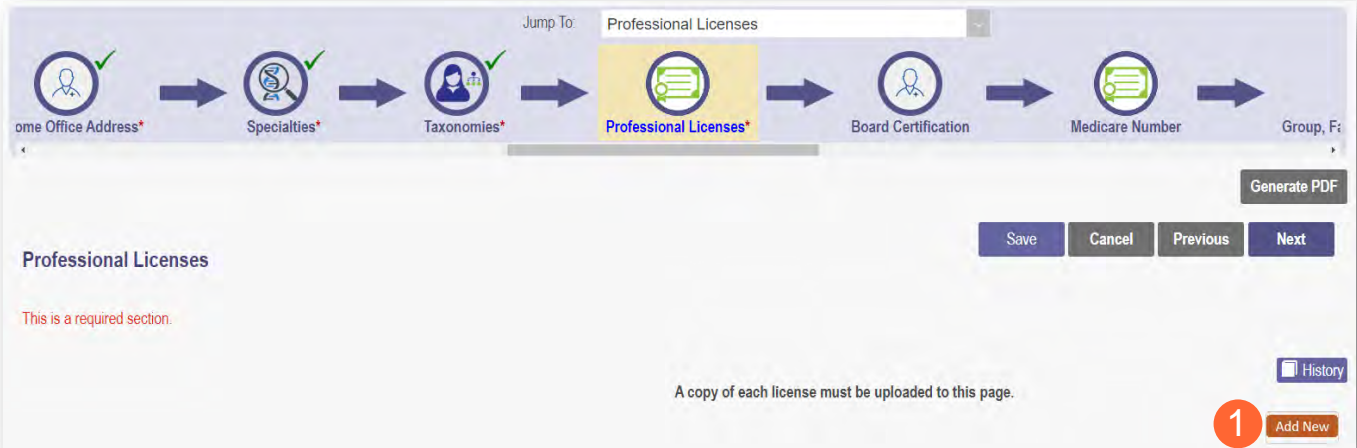
Professional Licenses

Note: License information and a copy of a valid license are not required for every provider type. Click **Next** to skip, if not required.

If the license is in Ohio, a digital Ohio e-license check may be completed after entering some preliminary details. If a successful e-license check inputs data into PNM, an upload of a license document is not required.

This page allows you to enter and upload information related to the practitioner's professional licenses.

Step 1: To add a Professional License, click **Add New**.



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

Note: Most fields will auto-populate if the license is active in Ohio and an e-license check can be completed. If this is the case, an upload of a license document is not required. Out-of-state licenses require an upload.

Step 3: If necessary, upload a copy of the 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.

Save Cancel Previous **Next** Get PDF 4

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

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

County

Zip

Endorsement Number ⓘ

Endorsement Status ⓘ

Endorsement Focus ⓘ

Endorsement Specialty ⓘ

Certifying Organization ⓘ

Certificate Date

Certificate Expiration

Uploaded Documents
Optional Document

Professional License **3** Browse

Board Certification Page

The Board Certification page allows for the ability to add any recognized board certifications.

Note: Board Certification information is not required for every provider type. Click **Next** to skip, if not required.

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

The screenshot shows a navigation bar with icons for Specialties*, Taxonomies*, Professional Licenses*, Board Certification (highlighted), CLIA Certifications, Medicare Number, and Group, Facility &. A 'Jump To:' dropdown menu is set to 'Board Certification'. Below the navigation bar, the 'Board Certification' section is titled, with a note: 'This is not a required section. To skip this section click on Next button.' There are buttons for 'Save', 'Cancel', 'Previous', and 'Next'. A 'Generate PDF' button is also present. The text 'No Board Certification found' is displayed. A red circle with the number '1' highlights an 'Add New' button in the bottom right corner.

Step 2: Click the radio button to identify if the provider is Board Certified (Yes or No).

The screenshot shows the 'Board Certification' section with the same note as above. The 'Add New' button is highlighted with a red circle and the number '2'. Below the 'No Board Certification found' text, the question 'Are you Board Certified?' is displayed with radio buttons for 'No' and 'Yes'. A note below the question reads: 'If Yes, Please enter board certification information requested or confirm previously entered information is correct'. Buttons for 'Save', 'Cancel', 'Previous', and 'Next' are visible at the top right.

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

Note: A primary board certification must be entered first before any secondary verifications can be added.

- Board Certification – *select the appropriate board.*
- Board Specialty
- Certificate Number (This is not a required field, but certification identification can be included here)
- Effective Date (Date when certification was received in MM/DD/YYYY format.)
- Expiration Date (Date the certification expires in MM/DD/YYYY format.)

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

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

Step 5: Click **Next** to save and advance to the next screen.

The screenshot shows a web form titled "Board Certification". At the top right, there are buttons for "Save", "Cancel", "Previous", and "Next". A red circle with the number "4" is placed over the "Save" button, and a red circle with the number "5" is placed over the "Next" button. Below the buttons, a message reads: "This is not a required section. To skip this section click on Next button." In the center, it says "No Board Certification found". On the right side, there is a "History" button and an "Add New" button with a red circle containing the number "4" next to it. On the left, there is a circular icon of a person with a plus sign. The main form area asks "Are you Board Certified?" with radio buttons for "No" and "Yes" (selected). Below this, it says "If Yes, Please enter board certification information requested or confirm previously entered information is correct". A red circle with the number "3" is next to a checked checkbox labeled "Designate as Primary Board Certification. Designate a primary Board Certification and save first before secondary boards can be added." Below this are five input fields: "Board Certification*" (dropdown), "Board Specialty*" (dropdown), "Certification Number" (text), "Effective Date*" (text), and "Expiration Date*" (text).

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

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.

Step 4: Click **Save** to save your work.

Step 5: Click **Next** to move to the next screen.

Medicare Number

4 Save Cancel Previo 5 Next

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

Group, Facility & Hospital Affiliations (Individual) Page


This page will allow you to indicate any group, facility, or hospital affiliations that the provider may have.

Note: This section is not required for all provider types. To skip this section, click **Next**.


Adding a Group Affiliation

Step 1: To add a Group/Organization/Agency 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

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.

If you are a provider working as a hospitalist or strictly inpatient only, Please click add new under hospital affiliations, and designate that you practice exclusively within the inpatient setting

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 | Edit | Delete |
|--------------------------------|-----|-------------|------------|----------|--------------------|---------|------|--------|
| 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

Step 2: On the Group Affiliation pop-up window, enter the Medicaid ID for the group/organization/agency the provider is requesting affiliation to.

- Click outside of the Medicaid ID field and the NPI field will automatically populate.

Step 3: Click **Save** to continue.

Step 4: Confirm the affiliation is listed on the screen (*Repeat the steps above to add additional affiliations*).

Group, Facility & Hospital Affiliations (Individual) Save Cancel Previous Next

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

If you are a provider working as a hospitalist or strictly inpatient only, Please click add new under hospital affiliations, and designate that you practice exclusively within the inpatient setting

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 | Edit | Delete |
|--------------------------|------------|-------------|------------|------------|--------------------|--|------|--------|
| 4 Training Medical Group | 1245585009 | 9999876 | 12/29/2023 | 12/31/2299 | Pending Approval | 2400 CORPORATE EXCHANGE DR STE 240 COLUMBUS, OH 43231- 7607 614-654-5000 | | |

Add New

Step 5: An individual affiliation will remain 'Pending' until the group/organization/agency confirms the affiliation. Once confirmed, the affiliation will display under the 'Confirmed Group Affiliations' section.

Group, Facility & Hospital Affiliations (Individual) Save Cancel Previous Next

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

If you are a provider working as a hospitalist or strictly inpatient only, Please click add new under hospital affiliations, and designate that you practice exclusively within the inpatient setting

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 | Edit | Delete |
|------------------------|------------|-------------|------------|------------|--------------------|--|------|--------|
| Training Medical Group | 1245585009 | 9999876 | 12/29/2023 | 12/31/2299 | Pending Approval | 2400 CORPORATE EXCHANGE DR STE 240 COLUMBUS, OH 43231- 7607 614-654-5000 | | |

Add New

5 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 |
|---|-----|-------------|------------|----------|--------------------|---------|
| <i>No confirmed affiliations found.</i> | | | | | | |

Adding a Hospital Affiliation

Step 1: Click **Add New** under the Hospital Affiliations section.

Hospital Affiliations

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

1 **Add New**

Step 2: Enter all relevant and required information:

- Do you practice exclusively within the Inpatient Setting?
- Do you have hospital privileges?
- 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 Staff Category from the drop-down menu.
- Select Status of Privileges from the drop-down menu.
- Enter the Start Date (MM/DD/YYYY)
- 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."

Hospital Affiliation

2 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*

Staff Category*

Status of Privileges*

Start Date*

End Date

Any past or present restriction of privileges? Yes No

If 'Yes', please specify

3 **Save** **Cancel**

Step 3: Click **Save** to continue.

Step 4: Confirm Hospital Affiliation has saved (*Repeat the process to add additional affiliations*).

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.

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

Save Cancel Previous Next

5 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

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

4

Delegated Credentialing

A 'Delegated Credentialing' section appears on this page. If appropriate, select the checkbox to indicate the practitioner has an agreement for delegated credentialing. Information regarding the specific delegate(s) will be updated by the ODM Credentialing staff after submission of the application.

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. | | |

Delegates can use a workaround to 'bypass' the following required credentialing pages in PNM. Please note that for accurate data report in the PNM directory, the board certification and hospital privileges information will need to be entered on the appropriate screens in PNM.

- **Professional Liability Insurance page** – Answer “No” to the ‘Carrying Malpractice Insurance’ question and enter the delegate organization/agency name as the ‘Explanation Regarding Malpractice Insurance.’
- **Education page** – List one entry only. For physicians, list the highest level of education/training for their residency/fellowship. For all other provider types, list the professional school.
- **Malpractice Claims History page** – Answer “No” to the question on this page.
- **Work History page** – List only an entry with the delegate location and start date.

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, Facility & Hospital Affiliations (Individual) → **MCP Affiliation** → Professional Liability Insurance* → Education* → Malpractice

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 | Tracking Number | MITS Specialty |
|----------------------------|------------|----------|---------------|-----------------|----------------|
| No MCP affiliations found. | | | | | |

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

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

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

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

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

Confirmed MCP Affiliations

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

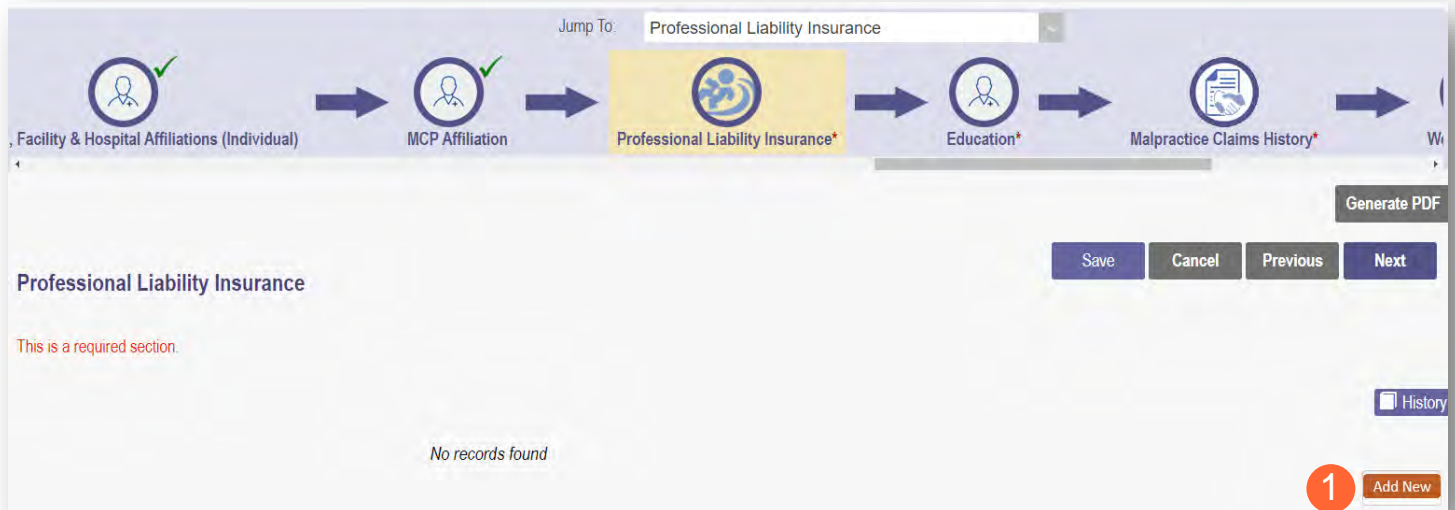
Note: Any confirmed MCP Affiliations would appear at the bottom of the page.

Professional Liability Insurance Page

This page allows for the entry of information about the provider's professional liability insurance.

Note: Professional Liability Insurance information is not required for every provider type. To bypass this page, click **Next**.

Step 1: To add professional liability insurance information, click **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 'Yes' is selected, you will be prompted to enter required corresponding information into the screen:

- Self-Insured?
- Policy Number
- Effective Date (MM/DD/YYYY)
- Original Effective Date (MM/DD/YYYY)
- Expiration Date (MM/DD/YYYY)
- 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

The screenshot shows a form titled 'Do you carry malpractice insurance?'. At the top right, there are radio buttons for 'Yes' (selected) and 'No'. A red circle with the number '2' highlights the 'Yes' radio button. Below the radio buttons, there are several input fields and dropdown menus: 'Self-Insured?' (dropdown menu with 'Yes' selected), 'Policy Number*', 'Effective Date*', 'Original Effective Date*', 'Expiration Date*', 'Type of Coverage*' (dropdown menu), 'Do you have unlimited coverage?' (checkbox), 'Policy includes tail coverage?' (checkbox), and 'Carrier or Self-Insured Name*'. Below these fields, there is a checkbox labeled 'Check here if insurance is through Federal Tort Claims Act (FTCA)'. Underneath, there are input fields for 'Carrier address 1', 'Carrier address 2', 'City*', 'State*' (dropdown menu), 'County' (dropdown menu), and 'Zip*'. At the bottom, there are input fields for 'Policy Holder*', 'Coverage Amount Per Occurrence*', and 'Coverage Amount Per Aggregate*'.

Step 3: If 'No' is selected, you will need to provide an explanation regarding malpractice insurance.

Do you carry malpractice insurance? 3 Yes No

If No, please provide explanation below.

Please provide an explanation regarding malpractice insurance

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

4 Get PDF

Professional Liability Insurance

This is a required section.

| Carrying malpractice insurance? | Policy Number | Effective Date | Expiration Date | Policy Holder | Coverage Account Per Occurrence | Coverage Account Per Aggregate | Explanation regarding malpractice insurance | Edit |
|---------------------------------|---------------|----------------|-----------------|--------------------|---------------------------------|--------------------------------|---|------|
| Yes | 4356345345 | 02/04/2023 | 02/04/2025 | Test Policy Holder | 1,000,000 | 3,000,000 | | |

Education Page

On this page, indicate all education and training that has been completed beginning with an undergraduate degree through 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 (MM/DD/YYYY)
- End Date (MM/DD/YYYY)
- Degree Awarded
- Address
- City
- State
- Zip Code
- Country

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 education.

Step 3: Click **Save** to continue.

Step 4: Confirm that the undergraduate education information saved.

Step 5: To enter additional education details, click **Add New** and follow the steps above.

Education 3 Save Cancel Previous Next

This is a required section.

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 | Edit |
|---|----------------------|----------------------|-----------|--------|------------|------------|------|
| | Undergraduate School | Undergraduate School | | MB | 08/01/2000 | 05/01/2004 | |

5 Add New
History

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

Step 7: Click **Next** to advance to the next page once all education information has been added.

Education 6 Save Cancel Previous Next 7

This is a required section.

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 | Edit |
|---|----------------------|----------------------|-----------|--------|------------|------------|------|
| | Undergraduate School | Undergraduate School | | BS | 08/01/2000 | 05/01/2004 | |
| | Professional School | Professional School | | PSYD | 06/01/2004 | 05/01/2008 | |

Add New
History

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 provider types.

Step 1: Click the **Add New** button.

- Select the ‘Yes’ or ‘No’ radio button to indicate your answer.

The screenshot shows the 'Malpractice Claims History' section. At the top right, there are buttons for 'Save', 'Cancel', 'Previous', and 'Next'. Below these, a red circle with the number '3' is next to a 'History' button. In the center, the text reads 'No MalpracticeClaim found.' At the bottom right, a red circle with the number '1' is next to an 'Add New' button. A red note at the top left says 'This is a required section.'

Yes/No Malpractice Claims History

Step 2: Complete the following:

- If ‘No’ is indicated, proceed to Step 3.
- If ‘Yes’ is indicated, complete the required information regarding each action.

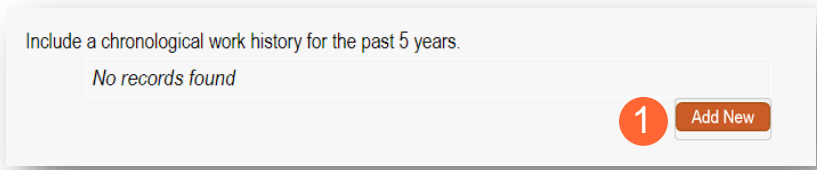
Note: Each action occurring in the past 10 years should have its own entry.

Step 3: After filling in the required fields, click **Next** to save the information and proceed to the next page.

The screenshot shows the form for adding a new malpractice claim. At the top, it asks 'Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?' with radio buttons for 'No' and 'Yes'. Below this, it says 'No MalpracticeClaim found.' and has an 'Add New' button. A red circle with the number '2' is next to the 'Date of Occurrence*' field. The form contains various input fields and dropdown menus: 'Date Claim Filed*', 'Status of the claim*' (with 'Open' selected), '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?' (with 'Primary Defendant' and 'Co-Defendant' options), 'No of Other Defendants (if any)', 'Your role in case*', 'Describe the alleged injury to the patient', 'Did the alleged injury result in death?', and 'To the best of your knowledge, is the case included in the NPDB?' (with 'Yes' selected).

Work History Page

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



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

- Select the check box for ‘Current Employer’ for to list the provider’s current employer.
- Enter the relevant and required fields:
 - Practice Employer Name
 - Start Date (MM/DD/YYYY)
 - End Date (MM/DD/YYYY)
 - 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)
 - Currently on active military duty or military reserve?

1 Current Employer

*Practice/ Employer Name:

* Start Date:

* End Date:

Organization Name*

Address 1*

Address 2

City*

State*

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?

Step 2: Click **Save** and 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 steps listed above.

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 (MM/DD/YYYY)
 - Gap End Date (MM/DD/YYYY)
 - Reason for Gap

Step 5: Click **Save** to save the work/gap details then click **Next** to advance to the next page.

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.

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.

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

EFT Banking Information Page

This page requires to you 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.

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.

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.

Generate PDF

10

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**.

Optional Document

Documentation of Training/Certification

Browse
1

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

Malpractice 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.

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

No file chosen

Name

Description

Upload file

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.

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: 1/18/2024

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.'

3 If you meet this provision, please check this box

Step 4: Complete the Additional Credentialing Statement questions if the 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 your full name as the person attesting.
- Confirm Provider Name and User ID auto-filled correctly.

Step 8: Click **Save**.

- A pop-up appears confirming your application is complete.

Provider Agreement Signature

7 Name of Person Attesting*: Tom Trainer ⓘ

Provider Name: John Trainer

User ID: testbh

8 Save

Step 9: 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.

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.

Jump To: Agreements

Education* Malpractice Claims History* Work History* W9 Form* EFT Banking* Required Documents Agreements*

Generate PDF

1 Submit for Review

Save Cancel Previous Next

Agreements

This is a required section.

Ohio Medicaid Provider Agreement

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

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

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: John Trainer

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: 518415

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 |
|--------|--------------|--------------------|----------------|------------|-------------|---------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 518415 | John Trainer | Return to Provider | 42 - PSYCHOLOG | 1285323642 | | LICENSED PSYCHOLOGI | | | | | 01/18/2024 | |

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: John Trainer Medicaid ID: Effective Date: Revalidation Due Date: Term Date:

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 | Workflow Complete |
|--------|--|----------|----------------|------------------------|---------------------------------|-----------------|-------------|-------------------|
| 518415 | Application Flow - Standard - NEW REGISTRATION | Medicaid | 606874 | Return to Provider | | | 01/18/24 | 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](#)

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**.

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 Subject | Correspondence Type | Date Sent | Date Viewed |
| Send Additional Information (RTP Notice) | ENROLLMENT | 12/26/2023 | |
| Ohio Medicaid Provider Application Received | 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 as a PDF.

Completing Return to Provider (RTP) Process

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

Provider Management Home

Registration Information Previous Page

Provider Name: John Trainer Medicaid ID: Effective Date: Revalidation Due Date: Term Date:

Manage Application

Enrollment Actions **1** + Enrollment Action Selections: [collapse icon]

Programs + Program Selections:

Self Service + Self Service Selections:

My Current and Previous Applications [collapse icon]

| Reg ID | Enrollment Action | Program | Application Id | PNM Application Status | Other Agency Application Status | DD Legal Status | Status Date | Workflow Complete |
|--------|--|----------|----------------|------------------------|---------------------------------|-----------------|-------------|-------------------|
| 518415 | Application Flow - Standard - NEW REGISTRATION | Medicaid | 606874 | Return to Provider | | | 01/18/24 | N |

Step 2: Click the 'Continue Registration' hyperlink.

Manage Application

Enrollment Actions

2 - Enrollment Action Selections: [collapse icon]

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

[help icon]

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.
Note: This is the same messaging that appeared in the correspondence.

Step 4: Correct or update the information on the page.

The screenshot shows a web application interface. At the top, a message states: "The license you provided is expired. Please provide a current license. (P042) - License expired on 8/1/2021". A red circle with the number 3 is next to this message. Below the message is a progress bar with icons for Home Office Address, Specialties, Taxonomies, Professional Licenses, Board Certification, Medicare Number, and Group, Facility. The Professional Licenses icon has a yellow background and a red circle with the number 3. Below the progress bar, the "Professional Licenses" section is highlighted. A red circle with the number 5 is next to the "Save" button. Below the section title, it says "This is a required section." and "A copy of each license must be uploaded to this page." Below this is a table with the following data:

| License Number | License Board | License State | Effective Date | Expiration Date | Address | Endorsement |
|----------------|--------------------|---------------|----------------|-----------------|---------|-------------|
| CR5435345543 | Chiropractic Board | OH | 6/1/2018 | 6/1/2023 | | |

A red circle with the number 4 is next to the first row of the table. At the bottom right of the table, there is an "Add New" button. Below the table, there are buttons for "Save", "Cancel", "Previous", and "Next". A "Generate PDF" button is also visible.

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.**

A red circle with the number 5 is next to the "OK" button.

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

Jump To: Professional Licenses

Specialties* Taxonomies* Professional Licenses* Board Certification Medicare Number Group, Facility & Hospital Affiliations (Individual)

Generate PDF

6 Submit for Review

Save Cancel Previous Next

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

No Board Certification found

Add New

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

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

7 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.

8 Return to Home Page

Submitting a Plan of Correction (Response to Notice of Operational Deficiency)

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 this.

Step 2: Access the application, which will be in 'Return to Provider for Site Visit' 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 |
|--------|---------------|-----------------------------------|------------------|------------|-------------|-----------------------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 517918 | Test Training | Return to Provider For Site Visit | 37 - SOCIAL WORK | 1912011818 | | LICENSED INDEPENDEN SOCIAL WORKER | | | | | 01/26/2022 | |

Step 3: Under the Manage Application section, click the '+' icon to expand 'Enrollment Actions.'

Provider Management Home
Registration Information

Previous Page

Provider Name: Test Training
 Medicaid ID:
 Effective Date:
 Revalidation Due Date:
 Term Date:

Manage Application

Enrollment Actions **3** + Enrollment Action Selections:

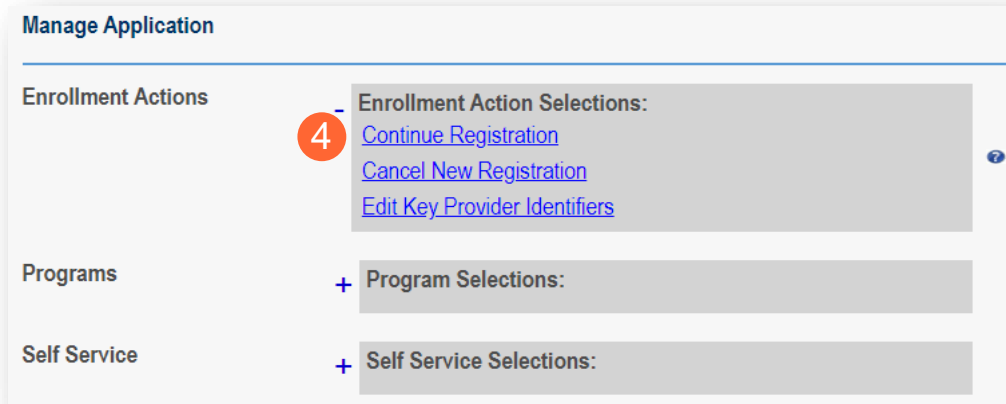
Programs + Program Selections:

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 |
|--------|---|----------|----------------|-----------------------------------|---------------------------------|-----------------|-------------|-------------------|
| 517965 | Application Flow - Standard - UPDATE REGISTRATION | Medicaid | 606117 | Return to Provider For Site Visit | | | 02/27/24 | N |

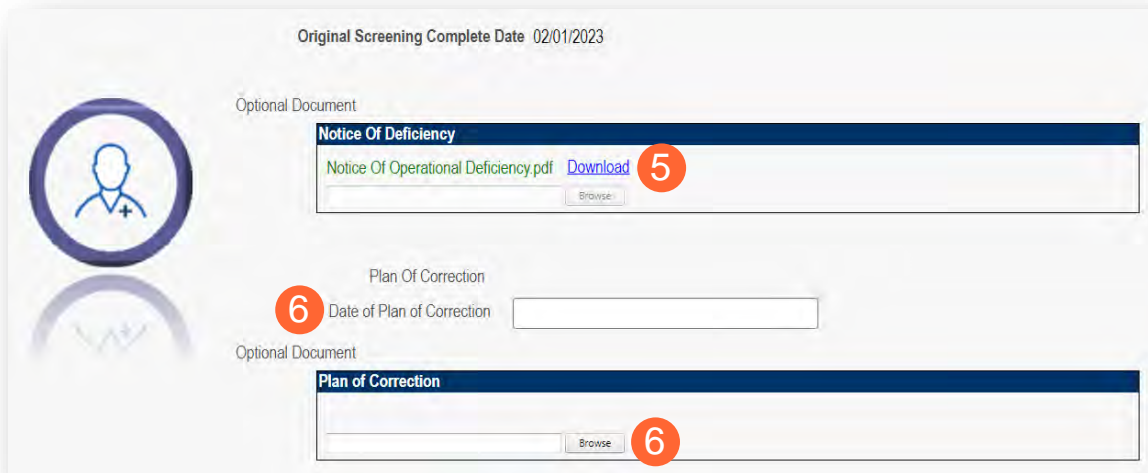
Step 4: To access the application, click 'Continue Registration.'



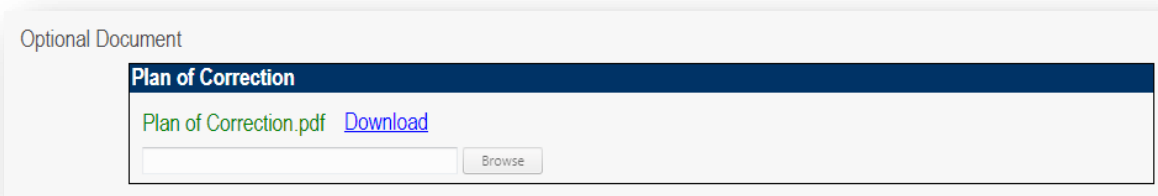
Step 5: You will be redirected to the 'Site Visit Screening' page where you will find the Notice of Operational Deficiency (NOD) issued by the Ohio Department of Medicaid (ODM). To view the Notice, click 'Download.'

Step 6: To address the Notice of Operational Deficiency (NOD), create a Plan of Correction (POC).

- Once developed, enter the date of the Plan of Correction (POC) in the space provided.
- Upload the Plan document by clicking **Browse** and choosing the file from your computer.



Note: To confirm the document uploaded successfully, the name of the document will appear in green text.



Note: If additional Notice of Operational Deficiency indications 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 Correction documents to address the information listed in the Notice of Operational Deficiency. Once the document has been added, click **Upload file**.

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

Step 7: Once uploaded, click **Plan of Correction**. This will send the file back to ODM for review.

Jump To: Site Visit Screening

ice Claims History* → Work History* → W9 Form* → EFT Banking* → 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 02/01/2023

Optional Document

Notice Of Deficiency

Notice Of Operational Deficiency.pdf [Download](#)

Plan Of Correction

Date of Plan of Correction

Optional Document

Plan of Correction

Plan of Correction.pdf [Download](#)

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.

| Reg ID | Provider | Status | Provider Type | NPI | Medicaid ID | Specialty | DD Contract Number | DD Facility Number | Location | Effective Date | Submit Date | Revalidation Due Date |
|------------------------|------------------------------|----------|----------------|------------|-------------|---------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 518415 | John Trainer | Complete | 42 - PSYCHOLOG | 1285323642 | 0000204 | LICENSED PSYCHOLOGI | | | | 01/18/2024 | 01/18/2024 | 01/18/2029 |

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.

| Reg ID | Provider | Status | Provider Type | NPI | Medicaid ID | Specialty | DD Contract Number | DD Facility Number | Location | Effective Date | Submit Date | Revalidation Due Date |
|------------------------|------------------------------|----------|----------------|------------|-------------|---------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 518415 | John Trainer | Complete | 42 - PSYCHOLOG | 1285323642 | 0000204 | LICENSED PSYCHOLOGI | | | | 01/18/2024 | 01/18/2024 | 01/18/2029 |

Completing an Update to a Medicaid Record

Review the PNM [Provider Education & Training Resources](#) page for guides containing steps for specific PNM page updates.

Step 1: Access the application in your dashboard by clicking on the link listed under Reg ID or 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 |
|--------|--------------|----------|----------------|------------|-------------|---------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 518415 | John Trainer | Complete | 42 - PSYCHOLOG | 1285323642 | 0000204 | LICENSED PSYCHOLOGI | | | | 01/18/2024 | 01/18/2024 | 01/18/2029 |

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

Provider Management Home

Registration Information

Provider Name: Test Training | Medicaid ID: 9999883 | Effective Date: 03/09/2022 | Revalidation Due Date: 03/23/2022 | Term Date:

Manage Application

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

Programs: + Program Selections: [dropdown arrow]

Self Service: + Self Service Selections: [dropdown arrow]

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

Note: A pop-up window displays informing you that you have 10 days to complete and submit the update. Click **OK** to proceed.

Manage Application

Enrollment Actions

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


Step 4: Choose which element on the application you wish to update from the provided list and click **Update** to be taken to that page.

Note: All updates, including changes to owner information, license information, address information, service locations, contact information, affiliations, etc. are completed through this same process.

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.

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

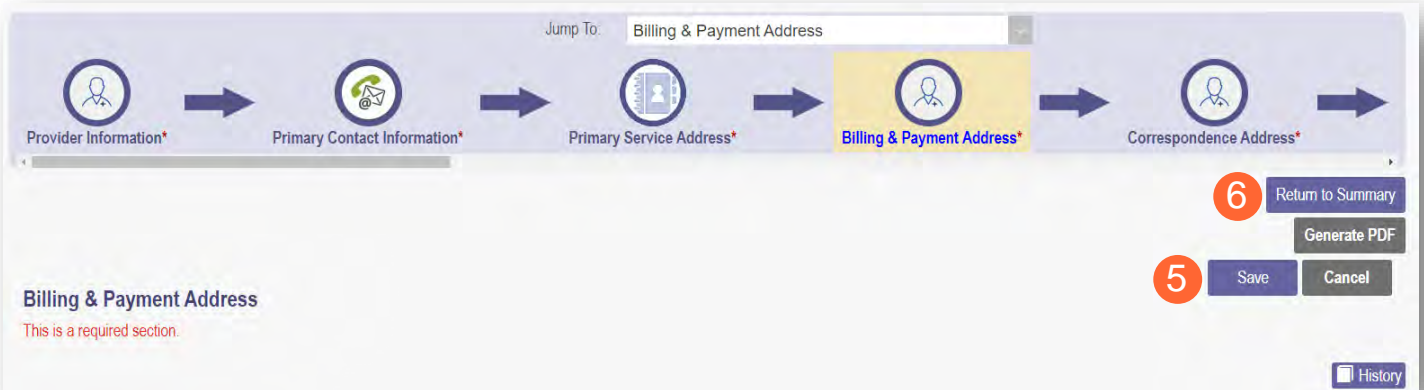


- [Update](#) Office Information
- [Update](#) Billing & Payment Address
- [Update](#) Correspondence Address
- [Update](#) Other Service Locations
- [Update](#) 1099 Address
- [Update](#) Home Office Address

Step 5: Update the application page that you selected and click **Save** once finished.

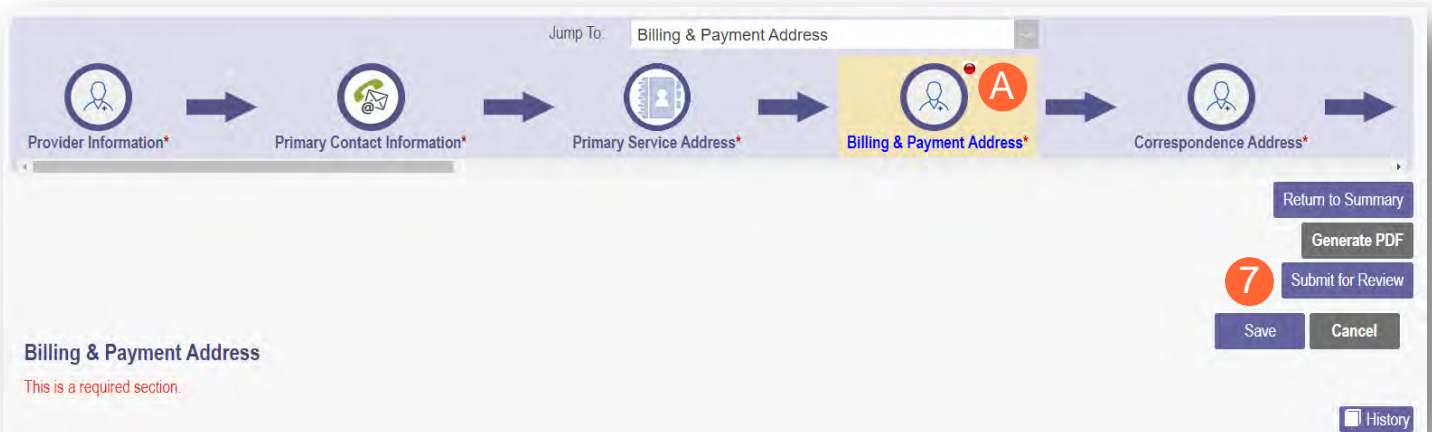
Note: A red dot will display on the updated page once it is saved (A) (see screenshot below Step 7)

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

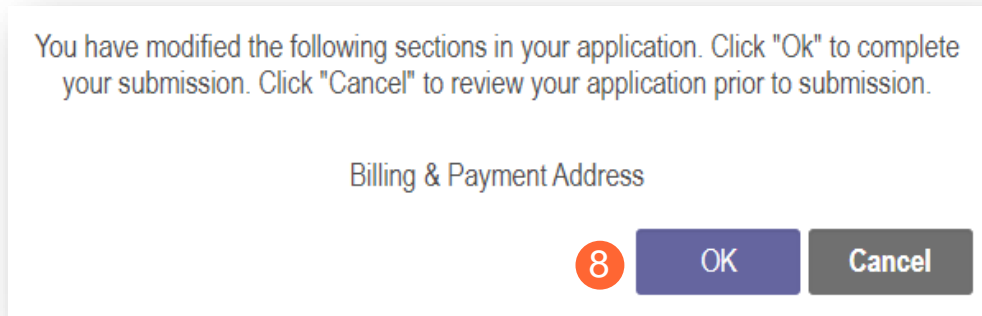


Step 7: Once all pages are updated, click **Submit for Review**.

Note: For an update to be processed correctly, the application must be submitted. Updates made without submitting will result in the updated information being 'lost' after the 10-day period.

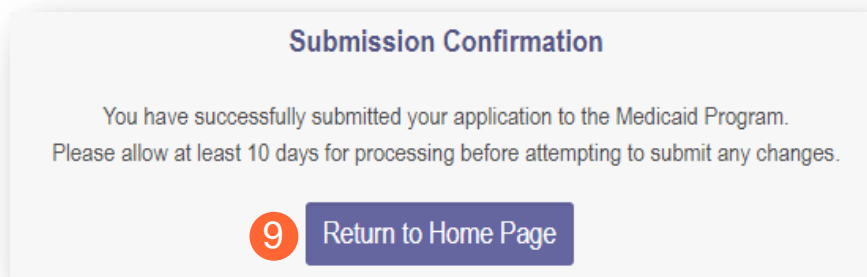


Step 8: A pop-up window displays confirming which page(s) received an update. Click **OK** to complete the submission.



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

- Click the **Return to Home Page** button to go to your dashboard.



Note: Depending on the information that was updated, the processing time for the updated data to display on the Medicaid record may vary.

For example, updates to a Billing & Payment Address or to Primary Contact Information may be processed in a matter of minutes/hours. However, changes to the Primary Service Address or changes to Specialties make take days/weeks to be fully processed. Please contact ODM Enrollment directly for status updates.

Updating Professional License Information

The steps below outline how to make changes to license information or add a new license to an existing individual's Medicaid record.

Step 1: Access the application on your dashboard by clicking on the link listed under Reg ID or 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 |
|--------|--|----------|--------------------------|------------|-------------|---|--------------------|--------------------|--------------|----------------|-------------|-----------------------|
| 518278 | 1 Bridget Adams | Complete | 54 - CHEMICAL DEPENDENCY | 1013542000 | 0000102 | CHEMICAL DEPENDENCY COUNSELOR ASSISTANT | | | 43231 - 7605 | 01/22/2023 | 02/10/2023 | 01/22/2028 |

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

Provider Management Home

Registration Information

Previous Page

| | | | | |
|---------------|-------------|----------------|-----------------------|-----------|
| Provider Name | Medicaid ID | Effective Date | Revalidation Due Date | Term Date |
| Bridget Adams | 0000102 | 01/22/2023 | 01/22/2028 | |

Manage Application

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

Programs + Program Selections: [icon]

Self Service + Self Service Selections: [icon]

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

Manage Application

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

- [Begin ODM Enrollment Profile Update](#)
- [Edit Key Provider Identifiers](#)
- [Request Disenrollment](#)

Step 4: Click **Update** next to Professional Licenses.

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.

Most Common Updates



4

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

Step 5: To edit the existing license information, click the 'pencil and paper' icon for the license that needs to be edited.

Professional Licenses Save Cancel

This is a required section.

History

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

| License Number | License Board | License State | Effective Date | Expiration Date | Address | Endorsement | |
|----------------|---|---------------|----------------|-----------------|---------|-------------|----------------|
| 66680112 | CHEMICAL DEPENDENCY PROFESSIONALS BOARD | OH | 1/25/2023 | 1/25/2024 | | | 5 |

Add New

Step 6: Update the license details.

Note: If the license is issued by the state of Ohio, PNM will make a call to the Ohio e-license system. If the call is successful, information will be returned and may be grayed out, not allowing for manual changes.

History

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

| License Number | License Board | License State | Effective Date | Expiration Date | Address | Endorsement | |
|----------------|---|---------------|----------------|-----------------|---------|-------------|---|
| 66680112 | CHEMICAL DEPENDENCY PROFESSIONALS BOARD | OH | 1/25/2023 | 1/25/2024 | | | 📄 ✖ |

Add New

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

6
State*

License Board Name*

If Other, enter Board Name:

License Number*

Effective Date*

Expiration Date*

License Status

Address 1

Address 2

City

State

County

Zip

Endorsement Number

ⓘ

Endorsement Status

ⓘ

Endorsement Focus

ⓘ

Endorsement Specialty

ⓘ

Certifying Organization

ⓘ

Certificate Date

Certificate Expiration

Step 7: Once information has been updated, click **Save**.

Step 8: If an additional license needs to be added, click **Add New** and [follow the steps](#) to add a professional license.

Professional Licenses

This is a required section.

History

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

| License Number | License Board | License State | Effective Date | Expiration Date | Address | Endorsement |
|----------------|---|---------------|----------------|-----------------|---------|-------------|
| 66680112 | CHEMICAL DEPENDENCY PROFESSIONALS BOARD | OH | 1/25/2023 | 1/25/2024 | | |

Add New

7 Save Cancel

Step 9: Once the license information has been changed, click **Submit for Review** to update the file.

Return to Summary

Generate PDF

9 Submit for Review

Save Cancel

Updating Specialties

The steps below outline how to make changes to specialty information or add new specialties to an existing individual's Medicaid record.

Step 1: Access the application on your dashboard by clicking on the link listed under Reg ID or 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 |
|--------|---------------|----------|--------------------------|------------|-------------|---|--------------------|--------------------|--------------|----------------|-------------|-----------------------|
| 518278 | Bridget Adams | Complete | 54 - CHEMICAL DEPENDENCY | 1013542000 | 0000102 | CHEMICAL DEPENDENCY COUNSELOR ASSISTANT | | | 43231 - 7605 | 01/22/2023 | 02/10/2023 | 01/22/2028 |

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

Provider Management Home

Registration Information

Previous Page

| | | | | |
|---------------|-------------|----------------|-----------------------|-----------|
| Provider Name | Medicaid ID | Effective Date | Revalidation Due Date | Term Date |
| Bridget Adams | 0000102 | 01/22/2023 | 01/22/2028 | |

Manage Application

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

Programs + Program Selections: [icon]

Self Service + Self Service Selections: [icon]

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

Manage Application

Enrollment Actions

3 - Enrollment Action Selections:

- [Begin ODM Enrollment Profile Update](#)
- [Edit Key Provider Identifiers](#)
- [Request Disenrollment](#)

Step 4: Click **Update** next to Specialties.

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.

Licenses and Classifications



- 4 Update **Specialties**

- Update **Taxonomies**

- Update **Board Certification**

- Update **CLIA Certifications**

- Update **Medicare Number**

- Update **Federal DEA Registration**

- Update **Education**

Step 5:

- To edit an existing secondary specialty, click the ‘pencil and paper’ icon for the specialty that needs to be edited.
- To indicate an additional specialty, click **Add New**.

Note: If changing to a new primary specialty, add the new specialty first. Then, to change the primary, please send an email to Medicaid_provider_update@medicaid.ohio.gov indicating the provider and specialty that should be the primary.

Specialties

Save Cancel

This is a required section.

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 | | |
| 540 LICENSED INDEPENDENT CHEMICAL DEPENDENCY COUNSELOR | Yes | 01/25/2023 | 12/31/2299 | ACTIVE | | |
| 542 CHEMICAL DEPEND COUNSELOR II | No | 06/01/2023 | 12/31/2299 | ACTIVE | 5 | |



5 Add New
History

Step 6: Enter the specialty details.

Note: If a specialty needs to be added to the record and the specialty does not appear on the specialty drop-down list, please send an email to Medicaid_provider_update@medicaid.ohio.gov indicating the provider and specialty that needs to be added. The ODM Enrollment team will then add this specialty to the record.

6 Specialty*

Start Date*

End Date

Step 7: Once information has been updated, click **Save**.

Note: An added specialty will appear on the table with a red 'x' under the Delete column. To remove the specialty added during this update process, click the red 'x' (A).

Specialties 7 Save Cancel

This is a required section.

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 | | |
| 540 LICENSED INDEPENDENT CHEMICAL DEPENDENCY COUNSELOR | Yes | 01/25/2023 | 12/31/2299 | ACTIVE | | |
| 541 CHEMICAL DEPEND COUNSELOR III | No | 12/26/2023 | 12/31/2299 | ACTIVE | | |
| 542 CHEMICAL DEPEND COUNSELOR II | No | 06/01/2023 | 12/31/2299 | INACTIVE | | (A) |

Add New
History

Step 8: Once the license information has been changed, click **Submit for Review** to update the file.

8

Return to Summary

Generate PDF

Submit for Review

Save Cancel

Request Disenrollment

A disenrollment request ends the provider’s enrollment with the Ohio Department of Medicaid.

Step 1: Access the file in your dashboard by clicking on link listed under Reg ID or 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 |
|--------|---------------|----------|--------------------------|------------|-------------|---|--------------------|--------------------|--------------|----------------|-------------|-----------------------|
| 518278 | Bridget Adams | Complete | 54 - CHEMICAL DEPENDENCY | 1013542000 | 0000102 | CHEMICAL DEPENDENCY COUNSELOR ASSISTANT | | | 43231 - 7805 | 01/22/2023 | 02/10/2023 | 01/22/2028 |

Step 2: Under the Manage Application, click the ‘+’ icon to expand the ‘Enrollment Action Selections.’

Provider Management Home

Registration Information

[Previous Page](#)

| Provider Name | Medicaid ID | Effective Date | Revalidation Due Date | Term Date |
|---------------|-------------|----------------|-----------------------|-----------|
| Bridget Adams | 0000102 | 01/22/2023 | 01/22/2028 | |

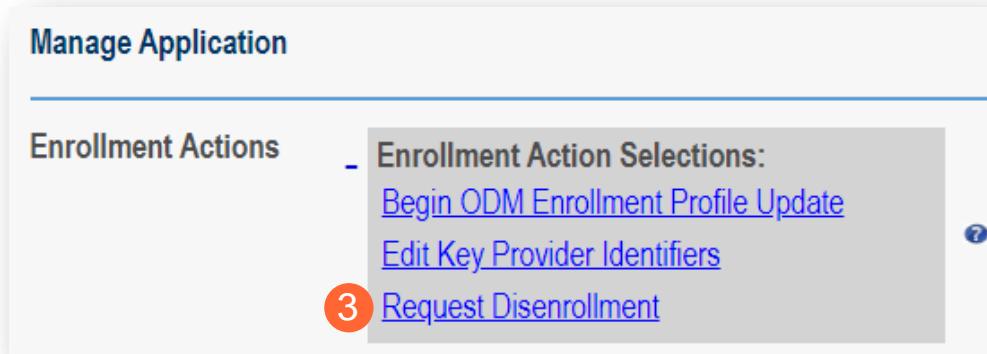
Manage Application

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

Programs + Program Selections:

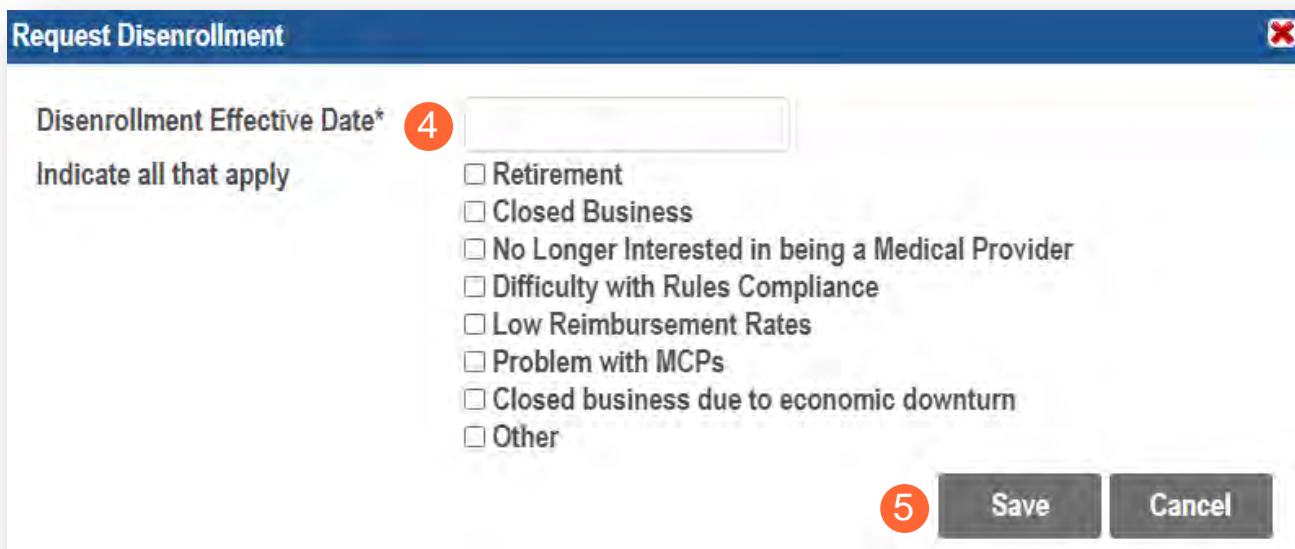
Self Service + Self Service Selections:

Step 3: Click 'Request Disenrollment' from the options provided.



Step 4: A pop-up window displays. Enter the Disenrollment Effective Date in the line provided and select a checkbox for the reason the disenrollment is being requested.

Step 5: Once entered, click **Save**.



Note: Once the disenrollment is submitted, it will be reviewed and processed by the Ohio Department of Medicaid Enrollment Team.

A status of 'Disenrolled' will display on the provider dashboard once the disenrollment has been processed.

To obtain a status update the disenrollment, please contact the ODM Integrated Help Desk at 1-800-686-1516.

Changing Provider Types

For Behavioral Health providers, if the practitioner is changing provider types (Ex. the provider is going from a Provider Type 96 to a Provider Type 54). The process for changing provider type is to request disenrollment of the 'current' provider, have ODM Enrollment process the disenrollment, and then enroll under the new provider type with a [new enrollment application](#).

Step 1: Access the file in your dashboard by clicking on link listed under Reg ID or 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 |
|--------|---------------|----------|--------------------------|------------|-------------|---|--------------------|--------------------|--------------|----------------|-------------|-----------------------|
| 518278 | Bridget Adams | Complete | 54 - CHEMICAL DEPENDENCY | 1013542000 | 0000102 | CHEMICAL DEPENDENCY COUNSELOR ASSISTANT | | | 43231 - 7605 | 01/22/2023 | 02/10/2023 | 01/22/2028 |

Step 2: Under the Manage Application, click the '+' icon to expand the 'Enrollment Action Selections.'

Provider Management Home

Registration Information

Previous Page

| | | | | |
|---------------|-------------|----------------|-----------------------|-----------|
| Provider Name | Medicaid ID | Effective Date | Revalidation Due Date | Term Date |
| Bridget Adams | 0000102 | 01/22/2023 | 01/22/2028 | |

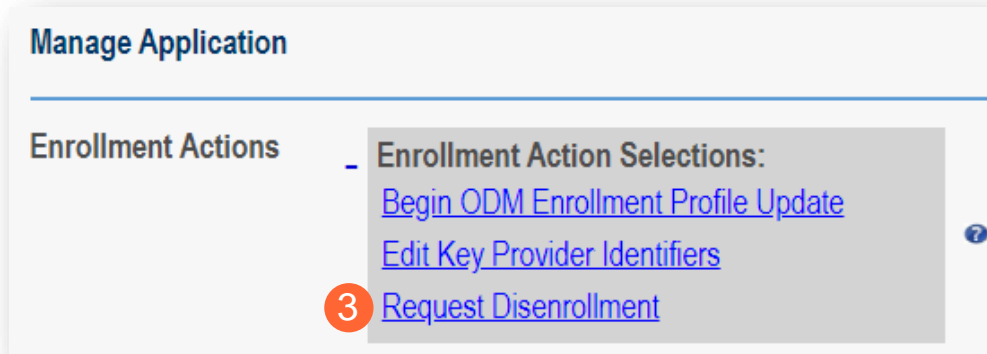
Manage Application

Enrollment Actions + Enrollment Action Selections: [icon]

Programs + Program Selections:

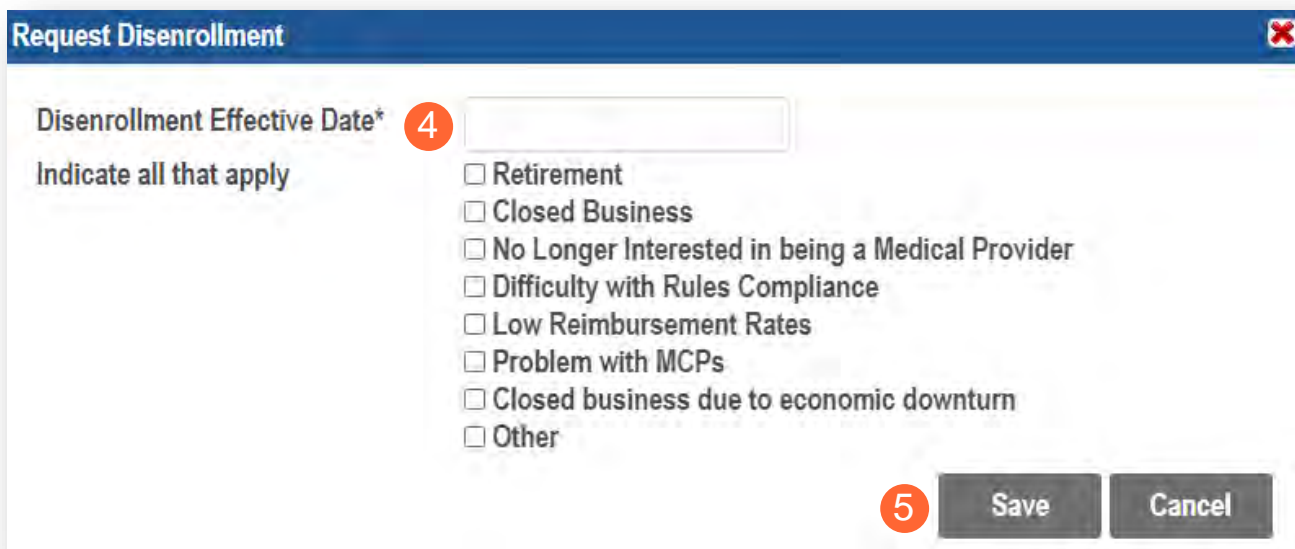
Self Service + Self Service Selections:

Step 3: Click 'Request Disenrollment' from the options provided.



Step 4: A pop-up window displays. Enter the Disenrollment Effective Date in the line provided and select a the 'Other' checkbox for the reason the disenrollment is being requested.

Step 5: Once entered, click **Save**.



Note: Once the disenrollment is submitted, it will be reviewed and processed by the Ohio Department of Medicaid Enrollment Team.

A status of 'Disenrolled' will display on the provider dashboard once the disenrollment has been processed.

To obtain a status update the disenrollment, please contact the ODM Integrated Help Desk at 1-800-686-1516.

Reapplication Steps (Enrollment Terminated)

Reapplication may be needed if a provider’s enrollment is terminated by the Ohio Department of Medicaid. The steps below indicate how to reapply, using the same Medicaid ID.

Step 1: Access the file in your dashboard that has been terminated by clicking on link listed under Reg ID or 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 |
|--------|---------------|------------|------------------|------------|-------------|-----------------------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 517919 | Test Training | Terminated | 37 - SOCIAL WORK | 1912011818 | 9999876 | LICENSED INDEPENDEN SOCIAL WORKER | | | | 02/09/2022 | 02/14/2024 | 02/09/2027 |

Step 2: Under the Manage Application, click the ‘+’ icon to expand the ‘Enrollment Action Selections.’

Provider Management Home

Registration Information

Previous Page

Provider Name: Test Training
 Medicaid ID: 9999883
 Effective Date: 03/09/2022
 Revalidation Due Date: 03/23/2022
 Term Date:

Manage Application

Enrollment Actions + Enrollment Action Selections: [icon]

Programs + Program Selections:

Self Service + Self Service Selections:

Step 3: Click the ‘Begin Reapplication’ hyperlink.

Note: If the reapplication process has been started, but has not been submitted, the link will show ‘Continue Reapplication.’

Enrollment Actions

- Enrollment Action Selections:

3 [Begin Reapplication](#)

[Edit Key Provider Identifiers](#)

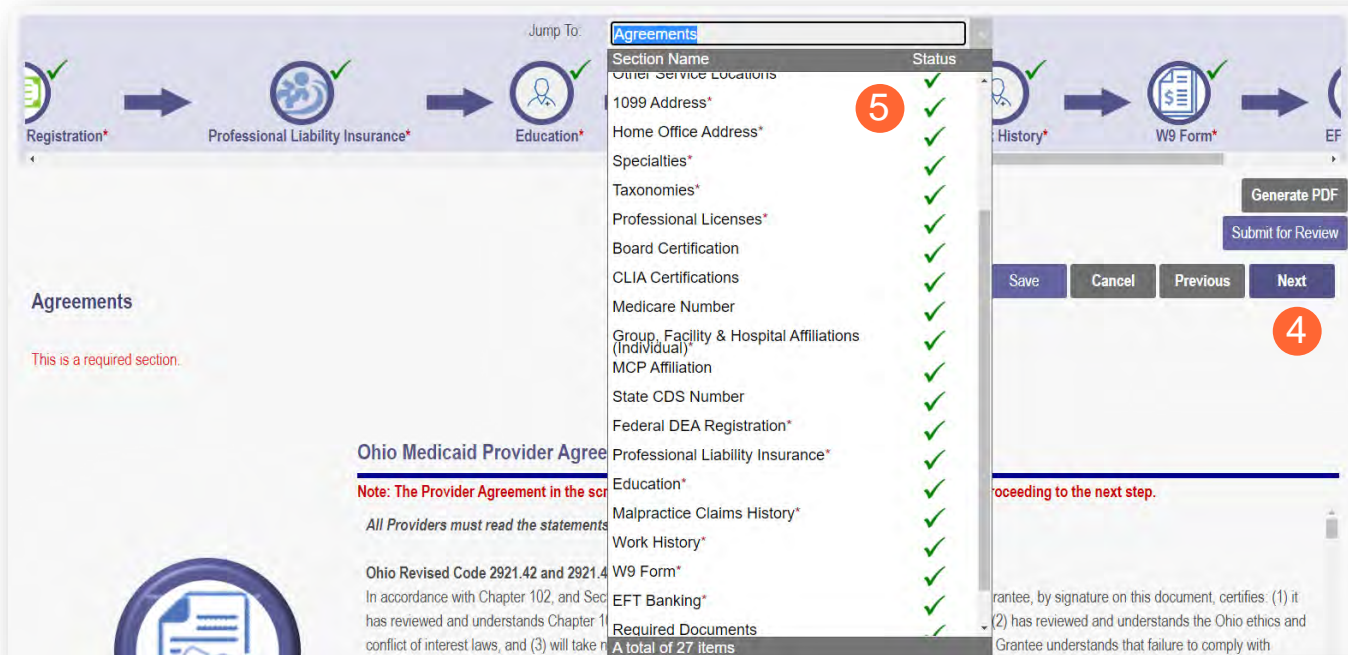
Step 4: Either change the information listed on the page OR review the information on the page and make no changes if it remains accurate.

Click **Next** to save and proceed to the next page.

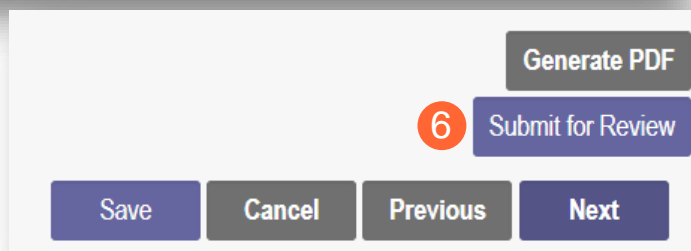
Note: Regardless of whether changes are made, each page needs to be reviewed and saved.

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: Application submission will not be available unless all required pages have a green checkmark.



Step 6: Once all pages have been completed, click **Submit for Review** to submit your application.



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. Email notices will be sent to the Primary Contact listed on the Medicaid record when the provider is due for revalidation/re-enrollment. The revalidation due date can also be viewed in the far-right column on the dashboard.

Note: The link to 'Begin Revalidation' will appear under the Enrollment Action Selections when the practitioner is within 120 days of the revalidation due date.

Step 1: Access the file in your dashboard by clicking on link listed under Reg ID or 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 |
|--------|---------------|----------|--------------------------|------------|-------------|---|--------------------|--------------------|--------------|----------------|-------------|-----------------------|
| 518278 | Bridget Adams | Complete | 54 - CHEMICAL DEPENDENCY | 1013542000 | 0000102 | CHEMICAL DEPENDENCY COUNSELOR ASSISTANT | | | 43231 - 7605 | 01/22/2023 | 02/10/2023 | 01/22/2028 |

Step 2: Under the Manage Application, click the '+' icon to expand the 'Enrollment Action Selections.'

Provider Management Home

Registration Information

Previous Page

Provider Name: Bridget Adams
 Medicaid ID: 0000102
 Effective Date: 01/22/2023
 Revalidation Due Date: 01/22/2028
 Term Date:

Manage Application

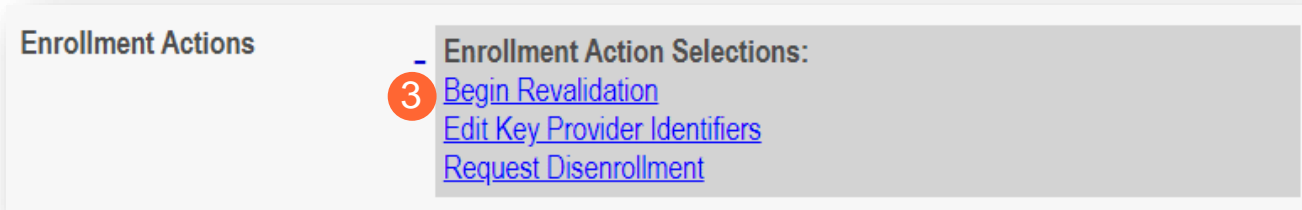
Enrollment Actions **2** + Enrollment Action Selections:

Programs + Program Selections:

Self Service + Self Service Selections:

Step 3: Click the 'Begin Revalidation' hyperlink.

Note: If the revalidation process has been started, but not submitted, the link will show 'Continue Revalidation.'



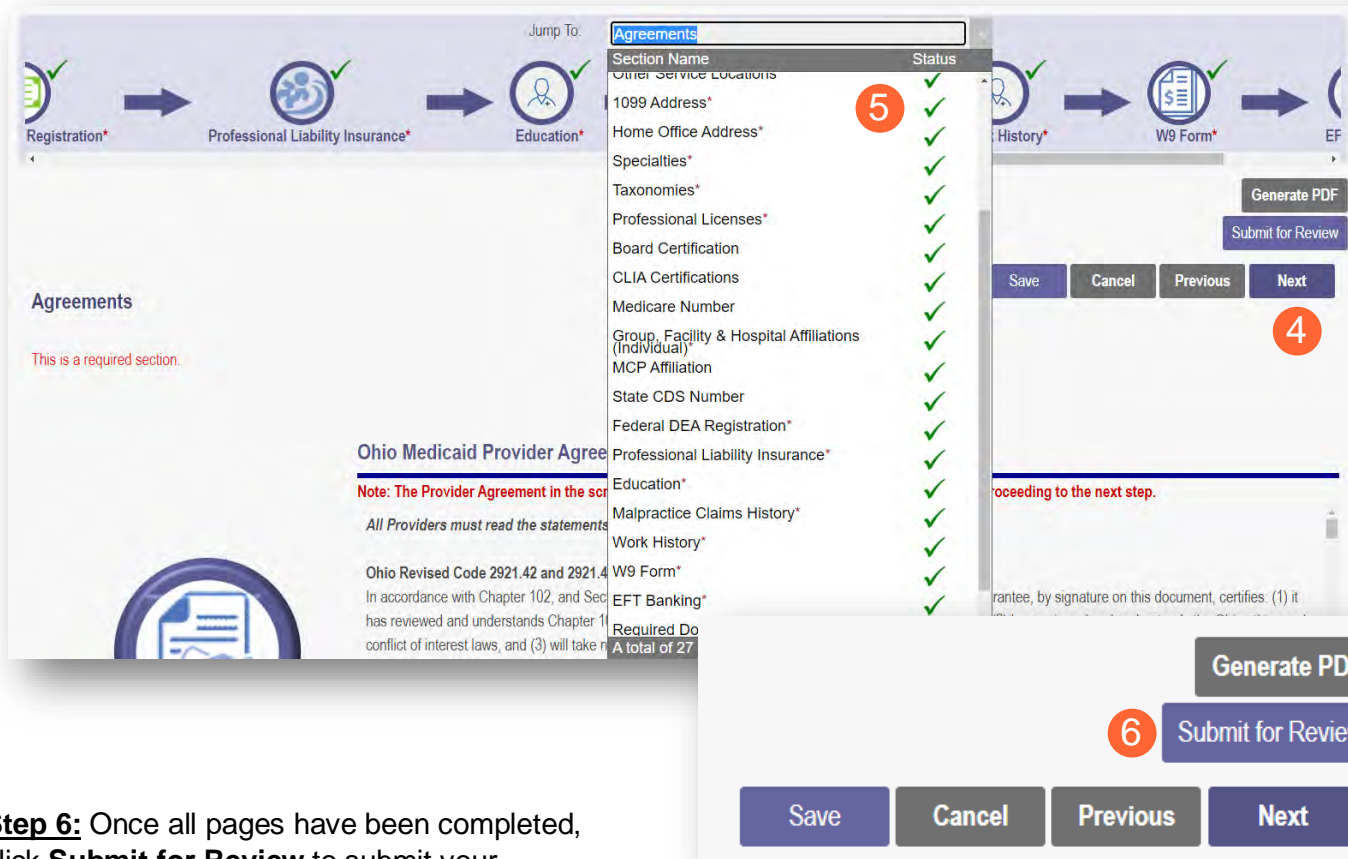
Step 4: Either change the information listed on the page OR review the information on the page and make no changes if it remains accurate.

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: Application submission will not be available unless all required pages have a green checkmark.



Step 6: Once all pages have been completed, click **Submit for Review** to submit your application for Revalidation.