



USER MANUAL

Behavioral Health Provider Enrollment Applications

Individual Provider



Department of
Medicaid

Table of Contents

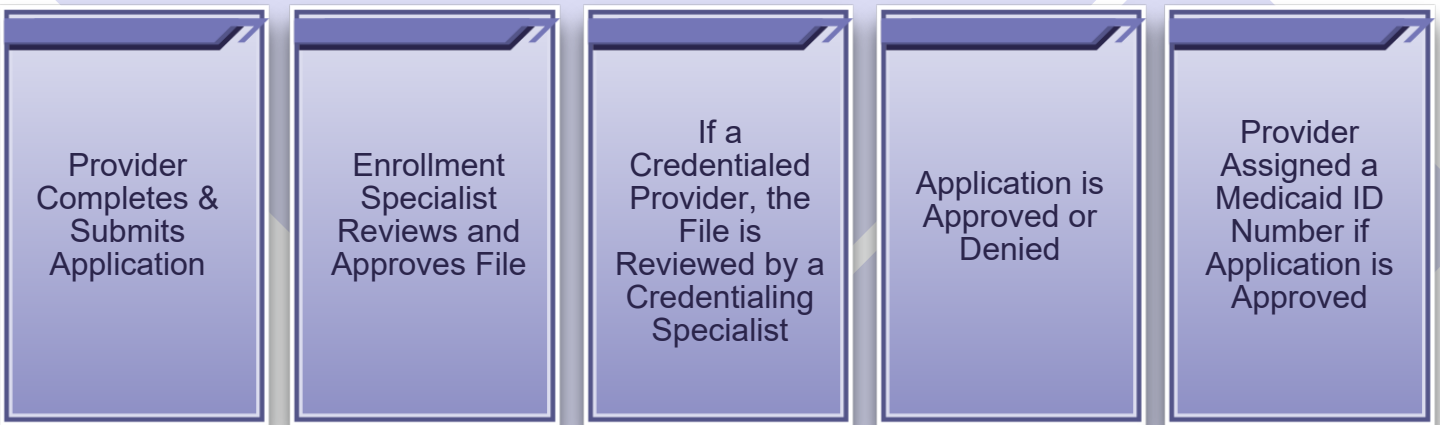
Provider Administrator Initial Login	4
Provider Home Page	6
Individual Provider - New Provider Entry	8
Key Identifier Information	10
Document Upload Process (Any Page)	11
Provider Information Page (Individual).....	12
Primary Contact Information Page	13
USPS Address Search Pop-Up.....	13
Credentialing Contact Page	14
Primary Service Address Page	15
Address Pages.....	17
Billing & Payment Address Page	17
1099 Address Page.....	18
Home Office Address	18
Other Service Locations.....	19
Specialties Page	21
Removing Specialties	22
Taxonomies Page	23
Editing or Changing Primary Taxonomy	25
Professional Licenses	26
Board Certification Page	28
Medicare Number Page	30
Group, Facility & Hospital Affiliations (Individual) Page	32
Adding a Group Affiliation.....	32
Medicaid Pop-Up	32
Adding a Hospital Affiliation	34
MCP Affiliation.....	36
Professional Liability Insurance Page	37
Yes/No Professional Liability Insurance	37
Education Page.....	39
Malpractice Claims History Page	41
Yes/No Malpractice Claims History	41
Work History Page	42
W9 Form Page	44

EFT Banking Information Page	45
Required Documents Page	48
Agreements Page	49
Submitting Application.....	53
Resubmitting an Application	54
Reviewing Correspondence	55
Completing Return to Provider (RTP) Process	57
Submitting a Plan of Correction	60
Review the Final Decision for Provider Submission	63
Completing an Update	64
Revalidation/Re-Enrollment Steps.....	68
Select and Transfer Providers	70

Introduction

This desk reference provides the steps and functions of entering a new Provider application to enroll in the Ohio Department of Medicaid (ODM) program. Once submitted, your application will be processed by the Medicaid Enrollment team and then sent to Credentialing, if Credentialing is required for your Provider type. When all the necessary steps are completed for Enrollment and Credentialing (if necessary), you will receive a 'Welcome Letter' notice and a Medicaid Identification Number will be assigned to the Provider.

This document also contains the steps required when the application is returned to Provider for additional information. Additionally, the process for completing Provider updates and revalidation is included in this document.



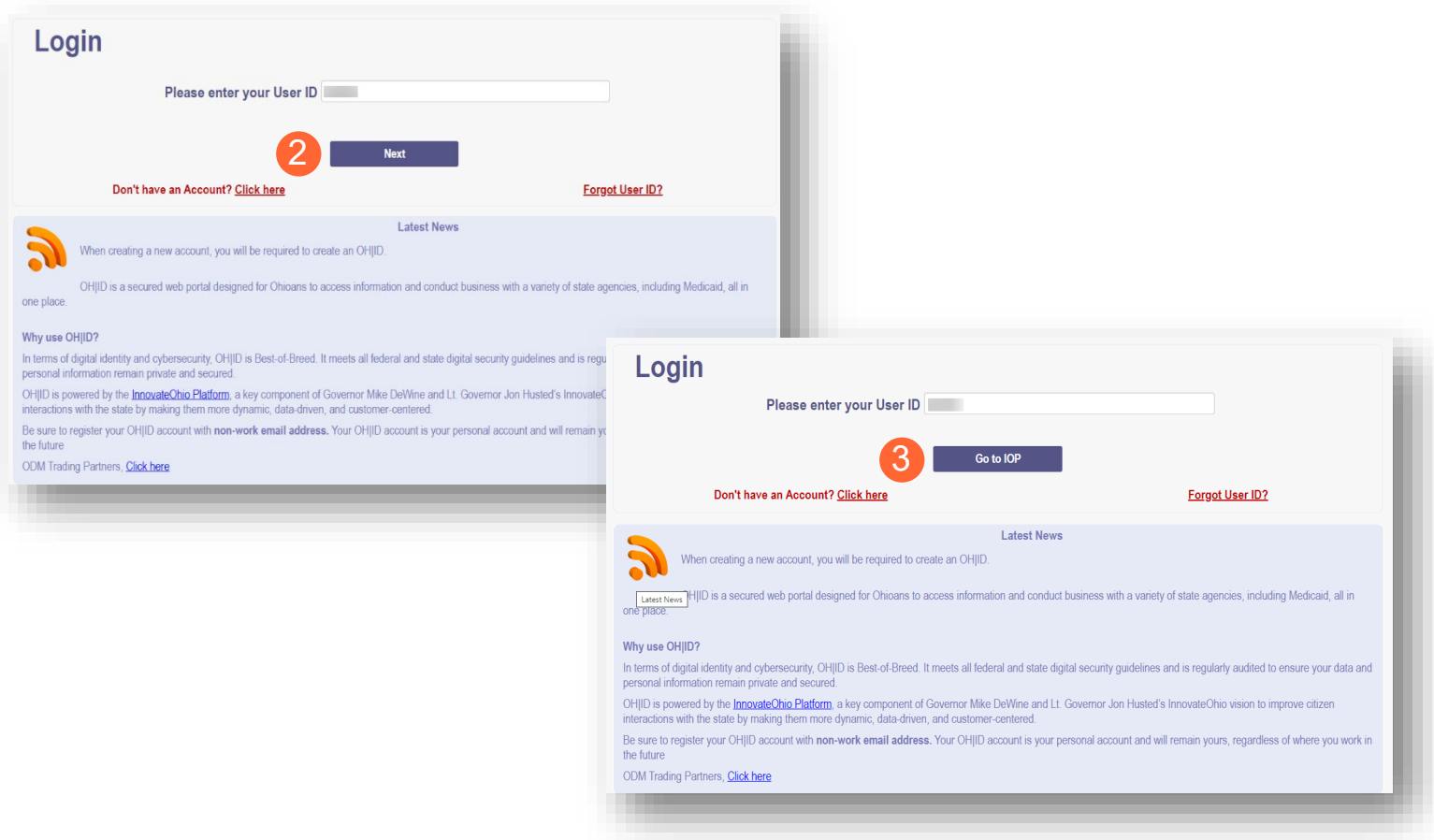
Provider Administrator Initial Login

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

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

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

Step 3: Click 'Go to IOP'



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

OH|ID

Ohio's Digital Identity. One State. One Account.

Register once, use across many State of Ohio websites

Create Account

4 Log In

OH|ID

Password

Log in

[Forgot OH|ID?](#) | [Forgot password?](#)

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

Terms

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

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

5 ☐ Yes, I have read the agreement

Cancel

Provider Home Page

When you first login to the PNM system you will see a variety of buttons to help with administering your Providers.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
154	Provider Trainer	All Complete Approved Return to Provider Not Submitted	Physician/Osteop Individual			Dual Licensed Dentist and Licensed MD/DO			45069 - 1234	09/29/21	09/09/21	09/29/24

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

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

Pending Agent Requests: This button allows you to approve Agent Requests for access to functions such as Submit Claims and Run Reports with Provider records when needed

Account Administration: This button allows you to transfer the Provider to another Account Administrator

New Provider?: This button is used to start a New Enrollment Application for any New Ohio Medicaid Provider that you will be responsible for administering

Page Navigation

Throughout each page on the application, you will have access to buttons to 'Save', 'Cancel' and 'Next' to proceed through the application.

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

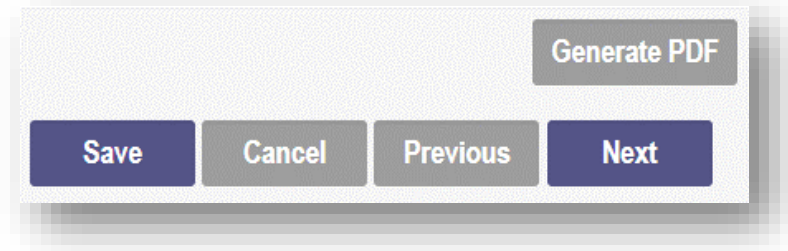
Cancel: Clears the work entered and does not save the page.

Previous: Returns to the previous page.

Next: Saves the current page while advancing to the next page in the application.

Generate PDF: Creates a file with all the application information to be saved to your records.

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

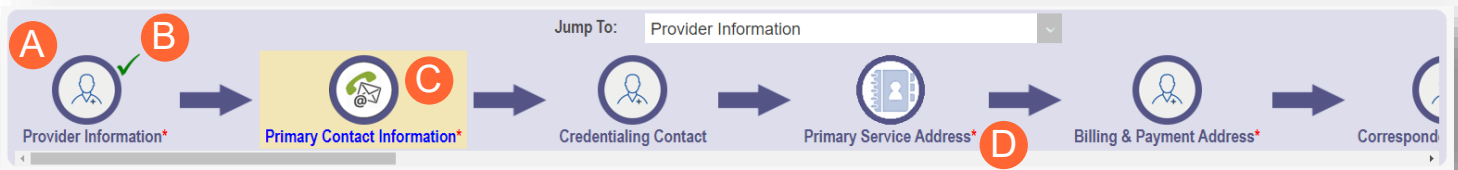


Navigational Bar: A workflow at the top of the page that shows the progress made throughout your application. Click the icon to review a specific page and jump to other pages for entry into the application (A).

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

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

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



Primary Contact Information

This is a required section.

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

Credentialing Contact

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

Individual Provider - New Provider Entry

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

Step 1: Click 'New Provider'

The screenshot shows the top navigation bar with four buttons: 'My Providers', 'Select Provider', 'Pending Agent Requests', and 'Account Administration'. To the right of these buttons is a red circle with the number '1' and a button labeled '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
162	Training WheelChair Van	Complete	WHEELCHAIR VAN			Wheelchair Van			43214 - 1564	09/15/21	09/10/21	09/10/26
190	Vicki J. Trainer	Approved	PHYSICIAN ASSISTANT			PHYSICIAN ASSISTANT			43231 - 7605		10/20/21	
195	Training J. Pharmacist	Complete	Pharmacist			PHARMACIST			43231 - 7605	10/18/21	10/18/21	10/18/24
198	Test Pharmacy	Submitted	PHARMACY			Pharmacy			43085 - 4706		10/19/21	

Step 2: Select the button for the application type for your new Provider

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

Standard application

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](#)

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

- 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	Ordering, Referring, Prescribing	Change of Operator	MCP Single Case
Use this application if you are applying to become a new individual, group, facility, or institutional provider to provide fee-for-service for the State Medicaid program.	Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing.	Use this option if you want to initiate a Change of Operator for Skilled Nursing Facility or Intermediate Care Facility for individuals with intellectual disabilities.	Use this application if you are entering into a Single Case agreement with a Managed Care Plan.
Select	Select	Select	Select 

Less... **2**






Medicaid Waiver (ODM)	Medicaid Waiver (ODA)	Medicaid Waiver (DODD)	Non-Medicaid DODD
Use this application if you are applying to become a Waiver Provider with Ohio Department of Medicaid.	Use this application if you are applying to become a Waiver Provider with Ohio Department of Aging or if you are initiating a Change of Ownership or Change of Operator as an ODA Provider.	Use this application if you are applying to become a Waiver Provider with Ohio Department of Developmental Disabilities.	Use this application if you are applying for one or more of the following options; Supported Living Service, Unpaid Support Broker, ICF Operators, or Licensees.
Select	Select	Select	Select

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

Step 3: Next, click ‘Individual’ to begin an Individual Provider application

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

3 Application Type [Change](#)

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

Key Identifier Information

Step 1: Enter key provider information for the Provider

Enter all required fields marked with an asterisk *

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

Step 2: Click 'Save' to save the information

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



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

Step 3: Select the appropriate primary Taxonomy associated with the Provider's NPI and click 'Save'. If you need to update or add Taxonomy Codes for an Individual Provider, that will be available on the 'Taxonomy' page of the application.

Document Upload Process (Any Page)

The option to upload documents is available on most pages of the application.

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

Step 2: Give the file a name

Step 3: Enter a Description (Optional)

Step 4: Click 'Upload File'

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

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

Uploaded Documents

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

1 Choose File No file chosen

2 Name

3 Description

4 Upload file

File Uploaded: test.pdf_29.pdf

6 Save Cancel Previous Next

Primary Contact Information (480295)

Provider Information Page (Individual)

The first page that displays is the Provider Information page. Fill in all fields and click 'Next' to continue with your application. **Note:** Some information will auto-fill from the key identifier page you previously completed.

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

For this page the following fields are required:

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

Additional fields for optional entry:

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

The screenshot displays the 'Provider Information' form for an individual provider. The form is titled 'Provider Information' with a sub-note 'This is a required section.' in red. A large blue circular icon with a white medical cross is on the left. The form fields are organized into two columns. The left column contains fields for 'Name of Business Entity*', 'DBA', 'Practice Type*', 'Ownership Type*', 'First Name*', 'Middle Initial', 'Last Name*', 'Title', 'Tax ID*', 'NPI', 'NPI Start Date' (09/20/2005), 'Gender*' (with radio buttons for Female, Male, and Unknown), 'Date of Birth*', 'Provider Type*' (Physician/Osteopath Individual), 'Revalidation Date' (Not Set Yet), 'Enrollment Status' (Not Set Yet), 'Enrollment Status Reason' (Not Set Yet), 'Birth Country', 'Birth State', 'Birth City', and 'CAQH #'. The right column contains a 'Save' button, a 'Cancel' button, and a 'Next' button. A red circle with the number '1' is placed over the 'Name of Business Entity*' field. A red circle with the number '2' is placed over the 'Next' button. At the bottom, there is a question 'Have you been a resident of the state OHIO for the last 5 years?' with radio buttons for 'Yes' and 'No' (selected).

Step 2:

- Click 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 for the Provider. This is the primary contact who will be responsible for managing communications and returning any required information that is needed to process the application for enrollment.

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

- Name
- Address
- City
- State
- Zip
- Phone Number
- Email Address

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

Step 3:

- Click the 'Save' button to save the information on the page
- Click the 'Next' button to save and move to the next screen

USPS Address Search Pop-Up

To maintain accurate mailing addresses, PNM uses a USPS system search validation for addresses. Enter an address into PNM and click 'Save' or 'Next.' A USPS system search will review the address and return corrections to the address based on the USPS review.

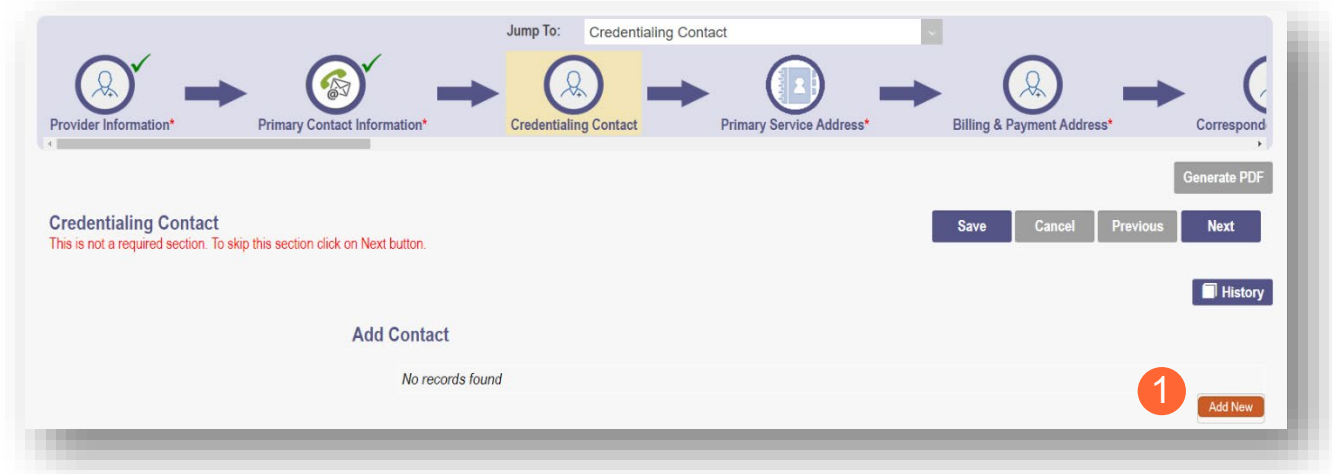
- Confirm the validation and accuracy of the address information
- Click 'Accept' on the USPS confirmation prompt
- Review the changes made to the address
- Click the 'Next' button again to proceed to the next page of the application
- **Note:** If 'Cancel' is selected, you will be taken back to the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

Credentialing Contact Page

This screen allows you to add an individual as a contact for Credentialing in case additional information needs to be gathered for Credentialing purposes.

Note: This page is not required for Behavioral Health Paraprofessionals or Dependently Licensed Behavioral Health Providers.

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

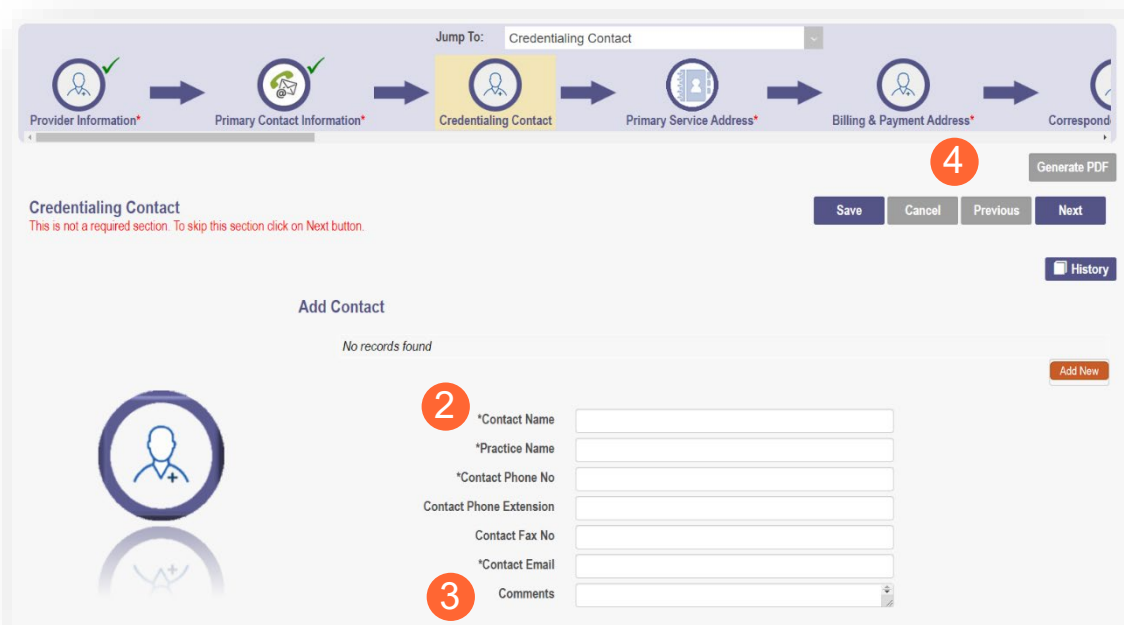


The screenshot shows the 'Credentialing Contact' page. At the top, there is a navigation bar with a 'Jump To:' dropdown menu set to 'Credentialing Contact'. Below the navigation bar, there is a breadcrumb trail with icons and labels: 'Provider Information*' (checked), 'Primary Contact Information*' (checked), 'Credentialing Contact' (highlighted), 'Primary Service Address*', 'Billing & Payment Address*', and 'Correspondence'. Below the breadcrumb trail, there is a 'Generate PDF' button. The main content area is titled 'Credentialing Contact' and contains a red warning message: 'This is not a required section. To skip this section click on Next button.' Below this, there is a 'Save' button, a 'Cancel' button, a 'Previous' button, and a 'Next' button. There is also a 'History' button. The 'Add Contact' section shows 'No records found'. A red circle with the number '1' is placed over the 'Add New' button in the bottom right corner.

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

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

Step 4: Click the 'Save' or 'Next' buttons to save the contact you added to the record and proceed to the next page



The screenshot shows the 'Credentialing Contact' page with the form fields for adding a new contact. The navigation bar and breadcrumb trail are the same as in the previous screenshot. The 'Add Contact' section shows 'No records found'. The form fields are as follows:

- *Contact Name (required)
- *Practice Name (required)
- *Contact Phone No (required)
- Contact Phone Extension
- Contact Fax No
- *Contact Email (required)
- Comments

 A red circle with the number '2' is placed over the 'Contact Name' field. A red circle with the number '3' is placed over the 'Comments' field. A red circle with the number '4' is placed over the 'Next' button in the bottom right corner.

Primary Service Address Page

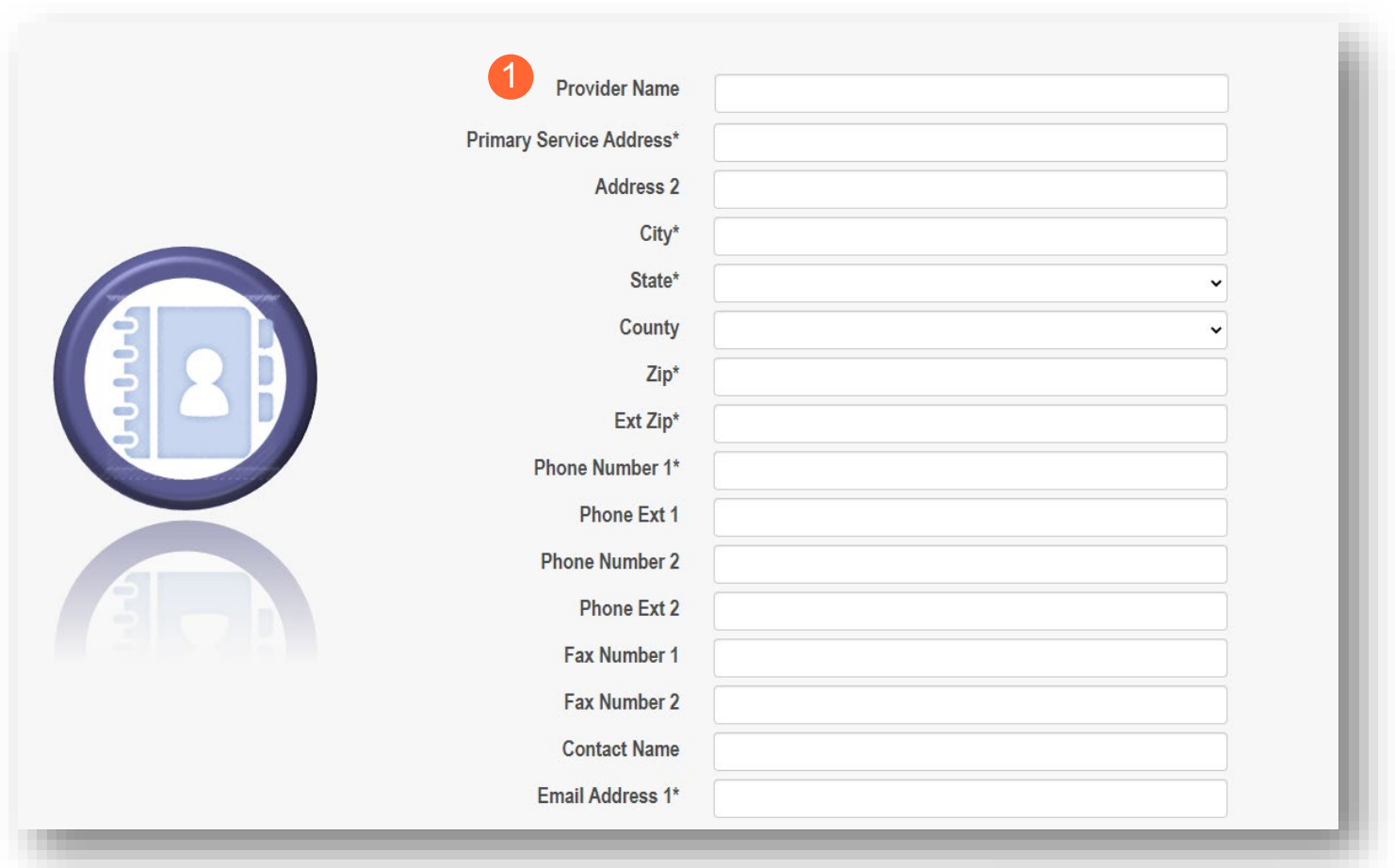
The Primary Service address page provides a place to enter the primary service address for your location along with specific information about your office that will be included in the Provider Directory.

Note: The expectation is for providers to maintain and update information on all address pages

Step 1: Complete the Primary Service Address information.

Required fields include:

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



1

Provider Name

Primary Service Address*

Address 2

City*

State*

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

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

☐ **Provider Directory Opt-Out**

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

- Cultural Competencies
- Languages Spoken
- Specialized Training

Step 3: Indicate specific operating information about yourself or your office using the drop-down menus/data entry fields

- Hours of Operation
- Whether the location is open 24 hours

Step 4: Indicate specific office information about yourself or your office using the drop-down menus/data entry fields

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

Step 5: Indicate specific information about the types of patients your office serves

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

Step 6:

- Click the 'Save' button to save the information on the page or
- Click the 'Next' button to save and move to the next screen

☐ Provider Directory Opt-Out

Provider Information *Only required for Individual registrations

Cultural Competencies

Languages Spoken

Specialized Training

Hours of Operation *Hours providers available for appointments

Monday ☐ Open 24 Hours

Tuesday ☐ Open 24 Hours

Wednesday ☐ Open 24 Hours

Thursday ☐ Open 24 Hours

Friday ☐ Open 24 Hours

Saturday ☐ Open 24 Hours

Sunday ☐ Open 24 Hours

Office Information

Website

24-hour telephone coverage

Public transportation access

Electronic billing

TDD/TTY

Cultural Competencies

Languages Spoken

Specialized Training

ADA Compliance*

ASL Offered*

Translation Services ☐ Language Line ☐ Translation

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

Billing & Payment Address Page


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

[Generate PDF](#)

Save Cancel Previous Next

Billing & Payment Address

This is a required section.



Same as Practice Location ☐

Address Type ☒ Individual ☐ Organization

Title	<input type="text"/>
First Name*	<input type="text"/>
Middle Name	<input type="text"/>
Last Name*	<input type="text"/>
Address 1*	<input type="text"/>
Address 2	<input type="text"/>
City*	<input type="text"/>
State*	<input type="text" value="OH"/>
County	<input type="text"/>
Zip*	<input type="text"/>
Ext Zip*	<input type="text"/>
Phone Number 1*	<input type="text"/>
Phone Ext 1	<input type="text"/>
Phone Number 2	<input type="text"/>
Phone Ext 2	<input type="text"/>
Fax Number 1	<input type="text"/>
Fax Number 2	<input type="text"/>
Contact Name	<input type="text"/>
Email Address 1*	<input type="text"/>

Correspondence Address Page

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

Correspondence Address

This is a required section.

Generate PDF

Save Cancel Previous Next

History

Same as Practice Location

Address Type

Individual

Organization

First Name*

Middle Name

Last Name*

Address 1*

Address 2

City*

State*

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*

OH

1099 Address Page

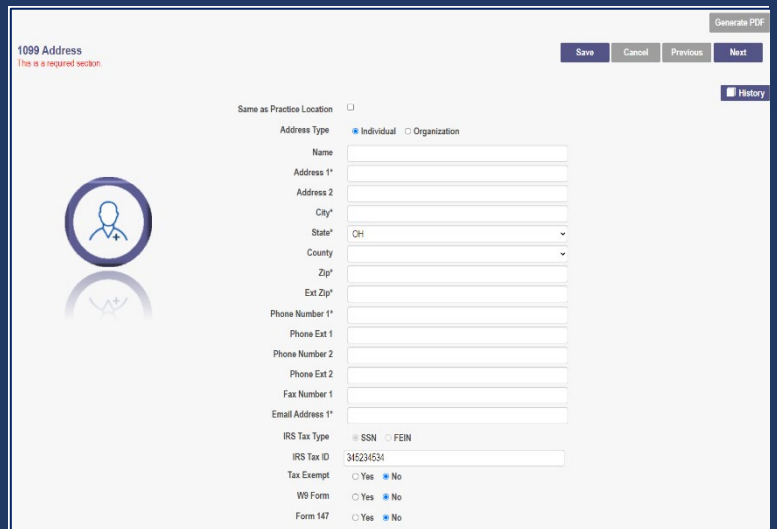
If the 1099 Address is the same as the Primary Service Address, select the check box to indicate it is the 'Same as the Practice Location.' This will pre-populate information that was entered on the previous screen into the fields.

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

Depending on the original Provider entry and Provider type, the relevant tax identification information will display automatically.

Select the radio buttons for 'Tax Exempt'; Type of form (W9 or 147)

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



1099 Address
This is a required section.

Generate PDF

Save Cancel Previous Next

History

Same as Practice Location ☐

Address Type ☒ Individual ☐ Organization

Name

Address 1*

Address 2

City*

State* OH

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Email Address 1*

IRS Tax Type ☒ SSN ☐ FEIN

IRS Tax ID

Tax Exempt ☐ Yes ☒ No

W9 Form ☐ Yes ☒ No

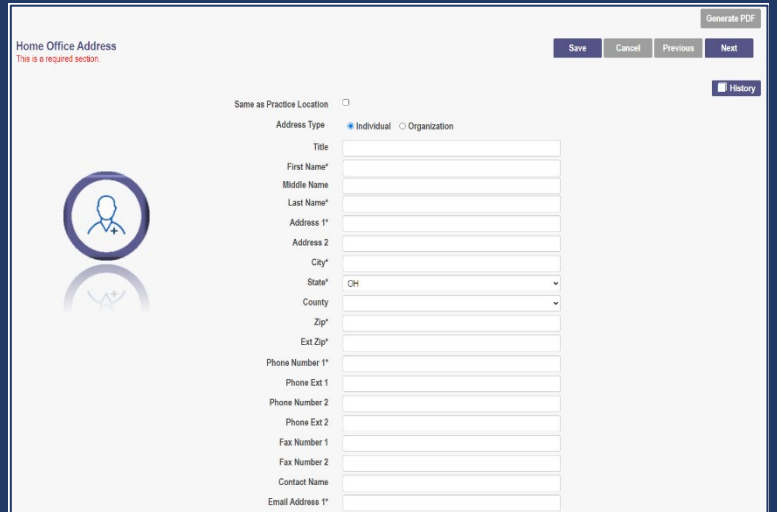
Form 147 ☐ Yes ☒ No

Home Office Address

If the Home Office Address is the same as the Primary Service Address, select the check box to indicate it is the 'Same as the Practice Location.'

This will pre-populate information that was entered on the previous screen into the fields.

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



Home Office Address
This is a required section.

Generate PDF

Save Cancel Previous Next

History

Same as Practice Location ☐

Address Type ☒ Individual ☐ Organization

Title

First Name*

Middle Name

Last Name*

Address 1*

Address 2

City*

State* OH

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

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

Step 2: Complete all line items with an asterisk *

Step 3: Click 'Save' to save the address

- Select 'Add New' to add any additional addresses

Step 4: Indicate additional operating information regarding the service location.

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

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

19

☐ Provider Directory Opt-Out

4

Provider Information *Only required for Individual registrations

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

Hours of Operation *Hours providers available for appointments

Monday	<input type="text"/>	<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

Office Information

Website	<input type="text"/>
24-hour telephone coverage	<input type="text" value="Yes"/>
Public transportation access	<input type="text" value="Yes"/>
Electronic billing	<input type="text" value="Yes"/>
TDD/TDY	<input type="text" value="Yes"/>
Cultural Competencies	<input type="text"/>
Languages Spoken	<input type="text"/>
Specialized Training	<input type="text"/>
ADA Compliance*	<input type="text" value="--Select ADA--"/>
ASL Offered*	<input type="text" value="Yes"/>
Translation Services	<input type="checkbox"/> Language Line <input type="checkbox"/> Translation

Patient Information

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

Specialties Page

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

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

Step 1: Click 'Add New' to add a Specialty

- The Specialty drop-down has a variety of specialties that are associated with your Provider type
- If it is your primary specialty, select the check box that allows you to 'Designate as Primary Specialty'

The screenshot shows the top navigation bar of the Specialties Page. It includes a 'Jump To:' dropdown menu set to 'Specialties'. Below the navigation bar, there is a progress indicator with icons for 'My Service Locations', '1099 Address*', 'Home Office Address*', 'Specialties*', 'Taxonomies*', 'Professional Licenses*', and 'CLIA Certifications'. The 'Specialties*' icon is highlighted. Below the progress bar, there is a 'Generate PDF' button and a row of buttons: 'Save', 'Cancel', 'Previous', and 'Next'. The 'Specialties' section title is followed by the text 'This is a required section.' Below this, a message states 'Primary Specialties are not editable by provider after application submission.' and 'No records found'. A red circle with the number '1' is next to the 'Add New' button.

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

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

The screenshot shows the 'Add New' form for specialties. At the top right, there is a 'Generate PDF' button and a row of buttons: 'Save', 'Cancel', 'Previous', and 'Next'. The 'Specialties' section title is followed by the text 'This is a required section.' Below this, a message states 'Primary Specialties are not editable by provider after application submission.' and 'No records found'. A red circle with the number '2' is next to the 'Save' button. A red circle with the number '3' is next to the 'Add New' button. On the left side, there is a circular icon with a DNA helix and a magnifying glass. Below the icon, there is a checkbox labeled 'Designate a Primary Specialty.' which is checked. Below the checkbox, there is a red text message: 'Designate a Primary Specialty and save first before secondary specialties can be entered.' A red circle with the number '1' is next to the 'Specialty*' dropdown menu. Below the dropdown menu, there are two input fields: 'Start Date*' with the value '5/5/2022' and 'End Date' with the value '12/31/2299'.

Note: The 'Enroll Status' of the Specialties will show as INACTIVE until your Enrollment Application has been fully approved

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

Specialties
This is a required section.

Generate PDF
4

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

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

Add New
History

Removing Specialties

Step 1: To Remove an added Specialty:

- Click the 'x' associated with the applicable specialty line

Specialties
This is a required section.

Generate PDF

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

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

Add New
History

Taxonomies Page

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

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

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

Taxonomies

This is a required section.

Generate PDF

SaveCancelPreviousNext

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

Add New

History

INDIVIDUAL PROVIDER

If you need to include additional taxonomy codes to your record, manually add them by following the process below:

Step 1: Click 'Add New' to add a taxonomy code

Step 2: Indicate a Primary Taxonomy by selecting the check box 'Is Primary Taxonomy'

Step 3: Enter the 'Start Date' (This is the date Taxonomy was added to your NPI record)

Step 4: Enter the 'End Date' (This field can be left blank)

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

Taxonomies
This is a required section.

GenPDF5

SaveCancelPreviousNext

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

Taxonomy*

2

☐ Is Primary Taxonomy

3

Start Date*

4

End Date

Editing or Changing Primary Taxonomy

Step 1: Click the 'Pencil and Notepad' icon next to the taxonomy on the list associated with your application

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

Step 3: Select the checkbox for 'Is Primary Taxonomy'

Step 4: Confirm your changes have been adjusted



Step 5: Click 'Save' to save your work

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

Taxonomies

This is a required section.

5 Save Cancel Prev 6 Next

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

Add New

History



Taxonomy* Social Worker Clinical (1041C0700X) 2

3 ☒ Is Primary Taxonomy

4 Start Date* 05/05/2022

End Date 12/31/2299

Professional Licenses

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

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

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

Professional Licenses

This is a required section.

Generate PDF

SaveCancelPreviousNext

History

1Add New

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

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

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

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

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

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

Professional Licenses
This is a required section.

Get PDF

Save Cancel Previous Next

History

Add New

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

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

2

State*

License Board Name*

If Other, enter Board Name:

License Number*

Effective Date*

Expiration Date*

License Status

Address 1

Address 2

City

State OH

County

Zip

Endorsement Number

Endorsement Status

Endorsement Focus

Endorsement Specialty

Certifying Organization

Certificate Date

Certificate Expiration

Uploaded Documents

Optional Document

Professional License

3

Browse

Board Certification Page

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

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

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

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

The screenshot shows the 'Board Certification' section with the same red note as before. To the right are buttons for 'Save', 'Cancel', 'Previous', and 'Next'. Below this, the text 'No Board Certification found' is displayed. In the bottom right corner, there is a red circle with the number '2' and an 'Add New' button. Below the 'Add New' button, the question 'Are you Board Certified?' is displayed with two radio buttons: 'No' and 'Yes'. Below the radio buttons, the text 'If Yes, Please enter board certification information requested or confirm previously entered information is correct' is displayed.

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

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

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

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

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

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

No Board Certification found

Are you Board Certified? ☐ No ☒ Yes

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

3 Board Certification*

Board Specialty*

Certificate Number

Effective Date*

Expiration Date*

4 4 Add New

4

Uploaded Documents

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

Medicare Number Page

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

Step 3: Determine if you need to add Medicaid through another State

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

Step 4: Click 'Save' to save your work

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

Medicare Number

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

4

Save

Cancel

Previous

5

Next

Group, Facility & Hospital Affiliations (Individual) Page

If you select a Specialty that is an Assistant, Intern, or Trainee, you will need to complete this page. Behavioral Health Paraprofessionals will also be required to complete.

Note: BH policy requires that initially enrolling dependently licensed providers and paraprofessional be affiliated with a BH Organization (Type 84 and/or 95) as a condition of enrollment

Adding a Group Affiliation

Step 1: To add a Group Affiliation:

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

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

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

Generate PDF

Save Cancel Previous Next

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

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

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

1 Add New

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

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

Hospital Affiliations

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

Add New

Medicaid Pop-Up

Step 2: Enter the Medicaid ID

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

Step 3: Click 'Save' to continue

Group Affiliation

2 Medicaid ID 0000046

NPI

3 Save Cancel

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

Group, Facility & Hospital Affiliations (Individual)

This is a required section.

Generate PDF

Save

Cancel

Previous

Next

Pending Group Affiliations

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

4

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

Add New

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

Group, Facility & Hospital Affiliations (Individual)

This is a required section.

Generate PDF

Save

Cancel

Previous

Next

Pending Group Affiliations

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

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

Add New



Confirmed Group Affiliations

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

5

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address
------------	-----	-------------	------------	----------	--------------------	---------

No confirmed affiliations found.

Adding a Hospital Affiliation

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

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

Step 2: Click 'Save' to continue

The screenshot shows a web form titled "Hospital Affiliation". A red circle with the number "1" is positioned above the first question. The form contains the following fields and controls:

- Question: "Do you practice exclusively within the Inpatient Setting?*" with radio buttons for "Yes" and "No" (selected).
- Question: "Do you have hospital privileges?*" with radio buttons for "Yes" and "No" (selected).
- Text input field: "If 'No', please specify" with a clear button.
- Form element: "This is my Primary Facility" with an unchecked checkbox.
- Text input field: "Ohio Medicaid ID*" with a clear button.
- Text input field: "Facility Name*" with a clear button.
- Dropdown menu: "Status of Privileges*" with a downward arrow.
- Dropdown menu: "Staff Category*" with a downward arrow.
- Text input field: "Start Date*" with a clear button.
- Text input field: "End Date" with the value "12/31/2299".
- Question: "Any past or present restriction of privileges?*" with radio buttons for "Yes" and "No" (selected).
- Text input field: "If 'Yes', please specify" with a clear button.
- Buttons: "Save" and "Cancel" at the bottom.

A red circle with the number "2" is positioned above the "Save" button.

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

Step 4: Click 'Save' to save your work

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

Group, Facility & Hospital Affiliations (Individual)

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

Save

Cancel

Previous

Next

4

5

Pending Group Affiliations

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

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

Add New

Confirmed Group Affiliations

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

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

3

Hospital Affiliations

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

Add New

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

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

Information will be updated by the ODM Credentialing staff after submission.

Delegated Credentialing

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

Assigned Delegates

Delegate Name	Delegate MED ID
---------------	-----------------

No delegates.

MCP Affiliation

This page allows you to confirm your interest with an Ohio Medicaid Managed Care Plan.

Step 1: Indicate if you are interested in contracting with any of the Ohio Medicaid Managed Care Plans by selecting 'Yes' or 'No' radio button

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

The screenshot shows a progress bar at the top with steps: Medicare Number, Group, Facility & Hospital Affiliations (Individual), MCP Affiliation (highlighted), State CDS Number, Federal DEA Registration*, and Professional. Below the progress bar, the 'MCP Affiliation' section is active. It includes a 'Generate PDF' button and a 'Save' button. The main question is 'Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans?' with a red circle '1' next to the 'No' radio button. A 'Please Note' message states: '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'. Below this is a table titled 'Confirmed MCP Affiliations' with columns: Name, Start Date, End Date, and Provider Type. The table is empty with the text '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

The screenshot shows the 'MCP Affiliation' section with the 'Yes' radio button selected. The question is 'Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans?'. Below the question, it says 'Indicate your interested in possible participation with one or more Ohio Medicaid Managed Care Plans'. A red circle '2' is next to a list of checkboxes for the following plans: AmeriHealth Caritas, Anthem Blue Cross, Aetna, Buckeye, CareSource, Humana, Molina, and United Health Care. A 'Please Note' message states: 'This indication does not ensure a contract with the Ohio Medicaid Managed Care Plans. Providers must still go thru the plan's contracting process, if applicable'.

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

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

Professional Liability Insurance Page

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

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

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

Professional Liability Insurance
This is a required section.

Generate PDF

Save Cancel Previous Next

History

No records found

1 Add New

Yes/No Professional Liability Insurance

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

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

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

Do you carry malpractice insurance? 2 ☒ Yes ☐ No

Self Insured? Yes

Policy Number*

Effective Date*

Original Effective Date*

Expiration Date*

Type of Coverage*

Do you have unlimited coverage?

Policy includes tail coverage*

Carrier or Self-Insured Name*

Carrier address 1

Carrier address 2

City*

State* OH

County

Zip*

Policy Holder*

Coverage Amount Per Occurrence*

Coverage Amount Per Aggregate*

Step 3: If you select ‘No,’ you will need to provide an explanation regarding malpractice insurance

Do you carry malpractice insurance?

☐ Yes ☒ No

If No, please provide explanation below.

3

Please provide an explanation regarding malpractice insurance

Step 4: Click ‘Next’ to save and move to the next screen

Professional Liability Insurance

This is a required section.

Get PDF

4

Save Cancel Previous Next

History

Carrying malpractice insurance?	Policy Number	Effective Date	Expiration Date	Policy Holder	Coverage Account Per Occurrence	Coverage Account Per Aggregate	Explanation regarding malpractice insurance	
Yes	3423423423	01/01/2020	01/01/2025	Test Policy Holder	3,000,000	5,000,000		

Add New

Education Page

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

Note: This page will only display for credentialed Providers

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

The screenshot shows the top navigation bar with a 'Jump To:' dropdown menu set to 'Education'. Below the navigation bar, the 'Education' section is highlighted. The main content area displays the message 'Please enter all education and training you have completed beginning with your undergraduate degree through your professional education and training.' and 'No records found'. A red circle with the number '1' and an 'Add New' button are visible in the bottom right corner.

Step 2: Enter the required fields with an asterisk

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

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

The screenshot shows the 'Education' form with a red circle and the number '2' indicating the start of the form. The form includes the following fields: *Education Type (dropdown), *Name Of School (text), *Start Date (text), *End Date (text), *Degree/ Certificate Awarded (dropdown), Speciality (dropdown), *Address 1 (text), Address 2 (text), *City (text), *State (dropdown), * Zip Code (text), *Country (dropdown, currently set to UNITED STATES), Phone Number (text), Fax (text), and Additional Information (text area).

Step 3: Click 'Save' to continue

Step 4: Confirm that the Undergraduate School saved

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

Education
This is a required section.

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

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

5 [Add New](#)

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

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

Education
This is a required section.

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

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

[Add New](#)

Malpractice Claims History Page

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

Note: This page will only display for required Providers

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

Yes/No Malpractice Claims History

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

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

1
☐ No
 ☒ Yes

No MalpracticeClaim found.

1
Add New

Date of Occurrence*

Date Claim Filed*

Status of the claim*
Open

If settled, the date the claim was settled

Professional liability carrier involved*

Carrier Address Line1*

Carrier Address Line2

City*

State*

Zip*

Phone Number 1*

Phone Ext 1

Policy Number

Method of Resolution

If settled, the amount of settlement

Describe the allegations against you*

Were You*
☐ Primary Defendant ☐ Co-Defendant

No of Other Defendants (if any)

Your role in case*

Describe the alleged injury to the patient

Did the alleged injury result in death?

To the best of your knowledge, is the case included in the NPDB?*

Step 2: After filling in the required fields, click ‘Next’ to save the information and proceed to the next page

Work History Page

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

Note: This page is only required to be completed by credentialed Providers

Include a chronological work history for the past 5 years.

No records found

1

Add New

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

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

1

Current Employer ☐

*Practice/ Employer Name:

* Start Date:

* End Date:

Organization Name*

Address 1*

Address 2

City*

State*

OH

County

Zip*

Phone Number 1

Phone Ext 1

Fax Number 1

Contact Name

Email Address 1*

Email Address 2

Additional Information:

Reason for Departure(If Applicable):

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

No

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

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

Jump To: Work History

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

Work History
This is a required section.

2

Generate PDF

Save Cancel Previous Next

Include a chronological work history for the past 5 years.

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

3 Add New

Gaps in Work History

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

No records found

4 Add New

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

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

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

Gaps in Work History

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

No records found

4

*Gap Start Date:

*Gap End Date:

*Reason For Gap:

W9 Form Page

On this page, indicate which tax filing category and document you complete to provide the correct EIN/TIN

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

The screenshot shows the 'W9 Form' page. At the top, a navigation bar includes icons for 'Personal Liability Insurance*', 'Education*', 'Malpractice Claims History*', 'Work History*', 'W9 Form*' (highlighted), 'Required Documents', and 'Agreements*'. A 'Jump To:' dropdown menu is set to 'W9 Form'. Below the navigation bar, there are buttons for 'Save', 'Cancel', 'Previous', and 'Next'. A 'Get PDF' button with a red circle containing the number '4' is also visible. The main section is titled 'W9 Form' with a red note: 'This is a required section.' Below this, a message states: 'Information from the Identification page displayed below. Corrections to this information must be made in Organization/Individual Identification and Primary Contact sections of the Identification page.' The 'Individual Name' field contains 'Training' and the 'SSN' field is masked. A red circle with the number '1' is next to the 'Select the most appropriate category below:' text. The categories are listed as radio buttons: Individual/sole proprietor of single-member LLC, C Corporation, S Corporation, Partnership, Trust/Estate, Limited Liability C Corporation, Limited Liability S Corporation, Limited Liability Partnership, and Other.

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

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

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

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

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

EFT Banking Information Page

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

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

Step 2: Read the instructions section before proceeding to Step 3

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

Step 3: To enter your Bank Account information, click 'Add New' under the Banking Information Section

EFT Banking Information

This is a required section.

Generate PDF

SaveCancelPreviousNext

1

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

☐ Yes
 ☐ No

2

Instructions

READ INSTRUCTIONS BEFORE COMPLETING

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

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

3

Please enter your banking information below.

Banking Information

No banking information found.

Add New

EFT Contact

No EFT contact found.

Add New

Confirm

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

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

☐ I confirm the information provided is true and accurate.

Step 4: Complete the required information

- Financial Institution Name
- Financial Routing Number
- Confirm the Routing Number
- Account Number
- Confirm the Account Number
- Account Type: Checking or Savings

Step 5: Click 'Save'

Banking Information

4

Financial Institution Name*

Financial Institution Routing Number*

Confirm Financial Institution Routing Number*

Account Number*

Confirm Account Number*

Account Type*
☒ Checking
☐ Savings

5

Save

Cancel

Step 6: Click 'Add New' to enter information for the EFT Contact

Banking Information

Financial Institution Name	Account Number	Account Type	
Training Bank	*****	Checking	

EFT Contact

No EFT contact found.

6

Add New

Confirm

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

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

☐ I confirm the information provided is true and accurate.

Step 7: Enter the following contact information for the person who will handle the Electric Funds Transfer account

Required

- Contact First Name
- Last Name
- Phone Number
- Email Address

Optional

- Middle Name
- Phone Extension
- Fax Number

EFT Contact Information
7

Provider Contact First Name*

Middle Name

Last Name*

Phone Number*

() - -

Extension

Email Address*

Fax Number

() - -

8

Save

Cancel

Step 8: Click 'Save'

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

Confirm

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

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

☒ I confirm the information provided is true and accurate.

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

EFT Banking Information
This is a required section.

Gen PDF

10

Save

Cancel

Previous

Next

Required Documents Page

The required documents page allows you to upload required or optional supporting documentation

Step 1: If you have additional documentation not uploaded on other pages, you can upload it here

Step 2: If you are required to upload documents, blue upload boxes will be displayed under the Required Documents section

- To upload a document, click 'Browse'
 - Select the file on your computer and open

Required Document

Documentation of Training/Certification

2

Step 3: If you want to upload a document not required by any previous page, click 'Choose File'

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

Jump To: Required Documents

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

Generate PDF

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

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

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

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

3

No file chosen

Name

Description

Agreements Page

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

Step 1: Complete the Ohio Medicaid Provider Agreement attestation. The agreement must be viewed in its entirety before the 'I Agree' box will be available for selection.

- Click 'I agree to Terms and Conditions'

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

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

Step 3: Under the Provision Check section:

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

Step 4: Complete the Additional Credentialing Statement questions if your Provider type requires credentialing

Possible 'Additional Credentialing Statement' questions:

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

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

Additional Credentialing Statement

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

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

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

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

Step 5: Complete the Individual Provider Questions

Possible Individual Provider Questions:

- Have you or any individuals or organizations having a direct or indirect ownership or controlling interest of 5 percent or more in the professional association or practice been indicted or convicted of a criminal offense related to the involvement of such persons or organization in any of the programs established by Titles XVIII, XIX, or XX?
- Have you or any of the employees of your professional association or practice ever been indicted or convicted of a criminal offense related to the involvement in such programs established by Titles XVIII, XIX, or XX?
- Have you as the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors; or Officers of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?

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

Individual Provider Questions

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

☐ No ☐ Yes

If, 'Yes' a comment is required.

5

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

☐ No ☐ Yes

If, 'Yes' a comment is required.

Step 6: Complete the Provider Agreement Attestation

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

Provider Agreement Attestation

6

☐

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

Step 7: Complete the Provider Agreement Signature

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

Step 8: Click 'Save'

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

Provider Agreement Signature

7 Name of Person Attesting*: Training ⓘ

Provider Name: Training

User ID: provaccount

8 Save

Step 9: Click 'OK' to review your application prior to submission

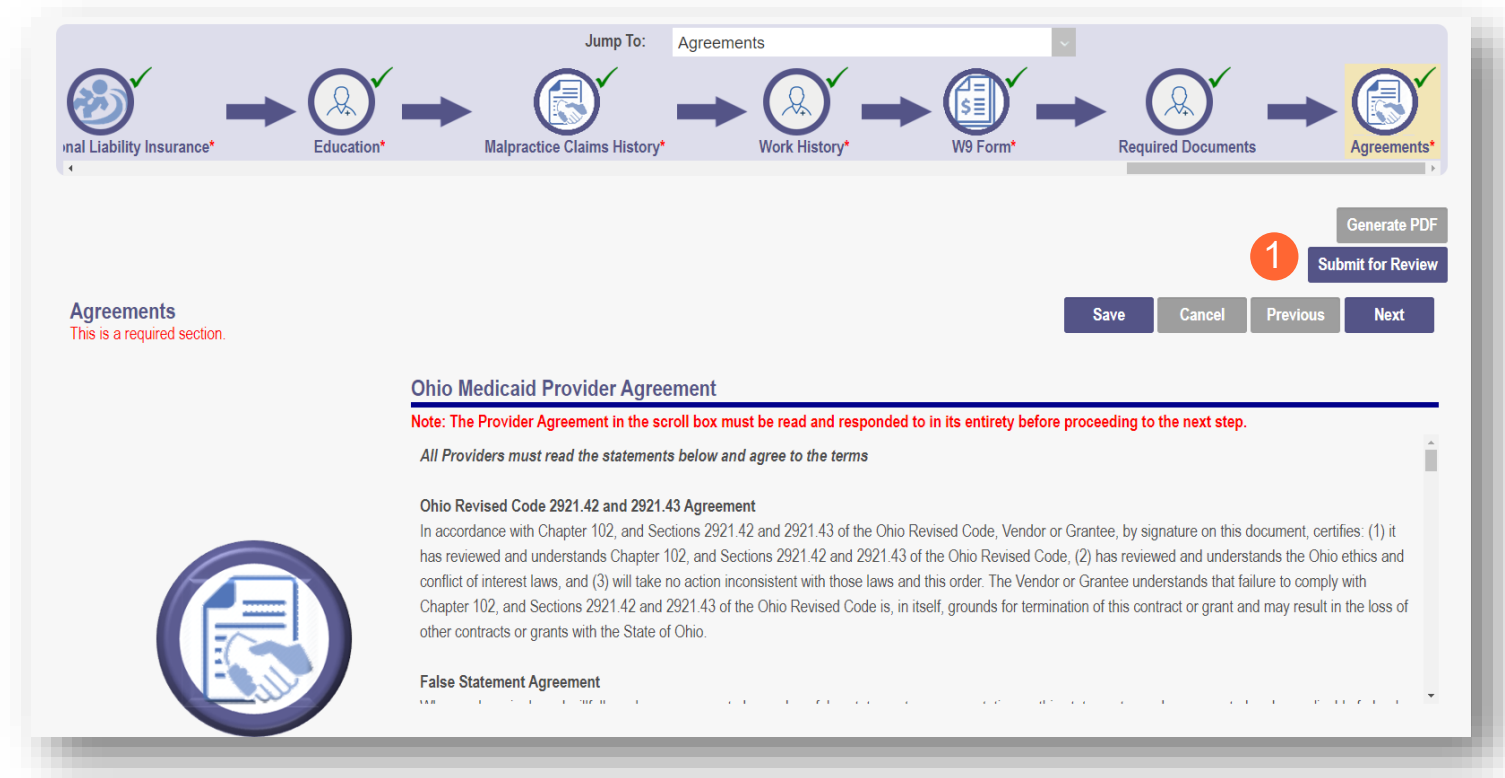
Your application is complete and has been saved. Please take time to review your application prior to submission. You will be able to generate your completed application in PDF form prior to submitting your application.

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

9 OK

Submitting Application

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



Jump To: Agreements

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

Generate PDF

1 Submit for Review

Save Cancel Previous Next

Agreements
This is a required section.

Ohio Medicaid Provider Agreement

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

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

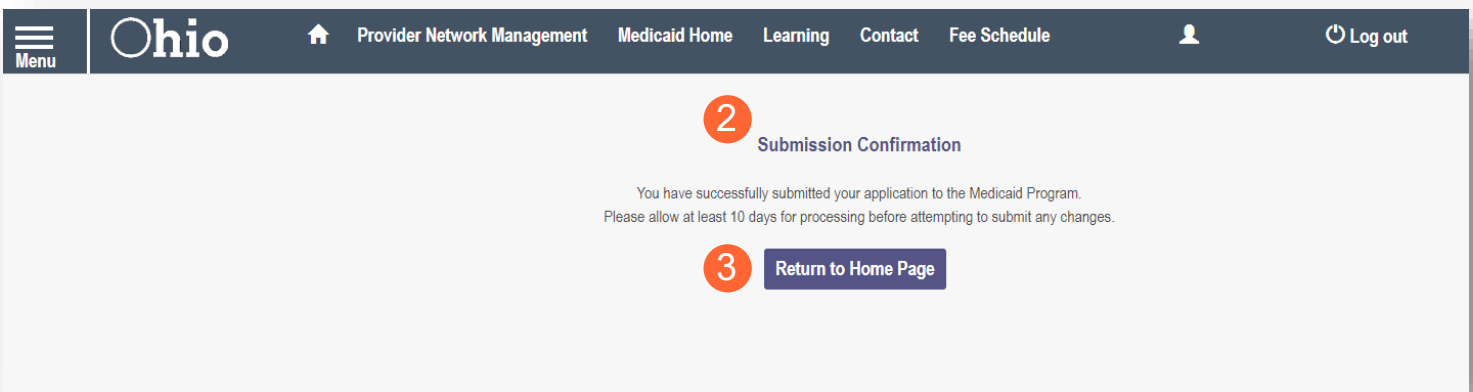
Ohio Revised Code 2921.42 and 2921.43 Agreement

In accordance with Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

False Statement Agreement

Step 2: You will receive a confirmation message stating that your application has been successfully submitted

Step 3: Click 'Return to Home Page' to go to your dashboard



Menu Ohio

Provider Network Management Medicaid Home Learning Contact Fee Schedule Log out

2 Submission Confirmation

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

3 Return to Home Page

Resubmitting an Application

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

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

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

Step 2: Access your application (in 'Return to Provider' status) by logging into PNM and clicking on the link either under the Reg ID or the Provider heading

<div> <div>Menu</div> <div>Ohio</div> <div> Provider Network Management Medicaid Home Learning Contact Fee Schedule </div> <div> <div>Log out</div> </div> </div>												
<div> <div>My Providers</div> <div>Select Provider</div> <div>Pending Agent Requests</div> <div>Account Administration</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
519460	Training Mental Health Provider	Not Submitted	95 - OMHAS CERTIFIED/LI TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program						
519468	Sharon Aaron	Return to Provider	47 - CLINICAL COUNSELING	1073521589		LICENSED PROFESSION COUNSELOR					05/05/22	

Reviewing Correspondence

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

Provider Management Home

Registration Information

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

Manage Application

Enrollment Actions	+ Enrollment Action Selections:
Programs	+ Program Selections:
Self Service	1 + Self Service Selections:

My Current and Previous Applications

Reg ID	Enrollment Action	Program	Application Id	PNM Application Status	Other Agency Application Status	DD Legal Status	Status Date
519468	Application Flow - Standard - NEW REGISTRATION	Medicaid	608334	NOT PROCESSED			05/05/22

Step 2: Click the 'Provider Correspondence' hyperlink

Manage Application

Enrollment Actions	+ Enrollment Action Selections:
Programs	+ Program Selections:
Self Service	- Self Service Selections:
	2 Provider Correspondence

Step 3: To locate correspondence, complete the following

- Select 'Enrollment Notifications' from the Correspondence Type drop-down menu
- Enter a data range for the search
- Click 'Search'

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

CORRESPONDENCE SEARCH RESULT				
Correspondence Search Results				
Correspondence Subject	Correspondence Type	Date Sent	Date Viewed	Printed
Send Additional Information (RTP Notice)	ENROLLMENT	03/21/2022		✓
Ohio Medicaid Provider Application Received	ENROLLMENT	03/21/2022		

Step 5: Review the correspondence to understand the reason for the return. Once you have viewed, you can click the 'X' in the top-right corner to close

Completing Return to Provider (RTP) Process

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

Provider Management Home

Registration Information

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

Manage Application

Enrollment Actions	1 + Enrollment Action Selections:
Programs	+ Program Selections:
Self Service	+ Self Service Selections:

My Current and Previous Applications

Reg ID	Enrollment Action	Program	Application Id	PNM Application Status	Other Agency Application Status	DD Legal Status	Status Date
519468	Application Flow - Standard - NEW REGISTRATION	Medicaid	608334	NOT PROCESSED			05/05/22

Step 2: Click the 'Continue Registration' hyperlink

Enrollment Actions

2

Enrollment Action Selections:

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

Programs

+

Program Selections:

Self Service

+

Self Service Selections:

Step 3: The application will open to the page that was rejected during the review

- Rejected pages are marked with a yellow exclamation point
- Messaging will appear at the top of the page indicating the reason the application was rejected

Step 4: Correct or update the information of the page

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

3

Jump To: Professional Licenses

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

Generate PDF


Save Cancel Previous Next

Professional Licenses
This is a required section.

History

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

4

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

Add New

Step 5: Click 'Save' to save the new information

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

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

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

5

OK

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

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

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

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

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

Submitting a Plan of Correction

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

Step 2: Access your application (in 'Return to Provider' status) by logging into PNM and clicking on the link either under the Reg ID or the Provider heading

Menu

Ohio

🏠

Provider Network Management

Medicaid Home

Learning

Contact

Fee Schedule

👤

Log out

My Providers

Select Provider

Pending Agent Requests

Account Administration

New Provider ?

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<div>169</div>	<div>Donald Trainer</div>	Approved	Physician/Oste Individual			Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706		09/16/21	
<div>170</div> <div>2</div>	<div>Training Clinic</div>	Submitted	CLINIC			Primary Care Clinic			43085 - 4706		09/16/21	
<div>171</div>	<div>Kim Trainer</div>	Return to Provider	Chiropractor Individual			Chiropractic Services			43085 - 4706		09/16/21	

1

2

3

4

5

6

7

8

9

10

Page size: 10

93 items in 10 pages

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

Provider Management Home

Registration Information

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

Manage Application

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

Step 4: Click the 'Continue Registration' hyperlink

The screenshot shows a sidebar menu on the left with three items: 'Enrollment Actions', 'Programs', and 'Self Service'. To the right of this menu are three expandable panels. The first panel, 'Enrollment Action Selections:', is expanded and contains three links: 'Continue Registration', 'Cancel New Registration', and 'Edit Key Provider Identifiers'. The second panel, 'Program Selections:', and the third panel, 'Self Service Selections:', are collapsed and show a plus sign icon.

Enrollment Actions	-	Enrollment Action Selections: Continue Registration Cancel New Registration Edit Key Provider Identifiers
Programs	+	Program Selections:
Self Service	+	Self Service Selections:

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

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

The screenshot shows the 'Site Visit Screening' page. At the top, it says 'Original Screening Complete Date 09/20/2021'. On the left is a circular icon with a person silhouette and a plus sign. The main content area has two sections. The first section, 'Notice Of Deficiency', is marked with a red circle containing the number 5. It shows a file named 'Notice of Deficiency.jpg' with a 'Download' link and a 'Browse' button. The second section, 'Plan Of Correction', is marked with a red circle containing the number 6. It shows a 'Date of Plan of Correction' field with the value '9/20/21', a file named 'Plan of Correction.jpg' with a 'Download' link, and a 'Browse' button. At the bottom left, there is a section titled 'Uploaded Documents'.

Original Screening Complete Date 09/20/2021

5 Notice Of Deficiency
Notice of Deficiency.jpg Download
Browse

Plan Of Correction
Date of Plan of Correction 9/20/21

6 Plan of Correction
Plan of Correction.jpg Download
Browse

Uploaded Documents

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

Jump To: Site Visit Screening

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

Generate PDF

7 Plan of Correction

Cancel

Site Visit Screening
This is a required section.

Original Screening Complete Date 09/20/2021

Notice Of Deficiency

Notice of Deficiency.jpg	Download
--------------------------	----------

Browse

Plan Of Correction

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

Uploaded Documents

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

No uploaded documents found.

	Choose File	No file chosen
Name	<input type="text"/>	
Description	<input type="text"/>	

Upload file

Review the Final Decision for Provider Submission

Step 1: Once the entire review process has been approved, you will be assigned a Medicaid ID number

- Use number timeline at the bottom to navigate to the last page
- Locate your newly assigned Medicaid ID number next to your application in the table

Ohio													
Provider Network Management Medicaid Home Learning Contact Fee Schedule Log out													
My Providers Select Provider Pending Agent Requests Account Administration New Provider ?													
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date	
169	Donald Trainer	Complete	Physician/Oste Individual		0000134	Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706	09/29/21	09/16/21	09/29/24	
170	Training Clinic	Complete	CLINIC		0000122	Primary Care Clinic			43085 - 4706	09/16/21	09/16/21	09/16/26	
171	Kim Trainer	Complete	Chiropractor Individual		0000135	Chiropractic Services			43085 - 4706	09/29/21	09/16/21	09/29/24	

Page size: 10 101 items in 11 pages

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

- Here you can view communications, view Provider file, begin revalidation, and access other Provider self service functions. Click the '+' icon to expand the Selections.

Ohio													
Provider Network Management Medicaid Home Learning Contact Fee Schedule Log out													
My Providers Select Provider Pending Agent Requests Account Administration													
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID								
169	Donald Trainer	Complete	Physician/Oste Individual		0000134								
170	Training Clinic	Complete	CLINIC		0000122								
171	Kim Trainer	Complete	Chiropractor Individual		0000135								

Completing an Update

Step 1: Access the file in your dashboard by clicking on link listed under Reg ID or Provider

My Providers

Select Provider

Pending Agent Requests

Account Administration

New Provider ?

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
519460	Training Mental Health Provider	Not Submitted	95 - OMHAS CERTIFIED/LI TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program						
519468	Sharon Aaron	Complete	47 - CLINICAL COUNSELING	1073521589	0000394	LICENSED PROFESSION COUNSELOR				05/05/22	05/05/22	05/05/27

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

Provider Management Home

Registration Information

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

Manage Application

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

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

Enrollment Actions

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

Step 4: Choose which element on the file you wish to update from the provided list and click 'Update'

Provider Update - Lets keep your information current !

Please click Update button to update your provider information. Once you have completed all your updates, you will be able to submit your changes from this screen.

4



Most Common Updates

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



Credentialing Information

- | | |
|--------|----------------------------------|
| Update | Credentialing Contact |
| Update | State CDS Number |
| Update | Professional Liability Insurance |
| Update | Malpractice Claims History |



Address Information

- | | |
|--------|---------------------------|
| Update | Office Information |
| Update | Billing & Payment Address |
| Update | Correspondence Address |
| Update | Other Service Locations |
| Update | 1099 Address |
| Update | Home Office Address |

Step 5: Update the file page that you selected and click 'Save' once finished

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

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

Jump To: Specialties

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

6 Return to Summary
5 Generate PDF
Save Cancel

Specialties
This is a required section.

Primary Specialties are not editable by provider after application submission.

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

Add New
History

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

Jump To: Specialties

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

Return to Summary
Generate PDF
7 Submit for Review
Save Cancel

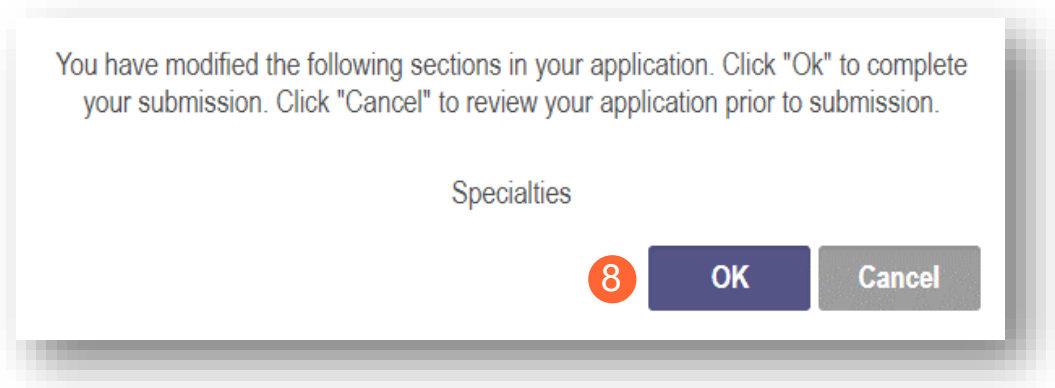
Specialties
This is a required section.

Primary Specialties are not editable by provider after application submission.

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

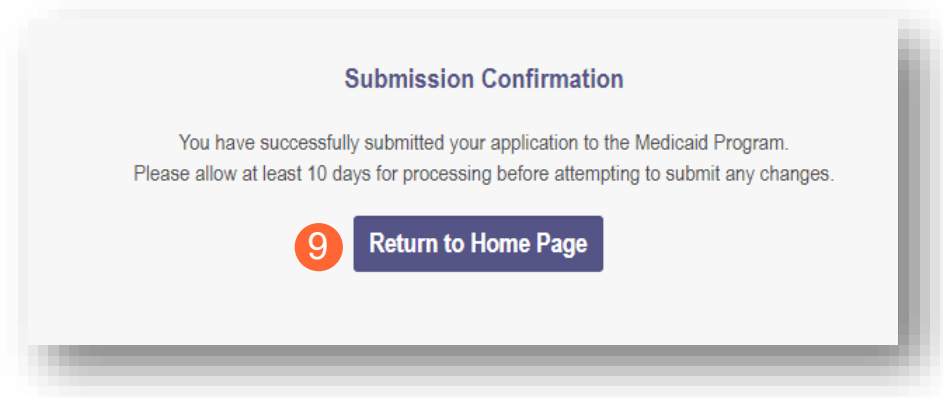
Add New
History

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



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

- Click the 'Return to Home Page' button to go to your dashboard



Revalidation/Re-Enrollment Steps

Revalidation/Re-Enrollment is required for all enrolled Providers. This occurs every three (3) years for Credentialed Providers and every five (5) years for Non-Credentialed Providers. You will receive emailed notices when your application is due for revalidation. You can also view the Revalidation Due Date in the far-right column on the dashboard.

Step 1: Access the application in your dashboard by clicking on link listed under Reg ID or Provider

My Providers Select Provider Pending Agent Requests Account Administration New Provider ?												
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
519460	Training Mental Health Provider	Not Submitted	95 - OMHAS CERTIFIED/LI TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program						
519468	Sharon Aaron	Complete	47 - CLINICAL COUNSELING	1073521589	0000394	LICENSED PROFESSION COUNSELOR				05/05/17	05/05/17	05/05/22

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

Provider Management Home

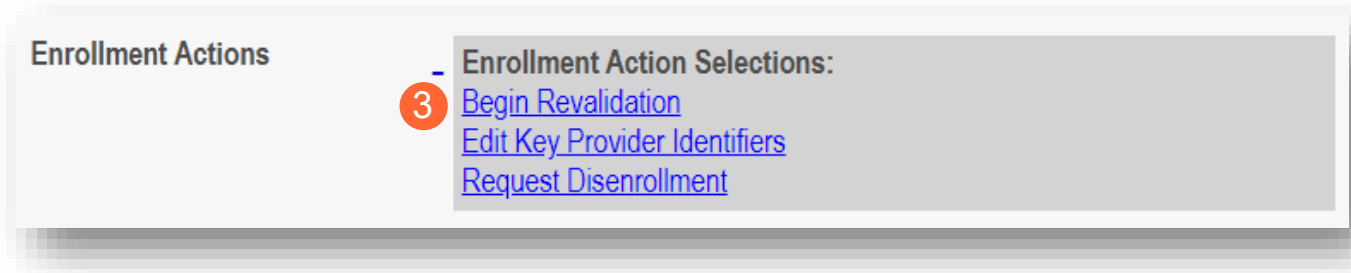
Registration Information

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

Manage Application

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

Step 3: Click the 'Begin Revalidation' hyperlink

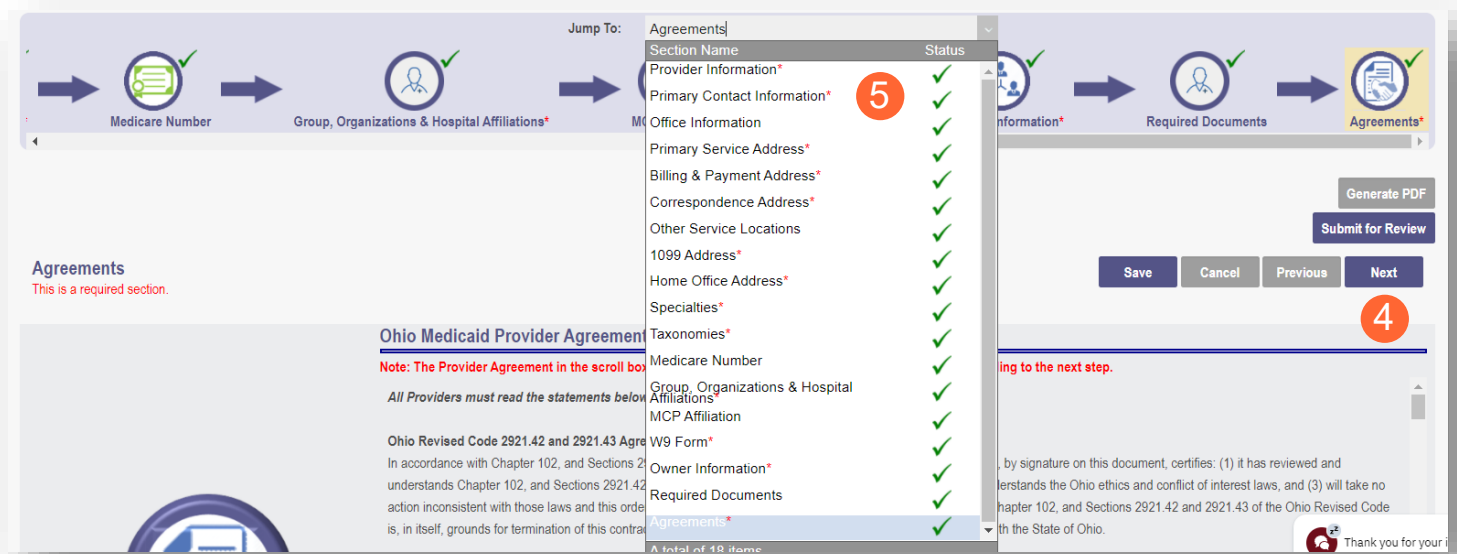


Step 4: Complete each page of the file. Click 'Next' to save and proceed to the next page

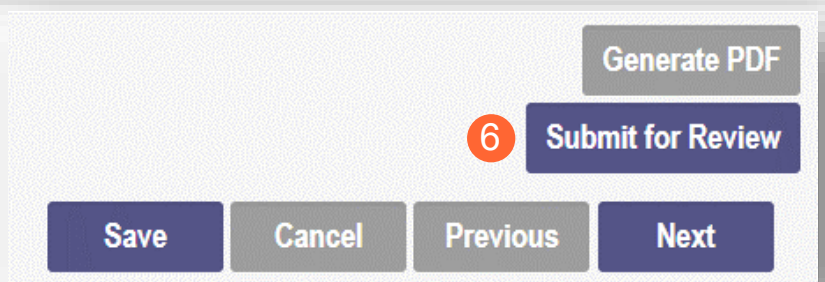
Note: Regardless of whether changes are made, each page needs to be reviewed and saved

Step 5: Confirm that each page has been reviewed, making sure a green checkmark appears for each page. If a green checkmark does not display for a page, review that page, and save the information.

Note: Submission will not be available unless all required pages have a green checkmark



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



Select and Transfer Providers

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

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

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

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
517966	Test Training	Complete	69 - Pharmacist	1952999328	9999885	PHARMACIST				03/11/22	03/18/22	03/11/25

Step 2: Enter the Medicaid ID, NPI, and Tax ID numbers for the provider you wish to move to your account

Step 3: Click 'Save'

2

Medicaid ID: 0000234

NPI: 1174088033

Tax ID: 117408803

3 Save Cancel

Step 4: The newly added Provider will appear on the list of Providers on the Dashboard

Note: If the new Provider does not appear, click the 'home icon' at the top of the page to refresh the screen and see the newly added provider in your Provider list

<div> <div>Menu</div> <div>Ohio</div> <div> Provider Network Management Medicaid Home Learning Contact Fee Schedule </div> <div> Training Log out </div> </div>												
<div> My Providers Select Provider Pending Agent Requests Account Administration New Provider ? </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
519390	Test Training	Complete	24 - PHYSICIAN ASSISTANT	1174088033	0000234	PHYSICIAN ASSISTANT				06/28/22	06/28/22	06/28/25

4