

**USER MANUAL**

# **Provider Enrollment Applications**

**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.

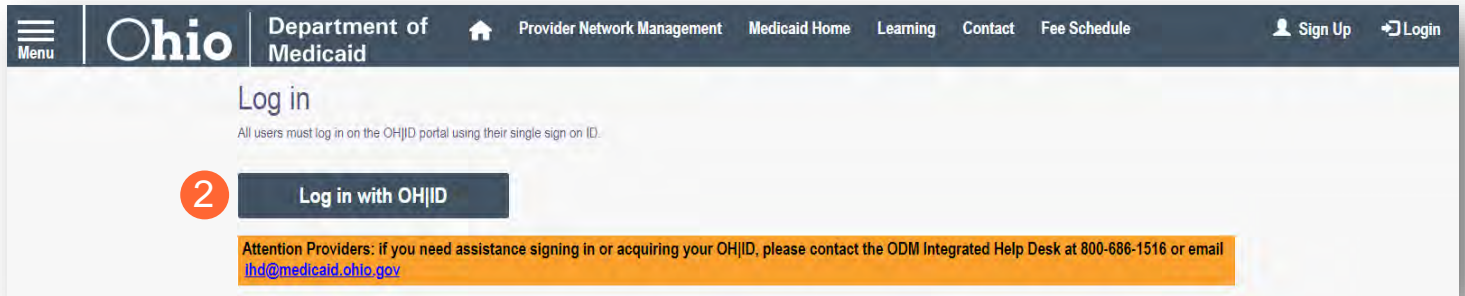


## Provider User Initial Login

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](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.

**A**  **Ohio** Department of Medicaid  Provider Network Management Medicaid Home Learning Contact Fee Schedule  Training  Log out

**B**  **C**   **D**  New Provider?

| Reg ID | Provider               | Status   | Provider Type                   | NPI        | Medicaid ID | Specialty                  | DO Contract Number | DO 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.

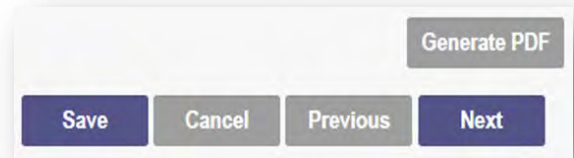
**Save:** Saves the current page and remains on the page.

**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.



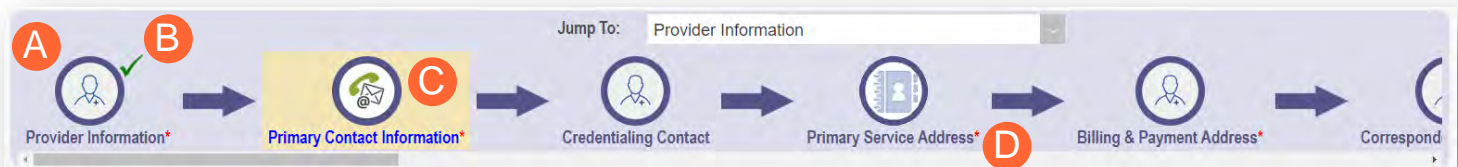
A green checkmark on any page indicates that you have completed the necessary information on that page and can continue through the subsequent pages.

**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?**

### 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."






|   |   |  |  |
|---|---|--|--|
| <b>Standard application</b><br>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.<br><a href="#">Select</a> | <b>Ordering, Referring, Prescribing</b><br>Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing.<br><a href="#">Select</a>   | <b>Change of Operator</b><br>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.<br><a href="#">Select</a> | <b>MCP Single Case</b><br>Use this application if you are entering into a Single Case agreement with a Managed Care Plan.<br><a href="#">Select</a> ⓘ  |
| <b>Medicaid Waiver (ODM)</b><br>Use this application if you are applying to become a Waiver Provider with Ohio Department of Medicaid.<br><a href="#">Select</a>  | <b>Medicaid Waiver (ODA)</b><br>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.<br><a href="#">Select</a> | <b>Medicaid Waiver (DODD)</b><br>Use this application if you are applying to become a Waiver Provider with Ohio Department of Developmental Disabilities.<br><a href="#">Select</a>  | <b>Non-Medicaid DODD</b><br>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.<br><a href="#">Select</a> |

**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](#)

|   |  |   |  |   |
|---|--|---|--|---|
|  <b>Individual</b> |  <b>Group</b> |  <b>Organization</b> |  <b>Facility/Institution</b> |  <b>Pharmacy</b> |
|---|--|---|--|---|

## 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 the 'Individual Provider' form. A red circle with the number '1' is placed next to the 'Category\*' dropdown menu, which is currently set to 'Individual'. A red circle with the number '2' is placed next to the 'Save' button at the bottom right of the form. The form includes fields for Application Type (Standard application), Category\* (Individual), Provider Type\*, First Name\*, Middle Name, Last Name\*, Tax ID Type\* (EIN or SSN), Tax ID\*, DD Contract Number (If Applicable), Requested Effective Date\* (12/28/2023), Gender\* (Female, Male, or Unknown), Date of Birth\*, Zip Code\*, and Zip Code Extension\*. There are 'Change' links next to the Application Type and Category\* fields. A checkbox for 'Are you requesting retro coverage?' is also present.

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.

Application Type: Standard application [Change](#)

Category\*: Individual [Change](#)

Provider Type\*: 20 - Physician/Osteopath Individual

First Name\*: Jordan

Middle Name\*:

Last Name\*: Trainer

Tax ID Type\*: ☐ EIN ☒ SSN

Tax ID\*: 119497554

Are you requesting retro coverage? ☐ What is this ?

NPI\*: 1194975555

DD Contract Number (If Applicable):

Requested Effective Date\*: 12/28/2023

Gender\*: ☐ Female ☒ Male ☐ Unknown

Date of Birth\*: 7/4/1976

Zip Code\*: 43231

Zip Code Extension\*: 7605

Taxonomy\*:

**3** [Save](#) [Cancel](#)

## 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.

| My Providers |               | Account Administration |                             |            |             |           |                    |                    |          |                |             |                       |  | New Provider ? |
|--------------|---------------|------------------------|-----------------------------|------------|-------------|-----------|--------------------|--------------------|----------|----------------|-------------|-----------------------|--|----------------|
| Reg ID       | Provider      | Status                 | Provider Type               | NPI        | Medicaid ID | Specialty | DD Contract Number | DD Facility Number | Location | Effective Date | Submit Date | Revalidation Due Date |  |                |
| 518405       | Test Training | Not Submitted          | 35 - Optometrist Individual | 1851462329 |             |           |                    |                    |          |                |             |                       |  |                |

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

### Manage Application

Enrollment Actions

2 + Enrollment Action Selections:

Programs

+ Program Selections:

Self Service

+ Self Service Selections:

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

### Manage Application

Enrollment Actions

-

3
 

[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.

Uploaded Documents

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

1 Choose File No file chosen

2 Name

3 Description

4 Upload File

File Uploaded: test.pdf\_29.pdf

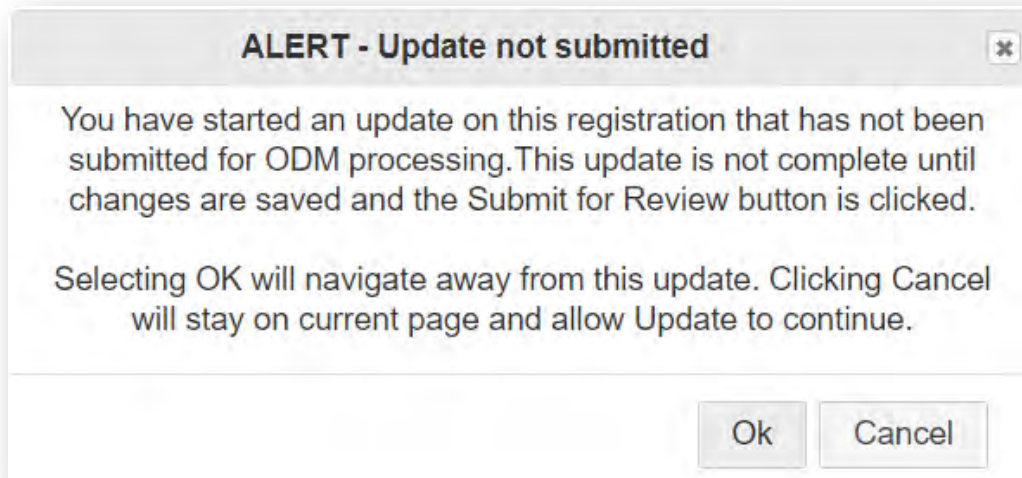
6 Save Cancel Previous Next

Primary Contact Information (480295)

## 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.

**Provider Information**

This is a required section.

An asterisk \* indicates a required field

1

2

Save Cancel Next

Name of Business Entity\* Jordan Train

DBA

Practice Type\*

Ownership Type\*

First Name\* Jordan

Middle Initial

Last Name\* Train

Title

Tax ID\* 119497554

NPI 1194975540

NPI Start Date 09/23/2008

Gender\* ☐ Female ☒ Male ☐ Unknown

Date of Birth\* 07/04/1975

Provider Type\* 20 - Physician/Osteopath Individual

Revalidation Date Not Set Yet

Enrollment Status Not Set Yet

Enrollment Status Reason Not Set Yet

Birth Country

Birth State

Birth City

CAQH #

Have you been a resident of the state OHIO for the last 5 years?\*

☐ Yes ☐ No

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**.

The screenshot shows the 'Credentialing Contact' page. At the top right, there is a 'Generate PDF' button. Below it are 'Save', 'Cancel', 'Previous', and 'Next' buttons. A 'History' button is also present. In the center, there is a large 'Add Contact' button. Below it, it says 'No records found'. In the bottom right corner, there is a red circle with the number '1' and an 'Add New' button.

**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.

The screenshot shows the 'Credentialing Contact' page with the form fields for adding a new contact. At the top right, there is a red circle with the number '4' and 'Save', 'Cancel', 'Previous', and 'Next' buttons. A 'History' button is also present. In the center, there is a large 'Add Contact' button. Below it, it says 'No records found'. On the left, there is a circular icon with a person silhouette and a plus sign. Below the icon, there is a red circle with the number '2' and a list of form fields: '\*Contact Name', '\*Practice Name', '\*Contact Phone No', 'Contact Phone Extension', 'Contact Fax No', '\*Contact Email', and a red circle with the number '3' next to 'Comments'. A red asterisk indicates a required field. In the bottom right corner, there is an 'Add New' button.

## 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

Primary Service Address

Save Cancel Previous Next

This is a required section.

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\*

History

**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 form for individual provider registration. It is divided into five numbered sections:

- 2 Provider Information** (Only required for individual registrations): Includes drop-down menus for Cultural Competencies, Languages Spoken, and Specialized Training.
- 3 Hours of Operation** (Hours providers available for appointments): Includes a table for days of the week (Monday through Sunday) with time slots (start and end) and checkboxes for 'Open 24 Hours'.
- 4 Office Information**: Includes text input for Website, and Yes/No dropdowns for 24-hour telephone coverage, Public transportation access, Electronic billing, and TDD/TTY. It also includes drop-downs for Cultural Competencies, Languages Spoken, Specialized Training, ADA Compliance (with a '--Select ADA--' option), and ASL Offered (Yes/No). There are checkboxes for Language and Translation services.
- 5 Patient Information**: Includes Yes/No dropdowns for Accept new patients, Accept new patients from referral only, and Accept newborns. It also includes text input fields for Youngest patients accepted and Oldest patients accepted, a dropdown for Gender of patient Accepted, and Yes/No dropdowns for Accept newborns and Accept pregnant women.

## Billing & Payment Address Page






Same as Practice Location ☐

Override Address Validation ☐

## Correspondence Address Page

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

Jump To: [Billing & Payment Address](#)

[Generate PDF](#)


[Save](#)
[Cancel](#)
[Previous](#)
[Next](#)

### Billing & Payment Address

This is a required section.

☐ Same as Practice Location  
☐ Override Address Validation

Address Type: ☒ Individual ☐ Organization



Title   
 First Name\*   
 Middle Name   
 Last Name\*   
 Address 1\*   
 Address 2   
 City\*   
 State\*   
 County\*   
 Zip\*   
 Ext Zip\*   
 Phone Number 1\*   
 Phone Ext 1   
 Phone Number 2   
 Phone Ext 2   
 Fax Number 1   
 Fax Number 2   
 Contact Name   
 Email Address 1\*

Jump to: [Correspondence Address](#)

Primary Service Address\* [Billing & Payment Address\\*](#) **Correspondence Address\*** [Other Service Locations](#) [1099 Address\\*](#) [Home](#)

[Generate PDF](#)

[Save](#) [Cancel](#) [Previous](#) [Next](#)

### Correspondence Address


*This is a required section*

*An asterisk\* indicates a required field*

☐ Same as Practice Location

☐ Override Address Validation

Address Type: ☒ Individual ☐ Organization



First Name\*   
 Middle Name\*   
 Last Name\*   
 Address 1\*   
 Address 2   
 City\*   
 State\*   
 County\*   
 Zip\*   
 Ext Zip\*   
 Phone Number 1\*   
 Phone Ext 1   
 Phone Number 2   
 Phone Ext 2   
 Fax Number 1   
 Fax Number 2   
 Contact Name   
 Email Address 1\*

## 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 are buttons: Save (3), Cancel, Previous, and Next (5). A red message states: 'This is not a required section. To skip this section click on Next button.' Below this is a note: '\*Please enter Other Service locations that bill/will bill under the same Medicaid ID' and 'No additional practice locations found.' On the right side, there are buttons 'Add New' (1) and 'History'. On the left, there is a circular icon with a person and a plus sign. The main form area includes a checkbox for 'Override Address Validation' (2) and a list of input fields: Name\*, Address 1\*, Address 2, City\*, State\* (dropdown), County (dropdown), Zip\*, Ext Zip\*, Phone Number 1\*, Phone Ext 1, Phone Number 2, Phone Ext 2, Effective Date\* (1/18/2024), and End Date (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.

**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.

The screenshot shows the provider profile navigation bar with icons for Service Locations, 1099 Address, Home Office Address, Specialties (highlighted), Taxonomies, Professional Licenses, and CLIA Certifications. Below the bar, the 'Specialties' section is titled 'Specialties' with a red note 'This is a required section.' A message states 'Primary Specialties are not editable by provider after application submission.' and 'No records found'. A red circle with the number '1' is next to an 'Add New' button. Navigation buttons 'Save', 'Cancel', 'Previous', and 'Next' are visible.

The screenshot shows the 'Add New' specialty form. It includes a red note 'This is a required section.' and a message 'Primary Specialties are not editable by provider after application submission.' A red circle with the number '1' is next to the 'Specialty\*' dropdown menu. The form includes a checkbox 'Designate a Primary Specialty' which is checked, and a red note 'Designate a Primary Specialty and save first before secondary specialties can be entered.' The 'Start Date\*' field is set to 12/26/2023 and the 'End Date' field is set to 12/31/2299. A large DNA helix icon is on the left. Navigation buttons 'Save', 'Cancel', 'Previous', and 'Next' are at the top right.



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

CLIA Cer

Generate PDF

Taxonomies

This is a required section.

| Taxonomy   | Taxonomy Description | Primary | Start Date | End Date   |                                   |
|------------|----------------------|---------|------------|------------|-----------------------------------|
| 207R00000X | INTERNAL MEDICINE    | Yes     | 12/28/2023 | 12/31/2299 | <div><div></div><div></div></div> |

Add New

History

Save

Cancel

Previous

Next

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   |  |  |
|------------|----------------------|---------|------------|------------|--|--|
| 207R00000X | INTERNAL MEDICINE    | Yes     | 12/28/2023 | 12/31/2299 |  |  |

Taxonomy\*

2

☐ Is Primary Taxonomy

3

Start Date\*

4

End Date

1

Add New

5

History

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.

| Taxonomy   | Taxonomy Description | Primary | Start Date | End Date   |  |
|------------|----------------------|---------|------------|------------|--|
| 207R00000X | INTERNAL MEDICINE    | Yes     | 12/28/2023 | 12/31/2299 | <div><div>1</div><div><div></div><div></div></div></div> |

Add New

History

2

Taxonomy\*

Internal Medicine (207R00000X)

3

☒ Is Primary Taxonomy

4

Start Date\*

12/28/2023

End Date

12/31/2299

5

Save

6

Next

## 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**.

The screenshot shows a multi-step form for adding a professional license. At the top, a progress bar includes icons for 'Home Office Address\*', 'Specialties\*', 'Taxonomies\*', 'Professional Licenses\*' (highlighted in yellow), 'Board Certification', 'Medicare Number', and 'Group, F...'. A 'Jump To' dropdown menu is set to 'Professional Licenses'. Below the progress bar, the 'Professional Licenses' section is titled, with a red message stating 'This is a required section.' A note at the bottom center says 'A copy of each license must be uploaded to this page.' On the right side, there are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', 'Next', and 'History'. A red circle with the number '1' and an 'Add New' button are located in the bottom right corner.

**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.

Get PDF
4

Save
Cancel
Previous
Next

History
Add New

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

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

2

State\*
License Board Name\*

If Other, enter Board Name:

License Number\*
Effective Date\*
Expiration Date\*
License Status

Address 1
Address 2
City
State
County
Zip

Endorsement Number
Endorsement Status
Endorsement Focus
Endorsement Specialty
Certifying Organization
Certificate Date
Certificate Expiration

Uploaded Documents
Optional Document

Professional License

Browse
3

## 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 the top 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 red note: 'This is not a required section. To skip this section click on Next button.' A 'Generate PDF' button is on the right. Below the title, it says 'No Board Certification found'. At the bottom right, there is a red circle with the number '1' next to an 'Add New' button. Navigation buttons 'Save', 'Cancel', 'Previous', and 'Next' are also visible.

**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 red note as before. Below the 'No Board Certification found' message, there is a question: 'Are you Board Certified?' with two radio buttons: 'No' and 'Yes'. A red circle with the number '2' is next to the 'No' radio button. Below the question, it says 'If Yes, Please enter board certification information requested or confirm previously entered information is correct'. The 'Add New' button is still visible at the bottom right. Navigation buttons 'Save', 'Cancel', 'Previous', and 'Next' are also visible.

**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 the 'Board Certification' section of a form. At the top right 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 these buttons is a 'History' button. In the center, it says 'No Board Certification found'. To the right of this is a red circle with the number '4' and an 'Add New' button. On the left is a circular icon with a person and a plus sign. Below the icon is a red circle with the number '3'. The form asks 'Are you Board Certified?' with 'No' and 'Yes' radio buttons. The 'Yes' button is selected. Below this is a red circle with the number '3' and a checkbox labeled 'Designate as Primary Board Certification'. To the right of the checkbox is a red text warning: 'Designate a primary Board Certification and save first before secondary boards can be added.' Below this are five input fields: 'Board Certification\*' (a dropdown menu), 'Board Specialty\*' (a dropdown menu), 'Certification Number' (a text field), 'Effective Date\*' (a date field), and 'Expiration Date\*' (a date field).

CLIA Certifications Page

**Step 1:** For some providers, this is not a required section.

- To move past the CLIA (Clinical Laboratory Improvement Amendments) Certification, click **Next**.

CLIA Certifications

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

No CLIA number found

Get PDF

1

Save

Cancel

Previous

Next

Add New

**Step 2:** If you are a provider that needs to enter a CLIA Certification, enter that information on this page.

- Click **Add New** to enter CLIA certification information.
- Click **Next** to save and proceed to the next page.

CLIA Certifications

Save

Cancel

Previous

Next

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

No CLIA number found

2

CLIA Number\*

CLIA Certification Type

CLIA Effective Date

CLIA Expiration Date

2

Add New

## 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



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 practitioner may have.

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

Note: If the provider is working as a hospitalist or strictly inpatient only, please click 'Add New' under hospital affiliations, and designate that the provider practices exclusively within the inpatient setting.

### 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.

### Group Affiliation

2

Medicaid ID

NPI

3

Save

Cancel

**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<br>STE 240 COLUMBUS, OH 43231- 7607<br>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<br>STE 240 COLUMBUS, OH 43231- 7607<br>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 |
|----------------------------------|-----|-------------|------------|----------|--------------------|---------|
| No confirmed affiliations found. |     |             |            |          |                    |         |

## 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."

2

### Hospital Affiliation

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

**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

## 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, Organizations & Hospital Affiliations → **MCP Affiliation** → Federal DEA Registration → W9 Form\* → EFT Banking\*

Generate PDF

Save Cancel Previous Next

### MCP Affiliation

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

Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans? **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.

## State CDS Number Page

If the provider has a state-registered Controlled Dangerous Substance number, enter that information on this page.

- If the provider does not have a CDS number, you can bypass the page by clicking **Next**.

**Step 1:** If the provider has a CDS Number:

- Click **Add New**.
- Fill in the required fields. *(Date fields require MM/DD/YYYY format.)*

**Step 2:** Upload your State CDS document by clicking **Browse**.

- Locate, on your computer, the file you wish to upload and click **Open**.

**Step 3:** Click **Next** to save and advance to the next screen.

Jump To: State CDS Number

Group, Facility & Hospital Affiliations (Individual)\* MCP Affiliation State CDS Number Federal DEA Registration\* Professional Liability Insurance\*

Generate PDF

Save Cancel Previous Next

3

History

1 Add New

### State CDS Number

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

No records found

1

CDS Number

State

Date Issued

Expiration Date

### Uploaded Documents

Required Document

State CDS Document Upload

Browse 2

## Federal Drug Enforcement Administration (DEA) Registration Page

**Step 1:** For some provider types, this is not a required page.

- To move past the Federal DEA Registration page, click **Next**.

**Step 2:** To complete this page, select the 'Yes' or 'No' radio buttons to answer the question: *"Do you have a current DEA registration?"*

Jump To: Federal DEA Registration

Group, Organizations & Hospital Affiliations → MCP Affiliation → **Federal DEA Registration** → W9 Form\* → EFT Banking\* → Application Fee\*

Generate PDF 1

Save Cancel Previous Next

### Federal DEA Registration

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

#### DEA Question

Do you have a current DEA registration? 2 ☐ Yes ☐ No

If Yes, make selection and Add New for each DEA and waiver including Waiver 2000.  
If No, make selection and fill in remaining information.

No records found

History

## Yes/No DEA Number

**Step 1:** If you select 'No', PNM will prompt you to enter the representative's information.

The screenshot shows the 'Federal DEA Registration' form. At the top right are buttons for 'Save', 'Cancel', 'Previous', and 'Next'. A red message states: 'This is not a required section. To skip this section click on Next button.' A 'History' button is in the top right corner. The 'DEA Question' section asks 'Do you have a current DEA registration?' with radio buttons for 'Yes' and 'No' (selected). A red circle with the number '1' highlights the instructions: 'If Yes, make selection and Add New for each DEA and waiver including Waiver 2000. If No, make selection and fill in remaining information.' Below this are input fields for 'Name of Provider that prescribes on your behalf', 'DEA Number of the prescribing Provider', 'DEA State of the prescribing Provider' (a dropdown menu), and 'Prescribing Comments'. At the bottom, it says 'No records found'.

**Step 2:** If you select 'Yes', PNM will prompt you to complete the screen with the corresponding DEA information by clicking **Add New**.

- DEA Number
- DEA State
- Issue Date (MM/DD/YYYY)
- Expiration Date (MM/DD/YYYY)

**Step 3:** Click **Next** to save and proceed to the next screen.

Federal DEA Registration

Save

Cancel

Previous

Next

3

History

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

DEA Question

2

Do you have a current DEA registration?

Yes

No

If Yes, make selection and Add New for each DEA and waiver including Waiver 2000.  
If No, make selection and fill in remaining information.

DEA Number

DEA State

Issue Date

Expiration Date

DEA Status

Active

No records found

2

Add New

44

## 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

**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.

Professional Liability Insurance

Save

Cancel

Previous

4Next

This is a required section.

History

| 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                      |   |      |

Add New

## 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

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.

| School               | Education            | Specialty | Degree | Start Date | End Date   | Edit |
|----------------------|----------------------|-----------|--------|------------|------------|------|
| Undergraduate School | Undergraduate School |           | MB     | 08/01/2000 | 05/01/2004 |      |

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

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.

| School               | Education            | Specialty                    | Degree | Start Date | End Date   | Edit |
|----------------------|----------------------|------------------------------|--------|------------|------------|------|
| Undergraduate School | Undergraduate School |                              | MB     | 08/01/2000 | 05/01/2004 |      |
| Professional School  | Professional School  |                              | MHS    | 06/01/2004 | 05/01/2008 |      |
| Hospital             | Residency            | Internal Medicine/Pediatrics | MD     | 06/01/2008 | 06/01/2012 |      |

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 top of the 'Malpractice Claims History' page. On the left, the title 'Malpractice Claims History' is displayed in blue, with a red note below it stating 'This is a required section.' In the center, the text 'No MalpracticeClaim found.' is visible. On the right, there is a navigation bar with buttons for 'Save', 'Cancel', 'Previous', and 'Next'. Below these buttons is a 'History' button with a document icon. At the bottom right, there is a red circle with the number '1' and an 'Add New' button. A red circle with the number '3' is also present near the 'Next' button.

## 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 main form for reporting a malpractice claim. At the top, the question 'Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?' is displayed with radio buttons for 'No' and 'Yes' (selected). Below this, the text 'No MalpracticeClaim found.' is shown. A red circle with the number '2' is next to the 'Date of Occurrence\*' field. The form contains numerous required fields marked with an asterisk (\*), including: 'Date Claim Filed\*', 'Status of the claim\*' (with a dropdown menu showing 'Open'), 'If settled, the date the claim was settled', 'Professional liability carrier involved\*', 'Carrier Address Line1\*', 'Carrier Address Line2', 'City\*', 'State\*' (with a dropdown menu), 'Zip\*', 'Phone Number 1\*', 'Phone Ext. 1', 'Policy Number', 'Method of Resolution' (with a dropdown menu), 'If settled, the amount of settlement', 'Describe the allegations against you\*' (with a dropdown menu), 'Were You\*' (with radio buttons for 'Primary Defendant' and 'Co-Defendant'), 'No of Other Defendants (if any)', 'Your role in case\*', 'Describe the alleged injury to the patient', 'Did the alleged injury result in death?' (with a dropdown menu), and 'To the best of your knowledge, is the case included in the NPDB?' (with a dropdown menu showing 'Yes'). An 'Add New' button is located in the top right corner.

## 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?

Include a chronological work history for the past 5 years.

No records found

1 Add New

1 Current Employer ☐

\*Practice/ Employer Name:

\* Start Date:

\* End Date:

Organization Name\*

Address 1\*

Address 2

City\*

State\*

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.

Jump To: Work History

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

Generate PDF

Save Cancel Previous Next

**Work History**

This is a required section

Include a chronological work history for the past 5 years.

| Practice/ Employer Name | Start Date | End Date | Edit |
|-------------------------|------------|----------|------|
| Training Clinic         | 01/01/2017 |          |      |

Add New History

**Gaps in Work History**

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

No records found

Add New

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

- Complete Information for any gaps in Work History
  - Gap Start Date (MM/DD/YYYY)
  - Gap End Date (MM/DD/YYYY)
  - Reason for Gap

**Gaps in Work History**

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

No records found

\*Gap Start Date:

\*Gap End Date:

\*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.

The screenshot shows the 'W9 Form' page. At the top, a navigation bar includes icons for Education, Malpractice Claims History, Work History, W9 Form (highlighted), EFT Banking, Required Documents, and Agreements. Below the navigation bar, the 'W9 Form' section is titled, and a message states 'This is a required section.' Information from the Identification page is displayed, including the Individual Name (Jordan Train) and SSN (119497554). A large blue icon of a document with a dollar sign is on the left. To the right, a list of categories is shown with radio buttons, and the first option, 'Individual/sole proprietor or single-member LLC', is selected and marked with a red circle containing the number 1.

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

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

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

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

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

## EFT Banking Information Page

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

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

Jump To: EFT Banking

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

Generate PDF

Save Cancel Previous Next

**EFT Banking Information**

This is a required section.

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

☐ Yes ☐ No

**Step 2:** If 'Yes' is answered, read the instructions section before proceeding to Step 3.

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

**Step 3:** To enter your Bank Account information, click **Add New** under the Banking Information section.

**Instructions**

**2** READ INSTRUCTIONS BEFORE COMPLETING

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

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

Please enter your banking information below.

**Banking Information**

No banking information found.

**3** Add New

**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**.

Required Document

EVW Training

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

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

Generate PDF

Save Cancel Previous Next

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

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

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

**Uploaded Documents**  
Please note that you will not be able to delete uploaded documents once your application has been submitted.  
No uploaded documents found.

2 Choose File 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.'

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

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

**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.'

**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\*:  ⓘ

Provider Name:

User ID:

8

**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

## 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.

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

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:** Jordan Train

**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:** 518412

**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.

Menu

Ohio

Department of Medicaid

Provider Network Management

Medicaid Home

Learning

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Fee Schedule

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Log out

My Providers

Account Administration

New Provider ?

| Reg ID | Provider      | Status             | Provider Type                  | NPI        | Medicaid ID | Specialty         | DD Contract Number | DD Facility Number | Location | Effective Date | Submit Date | Revalidation Due Date |
|--------|---------------|--------------------|--------------------------------|------------|-------------|-------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|
| 518405 | Daniel Devine | Not Submitted      | 35 - Optometrist Individual    | 1851462329 |             |                   |                    |                    |          |                |             |                       |
| 518412 | Jordan Train  | Return to Provider | 20 - Physician/Oste Individual | 1194975540 |             | INTERNAL MEDICINE |                    |                    |          |                | 01/02/2024  |                       |

## Reviewing Correspondence

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

Provider Management Home

Registration Information Previous Page

|               |             |                |                       |           |
|---------------|-------------|----------------|-----------------------|-----------|
| Provider Name | Medicaid ID | Effective Date | Revalidation Due Date | Term Date |
| Jordan Train  |             |                |                       |           |

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 |
|--------|--|----------|----------------|------------------------|---------------------------------|-----------------|-------------|-------------------|
| 518412 | Application Flow - Standard - NEW REGISTRATION | Medicaid | 606867         | Return to Provider     |                                 |                 | 01/02/24    | N                 |

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

Manage Application

Enrollment Actions + Enrollment Action Selections: ⓘ

Programs + Program Selections:

Self Service - Self Service Selections:

**2** [View Provider File](#)

[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**.

**\* SEARCH CORRESPONDENCE**

An asterisk \* indicates a required field

\*Correspondence TYPE  
 Enrollment Notifications

Date Available From: MM/DD/YYYY

Date Available To: MM/DD/YYYY

Search Clear

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

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

**Step 5:** Review the correspondence to understand the reason for the return. Once you have viewed, you can click the 'X' in the top-right corner to close or click **Close** at the bottom of the window.

Click **Print** to print a physical copy of the correspondence or download as a PDF.

**Provider Communication**

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

Dear Provider:

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

Please see the return reasons below:

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

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

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

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

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

Sincerely,

Print Close

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

Medicaid ID

Effective Date

Revalidation Due Date

Term Date

Jordan Train

Manage Application

Enrollment Actions

1 + Enrollment Action Selections:

Programs

+ Program Selections:

Self Service

+ Self Service Selections:

My Current and Previous Applications

| Reg ID | Enrollment Action                              | Program  | Application Id | PNM Application Status | Other Agency Application Status | DD Legal Status | Status Date | Workflow Complete |
|--------|--|----------|----------------|------------------------|---------------------------------|-----------------|-------------|-------------------|
| 518412 | Application Flow - Standard - NEW REGISTRATION | Medicaid | 606867         | Return to Provider     |                                 |                 | 01/02/24    | N                 |

**Step 2:** Click the ‘Continue Registration’ hyperlink.

Manage Application

Enrollment Actions

- Enrollment Action Selections:

2 [Continue Registration](#)

[Cancel New Registration](#)

[Edit Key Provider Identifiers](#)

**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 license you provided is expired. Please provide a current license. (P042)  
- License expired on 8/1/2021

Jump To: Professional Licenses

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

Professional Licenses  
This is a required section.

Generate PDF

Save Cancel Previous Next

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

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

Add New

**Step 5:** Click **Save** to save the new information.

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

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

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

OK

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

The screenshot shows a progress bar at the top with six steps: Specialties, Taxonomies, Professional Licenses, Board Certification, Medicare Number, and Group, Facility & Hospital Affiliations (Individual). The 'Board Certification' step is highlighted with a yellow background and a green checkmark. Below the progress bar, the 'Board Certification' section is displayed with the message 'No Board Certification found'. On the right side, there are buttons for 'Generate PDF', 'Submit for Review' (with a red circle containing the number 6), 'Save', 'Cancel', 'Previous', 'Next', and '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**.

The screenshot shows a confirmation message with the heading '7 Submission Confirmation'. The text reads: 'You have successfully submitted your application to the Medicaid Program. Please allow at least 10 days for processing before attempting to submit any changes.' Below the text is a button labeled '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.

| Ohio Department of Medicaid  |               |                                   |                                     |            |             |                  |                    |                    |          |                |             |                       |  |
|--|---------------|-----------------------------------|-------------------------------------|------------|-------------|------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|--|
| Provider Network Management Medicaid Home Learning Contact Fee Schedule Rodney Log out |               |                                   |                                     |            |             |                  |                    |                    |          |                |             |                       |  |
| My Providers Account Administration New Provider ?                                     |               |                                   |                                     |            |             |                  |                    |                    |          |                |             |                       |  |
| Reg ID   | Provider      | Status                            | Provider Type                       | NPI        | Medicaid ID | Specialty        | DD Contract Number | DD Facility Number | Location | Effective Date | Submit Date | Revalidation Due Date |  |
| 517919   | Test Training | Return to Provider For Site Visit | 39 - Physical Therapist, Individual | 1912011818 |             | Physical Therapy |                    |                    |          |                | 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:

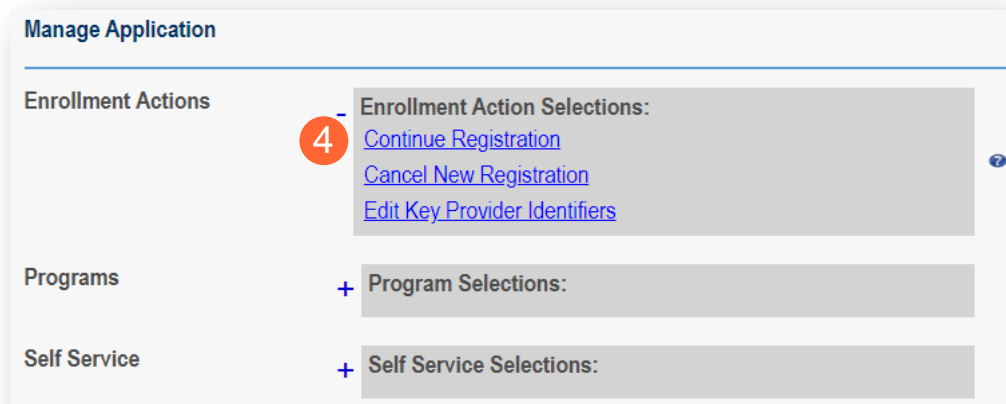
Self Service

+ 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.'



**Manage Application**

**Enrollment Actions** - Enrollment Action Selections:

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

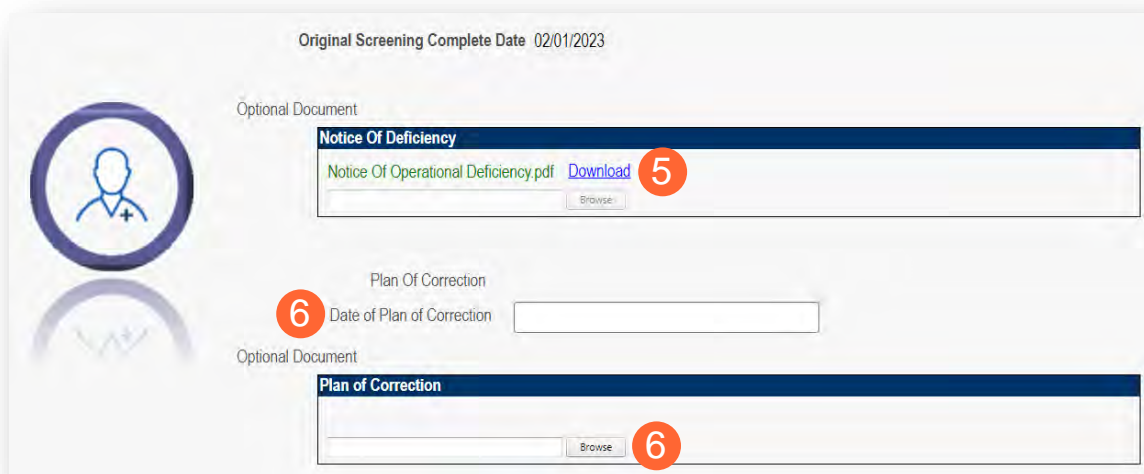
**Programs** + Program Selections:

**Self Service** + Self Service Selections:

**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.



Original Screening Complete Date 02/01/2023

**Optional Document**

**Notice Of Deficiency**

[Notice Of Operational Deficiency.pdf](#) [Download](#) **5**

**Plan Of Correction**

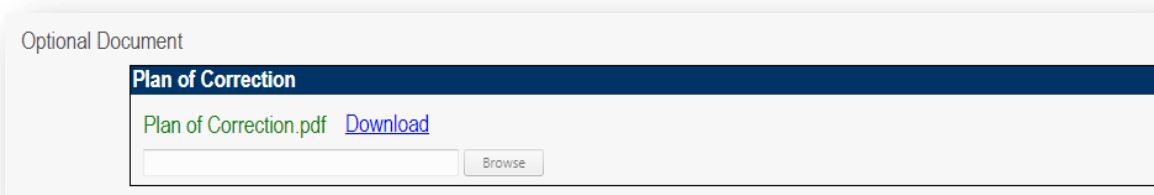
**6** Date of Plan of Correction

**Optional Document**

**Plan of Correction**

[Plan of Correction.pdf](#) [Download](#) **6**

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



**Optional Document**

**Plan of Correction**

[Plan of Correction.pdf](#) [Download](#)

[Browse](#)

**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

Upload

Plan Of Correction

Date of Plan of Correction

3/8/2024

Optional Document

Plan of Correction

Plan of Correction.pdf

Download

Upload

## Review the Final Decision for Provider Submission

**Step 1:** Once the entire review process has been completed, the provider will be assigned a Medicaid ID number by the Ohio Department of Medicaid.

- Locate the newly assigned Medicaid ID for the provider listed in the table on your dashboard.
- If the provider does not appear, use number timeline at the bottom to navigate to the correct page.

**Note:** The Medicaid ID is also listed on a 'Welcome Letter' which is accessible by [Reviewing Provider Correspondence](#) in PNM.

| <div> <div>Menu</div> <div>Ohio Department of Medicaid</div> <div> <a href="#">Provider Network Management</a> <a href="#">Medicaid Home</a> <a href="#">Learning</a> <a href="#">Contact</a> <a href="#">Fee Schedule</a> </div> <div> <a href="#">Training</a> <a href="#">Log out</a> </div> </div> |                                |                        |                         |            |             |                   |                    |                    |              |                |             |                       |  |
|--|--------------------------------|------------------------|-------------------------|------------|-------------|-------------------|--------------------|--------------------|--------------|----------------|-------------|-----------------------|--|
| My Providers   |                                | Account Administration |                         |            |             |                   |                    |                    |              |                |             | New Provider ?        |  |
| Reg ID   | Provider                       | Status                 | Provider Type           | NPI        | Medicaid ID | Specialty         | DD Contract Number | DD Facility Number | Location     | Effective Date | Submit Date | Revalidation Due Date |  |
| <a href="#">517957</a>   | <a href="#">Kyle Aaron</a>     | Submitted              | 30 - Dentist Individual | 1821228875 | 9999878     | General Dentistry |                    |                    | 43212 - 4706 | 02/28/2022     | 08/03/2022  | 02/28/2027            |  |
| <a href="#">517964</a>   | <a href="#">Madison Aaberg</a> | Approved               | 69 - Pharmacist         | 1043873938 | 0000002     | PHARMACIST        |                    |                    |              | 04/14/2022     | 03/09/2022  | 04/14/2025            |  |
| <a href="#">517965</a>   | <a href="#">Test Training</a>  | Complete               | 69 - Pharmacist         | 1316344583 | 9999883     | PHARMACIST        |                    |                    |              | 03/09/2022     | 03/23/2022  | 03/23/2026            |  |

**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.

| <div> <div>Menu</div> <div>Ohio Department of Medicaid</div> <div> <a href="#">Provider Network Management</a> </div> </div> |                                |                        |                         |            |             |  |
|--|--------------------------------|------------------------|-------------------------|------------|-------------|--|
| My Providers   |                                | Account Administration |                         |            |             |  |
| Reg ID   | Provider                       | Status                 | Provider Type           | NPI        | Medicaid ID |  |
| <a href="#">517957</a>   | <a href="#">Kyle Aaron</a>     | Submitted              | 30 - Dentist Individual | 1821228875 | 9999878     |  |
| <a href="#">517964</a>   | <a href="#">Madison Aaberg</a> | Approved               | 69 - Pharmacist         | 1043873938 | 0000002     |  |
| <a href="#">517965</a>   | <a href="#">Test Training</a>  | Complete               | 69 - Pharmacist         | 1316344583 | 9999883     |  |

## 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

| Ohio Department of Medicaid |                |                             |                         |               |             |                   |                    |                    |              |                |             |                       |  |
|-----------------------------|----------------|-----------------------------|-------------------------|---------------|-------------|-------------------|--------------------|--------------------|--------------|----------------|-------------|-----------------------|--|
| Menu                        |                | Provider Network Management |                         | Medicaid Home |             | Learning          |                    | Contact            |              | Fee Schedule   |             | Training              |  |
| My Providers                |                | Account Administration      |                         |               |             |                   |                    |                    |              |                |             | New Provider ?        |  |
| Reg ID                      | Provider       | Status                      | Provider Type           | NPI           | Medicaid ID | Specialty         | DD Contract Number | DD Facility Number | Location     | Effective Date | Submit Date | Revalidation Due Date |  |
| 517957                      | Kyle Aaron     | Submitted                   | 30 - Dentist Individual | 1821228875    | 9999878     | General Dentistry |                    |                    | 43212 - 4706 | 02/28/2022     | 08/03/2022  | 02/28/2027            |  |
| 517964                      | Madison Aaberg | Approved                    | 69 - Pharmacist         | 1043873938    | 0000002     | PHARMACIST        |                    |                    |              | 04/14/2022     | 03/09/2022  | 04/14/2025            |  |
| 517965                      | Test Training  | Complete                    | 69 - Pharmacist         | 1316344583    | 9999883     | PHARMACIST        |                    |                    |              | 03/09/2022     | 03/23/2022  | 03/23/2026            |  |

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

2 + Enrollment Action Selections:

Programs

+ Program Selections:

Self Service

+ Self Service Selections:

**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



4

[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.

Jump To: Billing & Payment Address

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

**Billing & Payment Address**  
This is a required section.

6 Return to Summary  
Generate PDF  
5 Save Cancel  
History

**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.

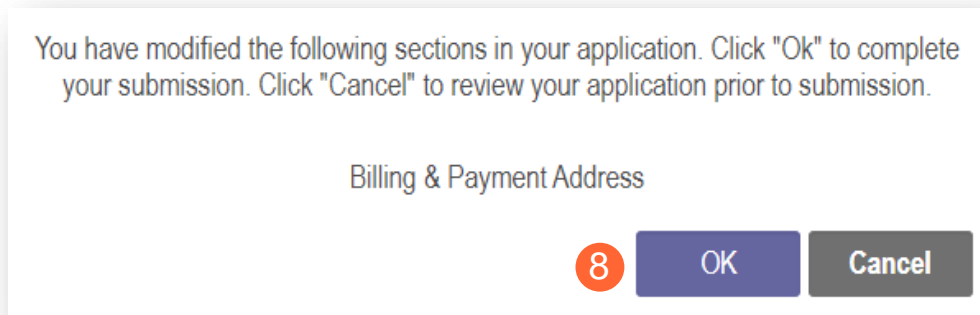
Jump To: Billing & Payment Address

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

**Billing & Payment Address**  
This is a required section.

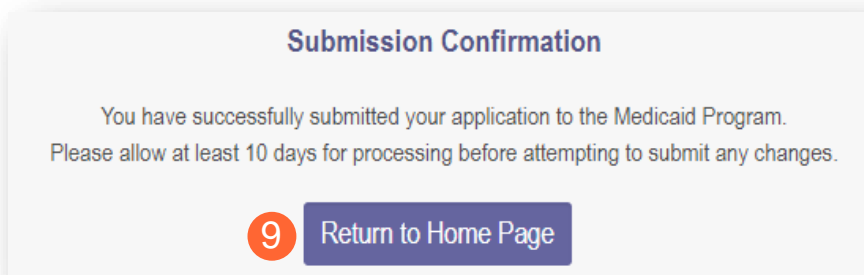
Return to Summary  
Generate PDF  
7 Submit for Review  
Save Cancel  
History

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



**Step 9:** You will receive a confirmation message stating that 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.

| Ohio Department of Medicaid  |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
|--|----------------|-----------|-------------------------|------------|-------------|-------------------|--------------------|--------------------|--------------|----------------|-------------|-----------------------|--|
| Provider Network Management Medicaid Home Learning Contact Fee Schedule Training Log out |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
| My Providers Account Administration New Provider ?                                       |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
| Reg ID   | Provider       | Status    | Provider Type           | NPI        | Medicaid ID | Specialty         | DD Contract Number | DD Facility Number | Location     | Effective Date | Submit Date | Revalidation Due Date |  |
| 517957   | Kyle Aaron     | Submitted | 30 - Dentist Individual | 1821228875 | 9999878     | General Dentistry |                    |                    | 43212 - 4706 | 02/28/2022     | 08/03/2022  | 02/28/2027            |  |
| 517964   | Madison Aaberg | Approved  | 69 - Pharmacist         | 1043873938 | 0000002     | PHARMACIST        |                    |                    |              | 04/14/2022     | 03/09/2022  | 04/14/2025            |  |
| 517965   | Test Training  | Complete  | 69 - Pharmacist         | 1316344583 | 9999883     | PHARMACIST        |                    |                    |              | 03/09/2022     | 03/23/2022  | 03/23/2026            |  |

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

2

+

Enrollment Action Selections:

Programs

+

Program Selections:

Self Service

+

Self Service Selections:

**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.



Most Common Updates

Update

Primary Contact Information

Update

Primary Service Address

4

Update

Professional Licenses

Update

Group, Facility & Hospital Affiliations (Individual)

Update

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

SaveCancel

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 |  |   |
|----------------|-------------------|---------------|----------------|-----------------|---------|-------------|--|---|
| PH34534565436  | BOARD OF PHARMACY | OH            | 1/1/2015       | 1/1/2025        |         |             | <div>5</div> <div></div> | <div></div> <div>Add New</div> |

**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 |  |  |
|----------------|-------------------|---------------|----------------|-----------------|---------|-------------|--|--|
| PH34534565436  | BOARD OF PHARMACY | OH            | 1/1/2015       | 1/1/2025        |         |             |  |  |

Add New

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

6

State\*

Ohio

License Board Name\*

Board Of Pharmacy

If Other, enter Board Name:

License Number\*

PH34534565436

Effective Date\*

01/01/2015

Expiration Date\*

License Status

ACTIVE

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

7

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 |                                   |
|----------------|-------------------|---------------|----------------|-----------------|---------|-------------|-----------------------------------|
| PH34534565436  | BOARD OF PHARMACY | OH            | 1/1/2015       | 1/1/2025        |         |             | <div><div></div><div></div></div> |

8

Add New

**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.

| Ohio Department of Medicaid  |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
|--|----------------|-----------|-------------------------|------------|-------------|-------------------|--------------------|--------------------|--------------|----------------|-------------|-----------------------|--|
| Provider Network Management Medicaid Home Learning Contact Fee Schedule Training Log out |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
| My Providers Account Administration New Provider ?                                       |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
| Reg ID   | Provider       | Status    | Provider Type           | NPI        | Medicaid ID | Specialty         | DD Contract Number | DD Facility Number | Location     | Effective Date | Submit Date | Revalidation Due Date |  |
| 517957   | Kyle Aaron     | Submitted | 30 - Dentist Individual | 1821228875 | 9999878     | General Dentistry |                    |                    | 43212 - 4706 | 02/28/2022     | 08/03/2022  | 02/28/2027            |  |
| 517964   | Madison Aaberg | Approved  | 69 - Pharmacist         | 1043873938 | 0000002     | PHARMACIST        |                    |                    |              | 04/14/2022     | 03/09/2022  | 04/14/2025            |  |
| 517965   | Test Training  | Complete  | 69 - Pharmacist         | 1316344583 | 9999883     | PHARMACIST        |                    |                    |              | 03/09/2022     | 03/23/2022  | 03/23/2026            |  |

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

2

+

Enrollment Action Selections:

Programs

+

Program Selections:

Self Service

+

Self Service Selections:

**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](mailto:Medicaid_provider_update@medicaid.ohio.gov) indicating the provider and specialty that should be the primary.

### Specialties

This is a required section.

Save

Cancel

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           |      |        |
| 207 Family Practice  | Yes                      | 03/20/2023           | 12/31/2299           | ACTIVE        |      |        |
| 215 Pediatric        | No                       | 10/01/2023           | 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](mailto: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\*

12/26/2023

End Date

12/31/2299

**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

This is a required section.

7

Save

Cancel

Primary Specialties are not editable by provider after application submission.

| Specialty           | Primary                  | Start Date | End Date   | Enroll Status | Edit | Delete         |
|---------------------|--------------------------|------------|------------|---------------|------|----------------|
|                     | <input type="checkbox"/> |            |            | All           |      |                |
| 207 Family Practice | Yes                      | 03/20/2023 | 12/31/2299 | ACTIVE        |      |                |
| 229 ALLERGY         | No                       | 12/26/2023 | 12/31/2299 | ACTIVE        |      |                |
| 215 Pediatric       | No                       | 10/01/2023 | 12/31/2299 | INACTIVE      |      | <div>x</div> A |

Add New

History

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

Return to Summary

Generate PDF

8

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.

| Ohio Department of Medicaid  |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
|--|----------------|-----------|-------------------------|------------|-------------|-------------------|--------------------|--------------------|--------------|----------------|-------------|-----------------------|--|
| Provider Network Management Medicaid Home Learning Contact Fee Schedule Training Log out |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
| My Providers Account Administration New Provider ?                                       |                |           |                         |            |             |                   |                    |                    |              |                |             |                       |  |
| Reg ID   | Provider       | Status    | Provider Type           | NPI        | Medicaid ID | Specialty         | DD Contract Number | DD Facility Number | Location     | Effective Date | Submit Date | Revalidation Due Date |  |
| 517957   | Kyle Aaron     | Submitted | 30 - Dentist Individual | 1821228875 | 9999878     | General Dentistry |                    |                    | 43212 - 4706 | 02/28/2022     | 08/03/2022  | 02/28/2027            |  |
| 517964   | Madison Aaberg | Approved  | 69 - Pharmacist         | 1043873938 | 0000002     | PHARMACIST        |                    |                    |              | 04/14/2022     | 03/09/2022  | 04/14/2025            |  |
| 517965   | Test Training  | Complete  | 69 - Pharmacist         | 1316344583 | 9999883     | PHARMACIST        |                    |                    |              | 03/09/2022     | 03/23/2022  | 03/23/2026            |  |

**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

2 +

Enrollment Action Selections:

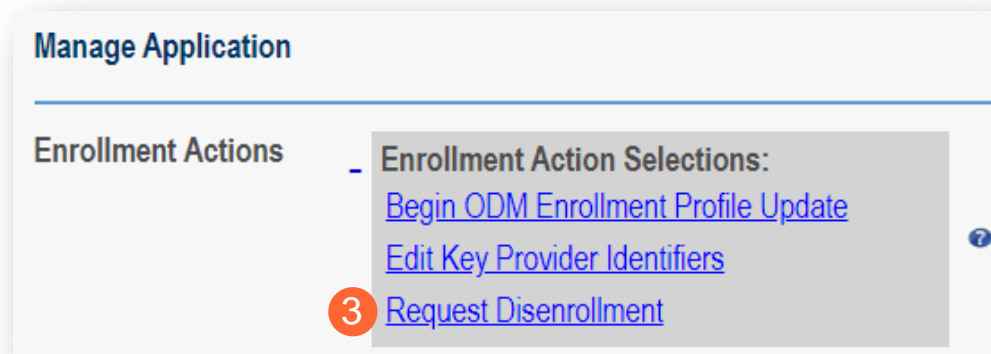
Programs

+ 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**.

The screenshot shows a 'Request Disenrollment' pop-up window. It features a text field for 'Disenrollment Effective Date\*' (marked with a red circle 4) and a list of reasons for disenrollment with checkboxes: Retirement, Closed Business, No Longer Interested in being a Medical Provider, Difficulty with Rules Compliance, Low Reimbursement Rates, Problem with MCPs, Closed business due to economic downturn, and Other. At the bottom right, there are 'Save' and 'Cancel' buttons (marked with a red circle 5).

**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.

|   |               |                        |                                     |            |             |                                    |                    |                    |          |                |             |                       |  |
|---|---------------|------------------------|-------------------------------------|------------|-------------|------------------------------------|--------------------|--------------------|----------|----------------|-------------|-----------------------|--|
| <div>Menu</div> <div>Ohio</div> <div>Department of Medicaid</div> <div>Provider Network Management</div> <div>Medicaid Home</div> <div>Learning</div> <div>Contact</div> <div>Fee Schedule</div> <div>Log out</div> |               |                        |                                     |            |             |                                    |                    |                    |          |                |             |                       |  |
| My Providers  |               | Account Administration |                                     |            |             |                                    |                    |                    |          |                |             |                       |  |
| 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             | 39 - Physical Therapist, Individual | 1912011818 | 9999876     | LICENSED INDEPENDENT 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

2 + Enrollment Action Selections:

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

3 - Enrollment Action Selections:

[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.

The screenshot displays the 'Agreements' section of the Ohio Medicaid Provider Agreement application. A progress bar at the top shows the following steps: Registration\* (green checkmark), Professional Liability Insurance\* (green checkmark), Education\* (green checkmark), Agreements\* (green checkmark), History\* (green checkmark), W9 Form\* (green checkmark), and EF (green checkmark). A red circle with the number 5 is next to the 'Agreements' step in the progress bar. Below the progress bar, a table lists various sections and their status:

| Section Name   | Status |
|--|--------|
| Other Service Locations                              | ✓      |
| 1099 Address*  | ✓      |
| Home Office Address*                                 | ✓      |
| Specialties*   | ✓      |
| Taxonomies*  | ✓      |
| Professional Licenses*                               | ✓      |
| Board Certification                                  | ✓      |
| CLIA Certifications                                  | ✓      |
| Medicare Number                                      | ✓      |
| Group, Facility & Hospital Affiliations (Individual) | ✓      |
| MCP Affiliation                                      | ✓      |
| State CDS Number                                     | ✓      |
| Federal DEA Registration*                            | ✓      |
| Professional Liability Insurance*                    | ✓      |
| Education*   | ✓      |
| Malpractice Claims History*                          | ✓      |
| Work History*  | ✓      |
| W9 Form*   | ✓      |
| EFT Banking*   | ✓      |
| Required Documents                                   | ✓      |
| A total of 27 items                                  | ✓      |

Below the table, there is a red circle with the number 4 next to the 'Submit for Review' button. The 'Submit for Review' button is highlighted in blue. Other buttons visible include 'Save', 'Cancel', 'Previous', 'Next', and 'Generate PDF'. A red message at the bottom states: 'Proceeding to the next step.'

**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.

| <div> <div>Menu</div> <div>Ohio Department of Medicaid</div> <div> <a href="#">Provider Network Management</a> <a href="#">Medicaid Home</a> <a href="#">Learning</a> <a href="#">Contact</a> <a href="#">Fee Schedule</a> </div> <div> <a href="#">Training</a> <a href="#">Log out</a> </div> </div> |                                |                        |                         |            |             |                   |                    |                    |              |                |             |                       |  |
|--|--------------------------------|------------------------|-------------------------|------------|-------------|-------------------|--------------------|--------------------|--------------|----------------|-------------|-----------------------|--|
| My Providers   |                                | Account Administration |                         |            |             |                   |                    |                    |              |                |             | New Provider ?        |  |
| Reg ID   | Provider                       | Status                 | Provider Type           | NPI        | Medicaid ID | Specialty         | DD Contract Number | DD Facility Number | Location     | Effective Date | Submit Date | Revalidation Due Date |  |
| <a href="#">517957</a>   | <a href="#">Kyle Aaron</a>     | Submitted              | 30 - Dentist Individual | 1821228875 | 9999878     | General Dentistry |                    |                    | 43212 - 4706 | 02/28/2022     | 08/03/2022  | 02/28/2027            |  |
| <a href="#">517964</a>   | <a href="#">Madison Aaberg</a> | Approved               | 69 - Pharmacist         | 1043873938 | 0000002     | PHARMACIST        |                    |                    |              | 04/14/2022     | 03/09/2022  | 04/14/2025            |  |
| <a href="#">517965</a> <b>1</b>  | <a href="#">Test Training</a>  | Complete               | 69 - Pharmacist         | 1316344583 | 9999883     | PHARMACIST        |                    |                    |              | 03/09/2022     | 03/23/2022  | 03/23/2026            |  |

**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 |
| Test Training | 9999883     | 03/09/2022     | 03/23/2022            |           |

Manage Application

Enrollment Actions

2 +

Enrollment Action Selections:

Programs

+

Program Selections:

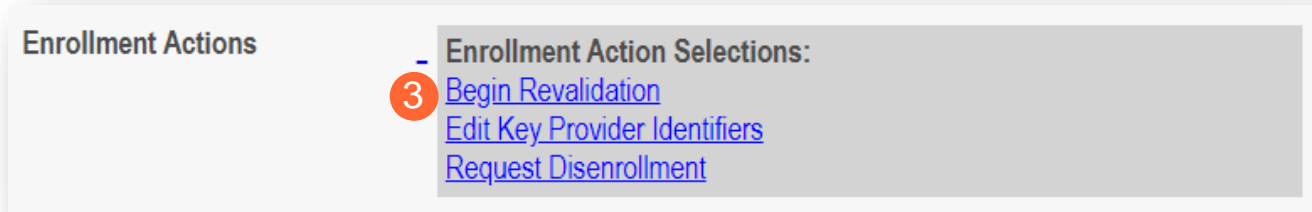
Self Service

+

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.'



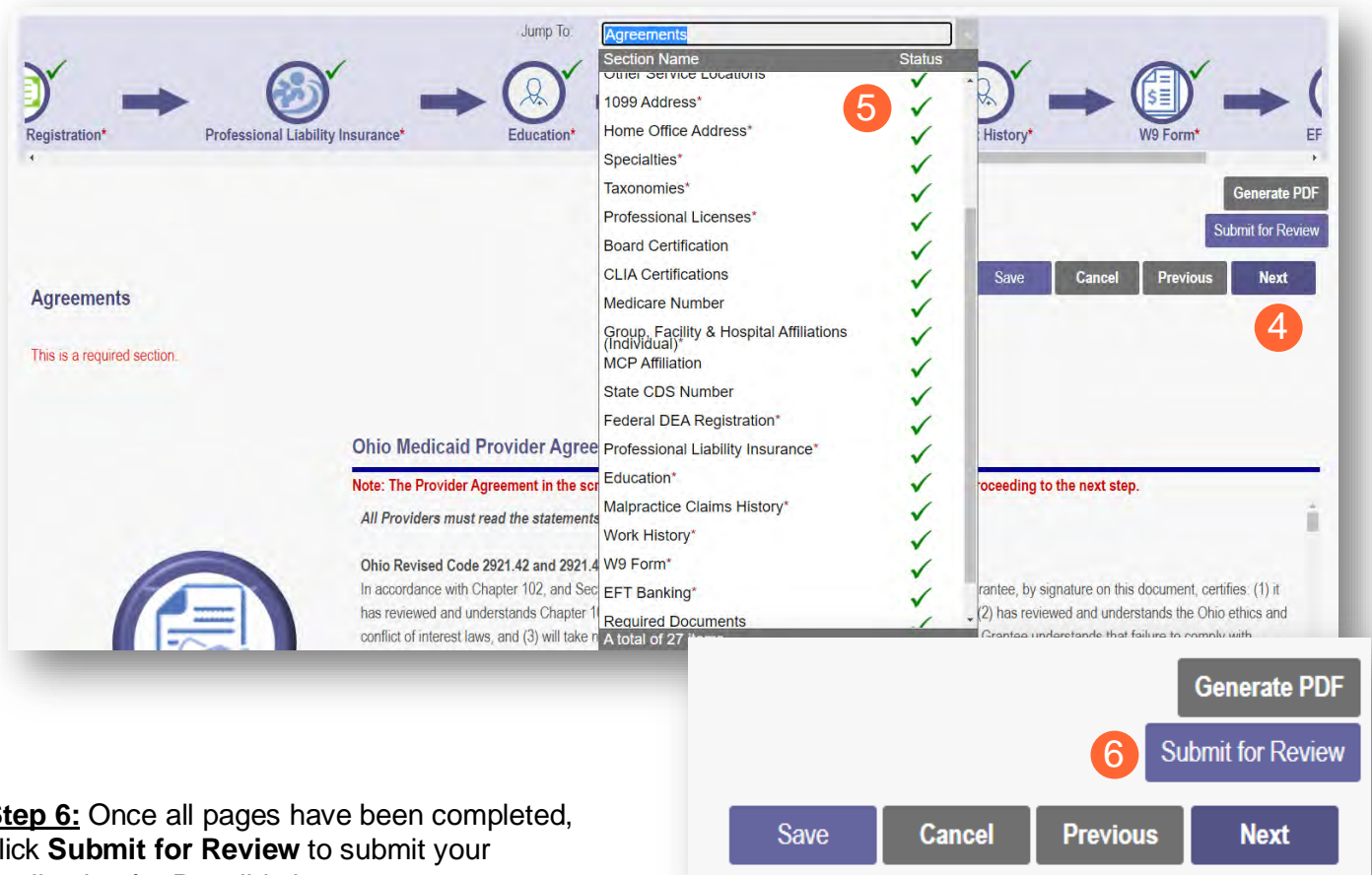
**Step 4:** Either change the information listed on the page OR review the information on the page and make no changes if it remains accurate.

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.