

The cover features a central collage of medical and technology-related images, including a hand holding a magnifying glass over a blue cross with a heart rate line, a stethoscope, and a tablet displaying a blue padlock icon. This central image is framed by large, overlapping geometric shapes in various shades of blue and purple.

USER MANUAL

Long-Term Care Facility Provider Enrollment Applications

Facility Provider



**Department of
Medicaid**

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Introduction

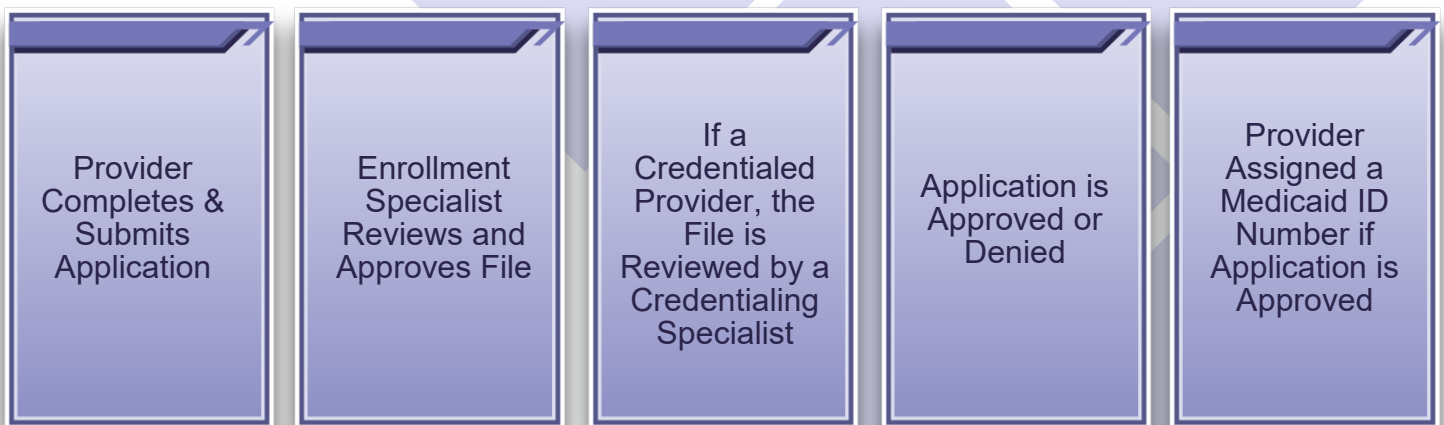
This user guide provides the steps and functions of entering a new provider application to enroll in the Ohio Department of Medicaid (ODM) program. An NPI number is required to complete an enrollment. Once submitted, your application will be processed by the Medicaid Enrollment team and then sent to 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.

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

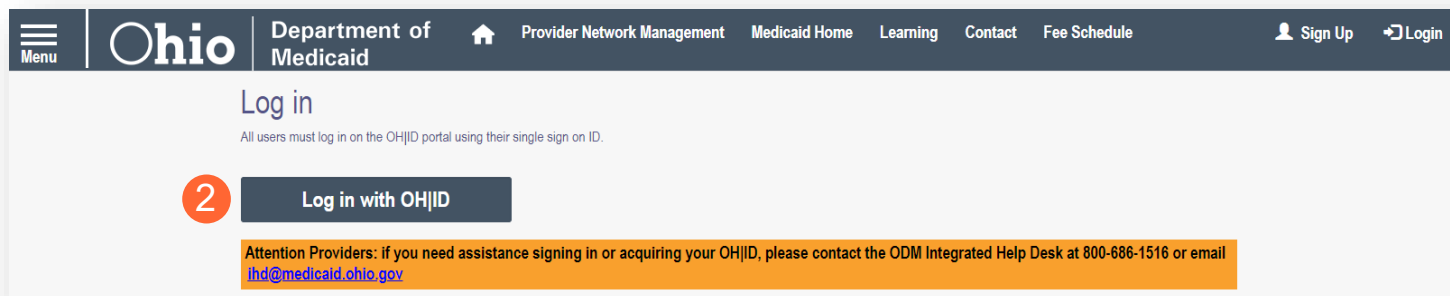


Provider User Initial Login

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

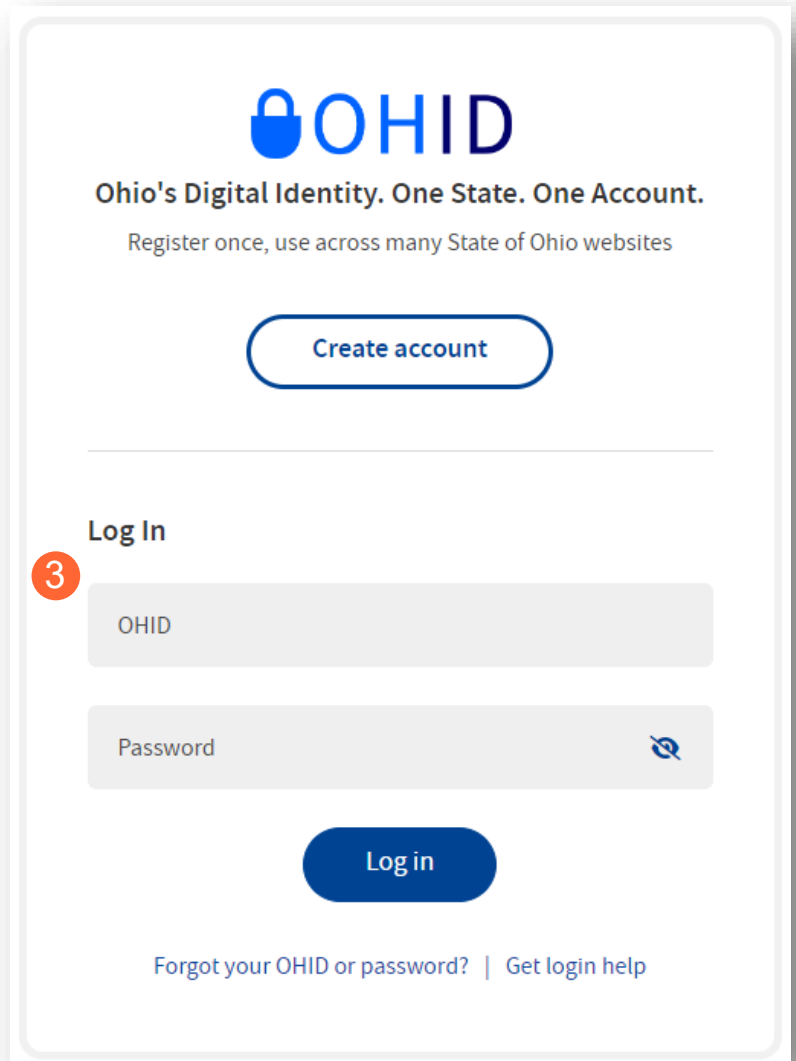
Step 1: Visit the PNM web address: https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx.

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

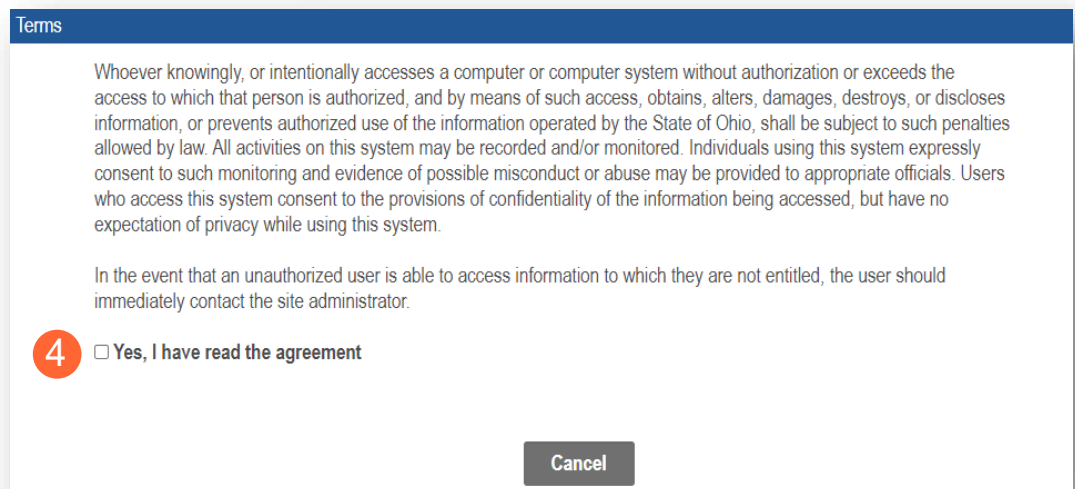


Step 3: The system will prompt you to enter your username and password on the IOP login screen. Once entered, click **Log in**.

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



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.



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

My Providers Account Administration **B**   **C** **D** 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
517946	Training Medical Group	Complete	21 - Professional Medical Group	1245585009	9999876	Professional Medical Group				02/09/2022	11/14/2023	02/09/2027

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

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

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

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

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.

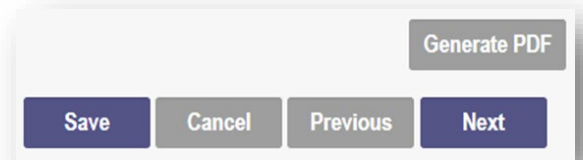
Save: Saves the current page and remains on the page.

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.



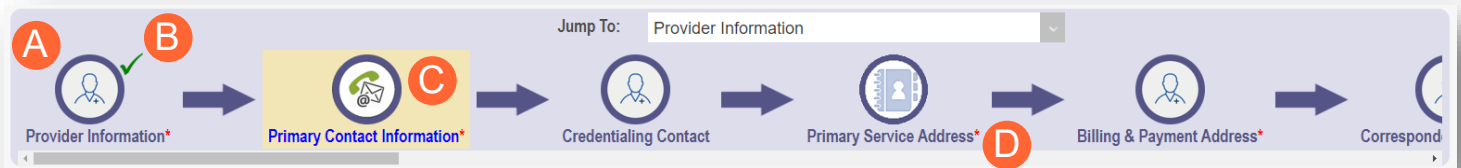
A green checkmark on any page indicates that you have completed the necessary information on that page and can continue through the subsequent pages.

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 your 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 – Facility/Institution Provider

This section displays the necessary steps for creating an initial application (first time enrolling with ODM, ODA or DODD) for a facility/institution.

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?

<div> <div>Menu</div> <div>Ohio Department of Medicaid</div> <div> Provider Network Management Medicaid Home Learning Contact Fee Schedule </div> <div> Training Log out </div> </div>													
My Providers		Account Administration		<div> <div>1</div> <div>New Provider ?</div> </div>									
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date	
517946	Training Medical Group	Complete	21 - Professional Medical Group	1245585009	9999876	Professional Medical Group				02/09/2022	11/14/2023	02/09/2027	

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

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

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

Standard application

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

2

Select

Ordering, Referring, Prescribing

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

Select

Change of Operator

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

Select

MCP Single Case

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

Select

2

Click here for more application types...

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

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

2

Less...

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

Step 3: Next, click Facility/Institution to begin a provider enrollment application.

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

Application Type [Change](#)

3



Individual



Group



Organization



Facility/Institution



Pharmacy

Key Identifiers Information Page

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

Step 1: Enter key provider information for the provider.

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

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

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



The NPI entered is not in the NPPES list.

The NPI entered must be a Type 2 NPI.

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

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

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

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	
518421	Training Nursing Facility	Not Submitted	86 - NURSING FACILITY	1013959857									

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

Manage Application

Enrollment Actions

2 + Enrollment Action Selections:

Programs

+ Program Selections:

Self Service

+ Self Service Selections:

Step 3: Click the hyperlink "Continue Registration."

Manage Application

Enrollment Actions

-

3

Enrollment Action Selections:

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

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

Document Upload Process (Any Page)

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

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

Step 2: Give the file a name.

Step 3: Enter a Description (Optional).

Step 4: Click **Upload File**.

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

Step 6: Click 'Save' or 'Next' to advance to the next page.

Uploaded Documents

Name	Description	File Name	Page Name	Username	View	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

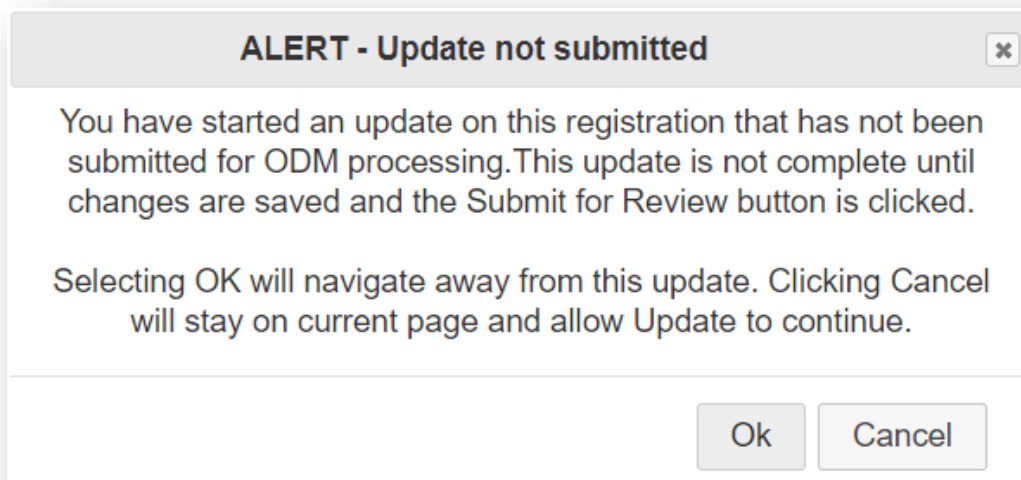
Primary Contact Information (480295)

6 Save Cancel Previous Next

Page Save Warning Message

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

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



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

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

Provider Information Page

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

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

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

For this page the following fields are required:

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

Step 2:

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

Primary Contact Information Page

The Primary Contact Page is the next page that displays on the application. This is the primary contact who will receive communications from PNM and be responsible for managing those communications as well as returning any required information that is needed to process the application for enrollment.

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

- Name
- Address
- City
- State
- Zip
- Phone Number 1 (*can enter multiple*)
- Email Address 1 (*can enter multiple*)

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

Step 3:

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

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 located on the right side. In the center, there is a large 'Add Contact' button. Below it, the text 'No records found' is displayed. 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 Primary Service Address Page

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 located on the right side. In the center, there is a large 'Add Contact' button. Below it, the text 'No records found' is displayed. On the left side, 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:

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

Primary Service Address

5 Save Cancel Previous Next

This is a required section.



An asterisk * indicates a required field

Override Address Validation ☐

1 Organization Name* Training Test Clinic

Primary Service Address* 2400 Corporate Exchange Drive

Address 2

City* Columbus

State* OH

County*

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1* trainingclinic@testtraining.com

History

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

☐ Provider Directory Opt-Out

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

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

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

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

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

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

2 **Provider Information** *Only required for Individual registrations

Cultural Competencies

Languages Spoken

Specialized Training

Hours of Operation *Hours providers available for appointments

Monday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Tuesday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Wednesday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Thursday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Friday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Saturday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Sunday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours

3 **Office Information**

Website

24-hour telephone coverage

Public transportation access

Electronic billing

TDD/TTY

Cultural Competencies

Languages Spoken

Specialized Training

ADA Compliance*

ASL Offered*

Translation Services ☐ Language ☐ Translation

4 **Patient Information**

Accept new patients

Accept new patients from referral only

Youngest patients accepted

Oldest patients accepted

Gender of patient Accepted

Accept newborn*

Accept pregnant women

Step 5:

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

Address Pages

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

Billing & Payment Address Page

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

Same as Practice Location☐

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

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

Override Address Validation☐

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

Jump To: Billing & Payment Address

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

Generate PDF

Save Cancel Previous Next

This is a required section.

Same as Practice Location☐

Override Address Validation☐

Address Type: Individual Organization

Organization Name*

Title

Address 1*

Address 2

City*

State*

County*

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

Correspondence Address Page

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

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

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

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

Jump To: Correspondence Address

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

Generate PDF

Save Cancel Previous Next

This is a required section.

An asterisk * indicates a required field

Same as Practice Location☐

Override Address Validation☐

Address Type: Individual Organization

Organization Name*

Address 1*

Address 2

City*

State*

County*

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

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.

Long Term Care Addresses Page

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

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

The screenshot shows a web application interface for managing facility information. At the top, a navigation bar contains a 'Jump To:' dropdown menu set to 'Long Term Care Addresses'. Below this is a horizontal flow of seven icons representing different sections: 'Idress*', '1099 Address*', 'Home Office Address*', 'Long Term Care Addresses*' (highlighted in yellow), 'Specialties*', 'Taxonomies*', and 'Medicare Number*'. The main content area is titled 'Long Term Care Addresses' and displays the message 'No records found.' in a light gray font. On the right side of the main area, there are four buttons: 'Save', 'Cancel', 'Previous', and 'Next'. Below these buttons is a 'History' link. In the bottom right corner, there is a red circle with the number '1' next to an 'Add New' button. Another red circle with the number '4' is located near the 'Next' button. A 'Generate PDF' button is also visible in the top right corner of the main content area.

Jump To: Long Term Care Addresses

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

Generate PDF

Save Cancel Previous Next

Long Term Care Addresses

This is a required section.

No records found.

History

1 Add New

4

Step 2:

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

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

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

The screenshot shows a form for entering facility address information. At the top, there are two checkboxes: 'Same as Practice Location' and 'Override Address Validation', both with red circle 2 callouts. Below these is a 'Location Type*' dropdown menu with a red circle 3 callout. Under the dropdown is the 'Address Type' section with radio buttons for 'Individual' and 'Organization' (selected). Below this is the 'Organization Name*' field with a red circle 2 callout. The form continues with fields for 'Address 1*', 'Address 2', 'City*', 'State*' (dropdown), 'County' (dropdown), 'Zip*', 'Ext Zip*', 'Phone Number 1*', 'Phone Ext 1', 'Phone Number 2', 'Phone Ext 2', 'Fax Number 1', 'Fax Number 2', 'Contact Name', and 'Email Address 1*'.

Same as Practice Location ☐ 2

Override Address Validation ☐

3 Location Type*

Address Type ☐ Individual ☒ Organization

2 Organization Name*

Address 1*

Address 2

City*

State*

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

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

Specialties Page

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

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

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

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

Jump To: Specialties

Service Locations

1099 Address*

Home Office Address*

Specialties*

Taxonomies*

Professional Licenses*

CLIA Certifications

Generate PDF

Save

Cancel

Previous

Next

Specialties

This is a required section.

Primary Specialties are not editable by provider after application submission.

No records found

1

Add New

Save

Cancel

Previous

Next

Specialties

This is a required section.

Primary Specialties are not editable by provider after application submission.

Add New

☒ Designate a Primary Specialty .

Designate a Primary Specialty and save first before secondary specialties can be entered.

1

Specialty*

Start Date*

End Date

1/19/2024

12/31/2299

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

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

Specialties
This is a required section.

2 Save Cancel Previous Next 4

Primary Specialties are not editable by provider after application submission.

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

3 Add New
History

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

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

Removing Specialties

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

Specialties
This is a required section.

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

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

Add New
History

Taxonomies Page

The Taxonomies page allows you to add, edit, or remove taxonomy codes that are associated in PNM. Taxonomies associated through NPPES will automatically appear as options within PNM.

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

Jump To: Taxonomies

Address*

Long Term Care Addresses*

Specialties*

Taxonomies*

Medicare Number*

MCP Affiliation

Nursing Facility V

Generate PDF

Save

Cancel

Previous

Next

Taxonomies

This is a required section.

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

Add New

History

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	
282E00000X	LONG TERM CARE HOSPITAL	Yes	01/19/2024	12/31/2299	<div><div></div><div></div></div>

1

Add New

History

Taxonomy*

2

☐ Is Primary Taxonomy

3

Start Date*

4

End Date

26

Editing or Changing Primary Taxonomy

Step 1: Click the ‘pencil and paper’ icon next to the Taxonomy on the list associated with your application.

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

Step 3: Select the checkbox for ‘Is Primary Taxonomy.’

Step 4: Confirm your changes have been adjusted.

Step 5: Click **Save** to save your work.

Step 6: Click **Next** to save and proceed to the next page.

Taxonomies

Save

Cancel

Previous

Next

5


6

This is a required section.

Taxonomy	Taxonomy Description	Primary	Start Date	End Date	1
282E00000X	LONG TERM CARE HOSPITAL	Yes	01/19/2024	12/31/2299	<div><div></div><div></div></div>

Add New

History



2

Taxonomy*

(282E00000X)

3

☒ Is Primary Taxonomy

4

Start Date*

01/19/2024

End Date

12/31/2299

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.

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.

Nursing Facility Ventilator

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

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

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

Jump To: Nursing Facility Ventilator

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

Generate PDF

Save Cancel Previous Next

Nursing Facility Ventilator
This is a required section.

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

Yes/No Nursing Facility Ventilator

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

Save Cancel Previous Next

Nursing Facility Ventilator
This is a required section.

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

2 Ventilator Questions

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

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

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

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

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

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

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

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

Weaning Questions

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

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

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

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

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

Nursing Facility Ventilator
This is a required section.

Save

Cancel

Previous

Next

3

Are you applying as a new nursing facility ventilator provider?

☒ No ☐ Yes

4

Professional Liability Insurance Page

This page allows 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**.

Jump To: Professional Liability Insurance

Group, Organizations & Hospital Affiliations → MCP Affiliation → **Professional Liability Insurance*** → W9 Form* → EFT Banking* → Owner Information

Generate PDF

Save Cancel Previous Next

Professional Liability Insurance

This is a required section.

History

No records found

1 Add New

Yes/No Professional Liability Insurance

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

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

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

Do you carry malpractice insurance? 2 ☒ Yes ☐ No

Self-Insured? Yes

Policy Number*

Effective Date*

Original Effective Date*

Expiration Date*

Type of Coverage*

Do you have unlimited coverage?*

Policy includes tail coverage?*

Carrier or Self-Insured Name*

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

Carrier address 1

Carrier address 2

City*

State*

County

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

W9 Form Page

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

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

Jump To: W9 Form

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

Generate PDF

Save Cancel Previous Next

W9 Form

This is a required section.

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

Legal Business Name: Training Nursing Facility
EIN: 101395985

1 Select the most appropriate category below:

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

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

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

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

Indicate the form you are uploading

2 ☒ W9 ☐ Form 147

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

Required Document

W-9
W9.pdf Download Remove
Browse

3

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

EFT Banking Information Page

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

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

Jump To: EFT Banking

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

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

Save Cancel Previous Next Generate PDF

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

Step 8: Click **Save**.

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

Confirm

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

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

☒ I confirm the information provided is true and accurate.

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

EFT Banking Information

This is a required section.

10

Application Fee

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

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

Paying The Fee

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

Step 2: Click **Select Payment**.

Application Fee

Save

Cancel

Previous

Next

This is a required section.

Application Fee

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

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

Fee Amount

\$688.00

Fee Status

Pending

Payment Type

1


☒ Credit Card

☐ Request Waiver of Application Fee

2

Authorize Payment

Select Payment



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

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

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

CBOSS BETA





Enter New Account

3

Name on Card

Card Number

MM/YY

Address Line 1

Address Line 2

City

State

Zip

Country

Phone Number

Email Address

☐ Remember For Future Use

Cancel

4 Submit

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

Application Fee

SaveCancelPreviousNext

This is a required section.

Application Fee

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

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

Fee Amount

\$688.00

Fee Status

Pending

Payment Type

☒ Credit Card

☐ Request Waiver of Application Fee

5

Authorize Payment

Select Payment

MasterCard ... 8767

Waiving the Fee

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

Application Fee

This is a required section.

Application Fee

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

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

Fee Amount

\$688.00

Fee Status

Pending

Payment Type

1

☐ Credit Card

☒ Request Waiver of Application Fee

Authorize Payment

Select Payment

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

Please note your Registration ID on the check.

Amount*

\$688.00

2

Waiver Reason

Medicare Enrolled

Paid in Another State

Paid in the past 5 years

Medicare Enrollment Pending

Comments

Fee Payment History

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

Please note your Registration ID on the check.

Amount*

\$688.00

Waiver Reason

Paid in the past 5 years

3

Comments

Paid 1/5/2023

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

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

Browse

4

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

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

Proof of Payment_2.pdf

Download

Remove

Browse

Owner Information

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

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

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

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

Jump To: Owner Information

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

Generate PDF

Save Cancel Previous Next

Owner Information
This is a required section

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

1 + Instructions

2 - Definitions & Requirements

2 - Owner, Managing Employee and Controlling Interest Information

No owner information found.

3 Add New

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

+ Real Estate Owners

+ Additional Disclosure

2 - Questions

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

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

Step 5: Click **Save**.

Owner Information

4

Owner Type*

Owner Title

Affiliation Type*

Address 1*

Address 2

City*

State*

County

Zip*

Percentage of Ownership*

Owner End Date

5 **Save** **Cancel**

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

- Owner, Managing Employee and Controlling Interest Information

6

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

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

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

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

- Questions

7

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No








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

☐ Yes

☐ No

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

Jump To: Owner Information

Owner Information
This is a required section.

Save Cancel Previous Next

8 DF

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

ODI Application-Please Upload a Completed and signed ODI Standardized Credentialing PartB (found at:"<https://insurance.ohio.gov/static/Forms/Documents/INS5036.pdf>")

Browse 1

Optional Document

Site Visit/Accreditation

Browse

Optional Document

ODH issued Certificate of Need - CON

Browse

Optional Document

ODH Nursing Home License

Browse

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.'

Agreements
This is a required section.

Ohio Medicaid Provider Agreement

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

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

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

☒ I agree to Terms and Conditions

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

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

☒ I agree to Terms and Conditions

Agreement Date: 1/19/2024

Step 3: Under the Provision Check section:

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

☐ If you meet this provision, please check this box

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

Agreements

This is a required section.

Save

Cancel

Previous

Next

Ohio Medicaid Provider Agreement

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

4 Long Term Care Facility (LTCF) Agreement

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

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

Provider Signature

☐ Option A **4**

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

☐ Option B **4**

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

Step 5: Complete the Provider Agreement Attestation:

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

Provider Agreement Attestation 5

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

Step 6: Complete the Provider Agreement Signature:

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

Step 7: Click Save.

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

Provider Agreement Signature

6 Name of Person Attesting*: ?

Provider Name:

User ID:

7

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

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

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

8

Submitting Application

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

The screenshot shows a progress bar at the top with seven steps: Liability Insurance*, W9 Form*, EFT Banking*, Application Fee*, Owner Information*, Required Documents*, and Agreements*. The 'Agreements' step is highlighted with a yellow background and a green checkmark. Below the progress bar, there is a 'Jump To:' dropdown menu set to 'Agreements'. On the right side, there are buttons for 'Generate PDF', 'Submit for Review' (with a red circle containing the number 1), 'Save', 'Cancel', 'Previous', and 'Next'. The main content area is titled 'Agreements' and contains a red message: 'This is a required section.' Below this, there is a section titled 'Ohio Medicaid Provider Agreement' with a red note: 'Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step.' and a smaller text: 'All Providers must read the statements below and agree to the terms'.

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

The screenshot shows a white message box with a black border. It contains the text: '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.' Below this, it says: 'Once your review is complete, you must click 'Submit for Review' at the top of the Agreements page to submit your application.' At the bottom right, there is a red circle containing the number 2 and a black button with the text '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.

The screenshot shows a white message box with a black border. At the top, there is a red circle containing the number 4 and the text 'Submission Confirmation'. Below this, it says: 'You have successfully submitted your application to the Medicaid Program. Please allow at least 10 days for processing before attempting to submit any changes.' At the bottom, there is a red circle containing the number 5 and a black button with the text 'Return to Home Page'.

Resubmitting an Application (Return to Provider – RTP)

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

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

Provider Name: Training Nursing Facility

Medicaid ID:

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

REG_ID: 518421

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

<div> <div>Menu</div> <div>Ohio Department of Medicaid</div> <div> Provider Network Management Medicaid Home Learning Contact Fee Schedule </div> <div>Ashley Reeves</div> <div>Log out</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	
518421	Training Nursing Facility	Return to Provider	86 - NURSING FACILITY	1013959857		Dual Certified Skilled Nursing Facility					01/19/2024		

Reviewing Correspondence

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

Provider Management Home

Registration Information

Previous Page

Provider Name

Medicaid ID

Effective Date

Revalidation Due Date

Term Date

Training Nursing Facility

Manage Application

Enrollment Actions

+

Enrollment Action Selections:

Programs

+

Program Selections:

Self Service

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
518421	Application Flow - Standard - NEW REGISTRATION	Medicaid	606881	Return to Provider			01/19/24	N

Step 2: Click the ‘Provider Correspondence’ hyperlink.

Manage Application

Enrollment Actions

+

Enrollment Action Selections:

Programs

+

Program Selections:

Self Service

-

Self Service Selections:

[View Provider File](#)

2

[Provider Correspondence](#)

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

3 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
Send Additional Information (RTP Notice) 4	ENROLLMENT	12/26/2023	
Ohio Medicaid Provider Application Received	ENROLLMENT	12/26/2023	

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

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

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 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,

5 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

Training Nursing Facility

Medicaid ID

Effective Date

Revalidation Due Date

Term Date

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
518421	Application Flow - Standard - NEW REGISTRATION	Medicaid	606881	Return to Provider			01/19/24	N

Step 2: Click the ‘Continue Registration’ hyperlink.

Manage Application

Enrollment Actions

2 - Enrollment Action Selections: ?

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. Above the progress bar is a 'Jump To:' dropdown menu currently set to 'Professional Licenses'. Below the progress bar, the 'Board Certification' section is active, displaying the message 'No Board Certification found'. To the right of this message are buttons for 'Save', 'Cancel', 'Previous', and 'Next'. Further right, there is a 'Generate PDF' button and a large red circle with the number '6' next to a 'Submit for Review' button. At the bottom right, there is an 'Add New' button.

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

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

The screenshot shows a confirmation message box with a light gray background. At the top, there is a red circle with the number '7' followed by the text 'Submission Confirmation'. Below this, the message 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.' At the bottom of the box, there is a red circle with the number '8' next to a blue button labeled 'Return to Home Page'.

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> Provider Network Management Medicaid Home Learning Contact Fee Schedule </div> <div>Ashley Reeves Log out</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
518421	Training Nursing Facility	Complete	86 - NURSING FACILITY	1013959857	9999886	Dual Certified Skilled Nursing Facility				01/19/2024	01/19/2024	01/19/2029

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

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

<div> <div>Menu</div> <div>Ohio Department of Medicaid</div> <div> Provider Network Management Medicaid Home Learning Contact Fee Schedule </div> <div>Ashley Reeves Log out</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
518421	Training Nursing Facility	Complete	86 - NURSING FACILITY	1013959857	9999886	Dual Certified Skilled Nursing Facility				01/19/2024	01/19/2024	01/19/2029

Completing an Update to a Medicaid Record

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

Step 1: Access the provider's record on your dashboard by clicking on the link listed under Reg ID or Provider.

Menu

Ohio

Department of Medicaid

Provider Network Management

Medicaid Home

Learning

Contact

Fee Schedule

Ashley Reeves

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
518421	Training Nursing Facility	Complete	86 - NURSING FACILITY	1013959857	9999886	Dual Certified Skilled Nursing Facility				01/19/2024	01/19/2024	01/19/2029

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

Provider Management Home

Registration Information

Previous Page

Provider Name

Medicaid ID

Effective Date

Revalidation Due Date

Term Date

Training Nursing Facility

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

3 - Enrollment Action Selections:

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, 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

Group, Organizations & Hospital Affiliations

Update

Required Documents

Identification



Update

Provider Information

Address 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.

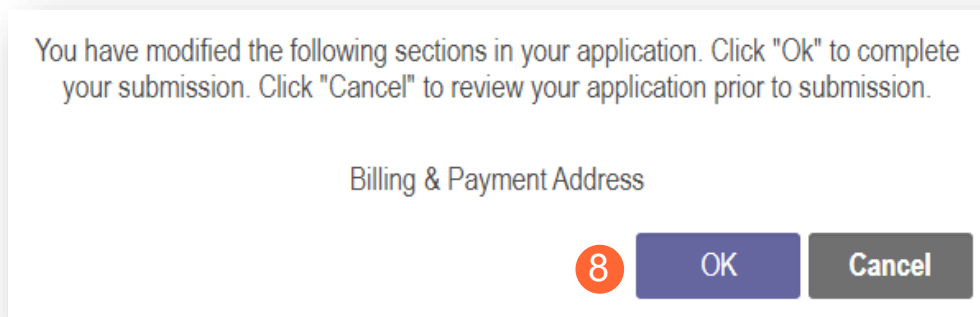
Jump To: Billing & Payment Address

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

Billing & Payment Address
This is a required section.

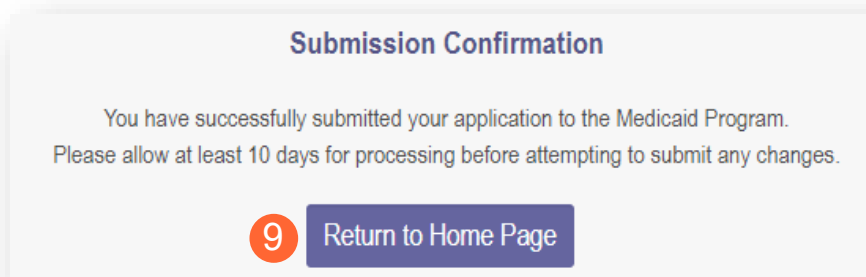
Return to Summary
Generate PDF
7 Submit for Review
Save Cancel
History

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 Affiliations 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.

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.

<div> <div>Menu</div> <div>Ohio Department of Medicaid</div> <div> Provider Network Management Medicaid Home Learning Contact Fee Schedule </div> <div>Ashley Reeves Log out</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	
518421	Training Nursing Facility	Complete	86 - NURSING FACILITY	1013959857	9999886	Dual Certified Skilled Nursing Facility				01/19/2024	01/19/2024	01/19/2029	

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

Provider Management Home

Registration Information

Previous Page

Provider Name

Training Nursing Facility

Medicaid ID

Effective Date

Revalidation Due Date

Term Date

Manage Application

Enrollment Actions

2

+

Enrollment Action Selections:

Programs

+

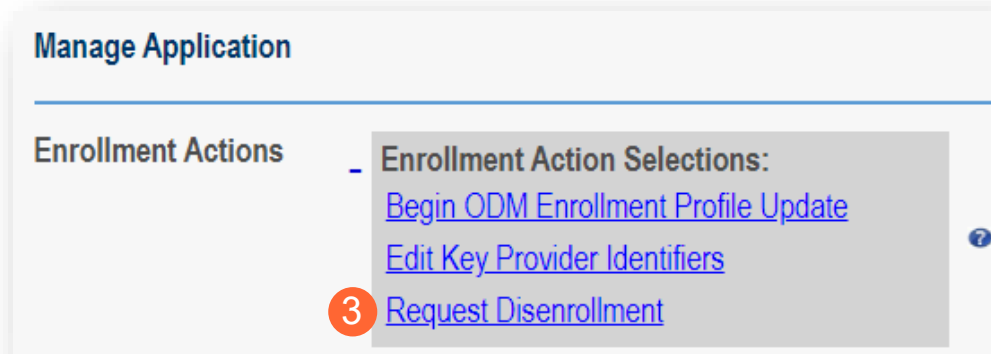
Program Selections:

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**.

A screenshot of a "Request Disenrollment" pop-up window. The window has a blue header bar with the title "Request Disenrollment" and a close button (X icon). Below the header, there is a text field labeled "Disenrollment Effective Date*" with a red circle containing the number 4 next to it. Below the text field, there is a section labeled "Indicate all that apply" followed by a list of 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 of the window, there are two buttons: "Save" and "Cancel", with a red circle containing the number 5 next to the "Save" button.

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.

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 provider 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.

Ohio Department of Medicaid													
Provider Network Management Medicaid Home Learning Contact Fee Schedule Ashley Reeves 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	
518421	Training Nursing Facility	Complete	86 - NURSING FACILITY	1013959857	9999886	Dual Certified Skilled Nursing Facility				01/19/2024	01/19/2024	01/19/2029	

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

Provider Management Home

Registration Information

Previous Page

Provider Name

Training Nursing Facility

Medicaid ID

Effective Date

Revalidation Due Date

Term Date

Manage Application

Enrollment Actions

2 + Enrollment Action Selections:

Programs

+ Program Selections:

Self Service

+ Self Service Selections:

Step 3: Click the 'Begin Revalidation' hyperlink.

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

Enrollment Actions

Enrollment Action Selections:

3

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

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.

Jump To:

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	

Agreements

This is a required section.

Ohio Medicaid Provider Agreement

Note: The Provider Agreement in the screenshot is for informational purposes only. All Providers must read the statements and sign the agreement.

Ohio Revised Code 2921.42 and 2921.43 require that a provider, in accordance with Chapter 102, and Section 2921.43, has reviewed and understands Chapter 102, conflict of interest laws, and (3) will take necessary steps to ensure compliance with these laws.

Proceeding to the next step.

Generate PDF

Submit for Review

Save Cancel Previous Next

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