

The cover features a central collage of medical and technology-related images, including a hand with a stethoscope, a smartphone displaying a padlock icon, and various medical symbols like a heart, a pill, and a microscope. This central image is framed by several overlapping geometric shapes in shades of blue and purple, creating a modern, abstract design.

USER MANUAL

Behavioral Health Provider Enrollment Applications

Organization Provider



Department of
Medicaid

Table of Contents

Introduction	3
Provider Administrator Initial Login	4
Provider Home Page	6
Organization Provider - New Provider Entry	8
Key Identifier Information	10
Document Upload Process (Any Page)	11
Provider Information Page (Organization).....	12
Primary Contact Information Page	13
USPS Address Search Pop-Up.....	13
Primary Service Address Page	14
Address Pages.....	16
Billing & Payment Address Page	16
1099 Address Page.....	17
Home Office Address	17
Other Service Locations.....	18
Specialties Page	20
Removing Specialties	21
Taxonomies Page	22
Editing or Changing Primary Taxonomy	24
Professional Licenses	25
Medicare Number Page	27
Behavioral Health Information Page	29
Group, Organizations & Hospital Affiliations Page.....	30
Adding an Individual Provider Associated with Your Organization	30
Professional Liability Insurance Page	33
Yes/No Professional Liability Insurance	33
W9 Form Page	35
EFT Banking Information Page	36
Application Fee	39
Paying The Fee	39
Waiving the Fee.....	42
Owner Information.....	43
Required Documents Page	46
Agreements Page	48

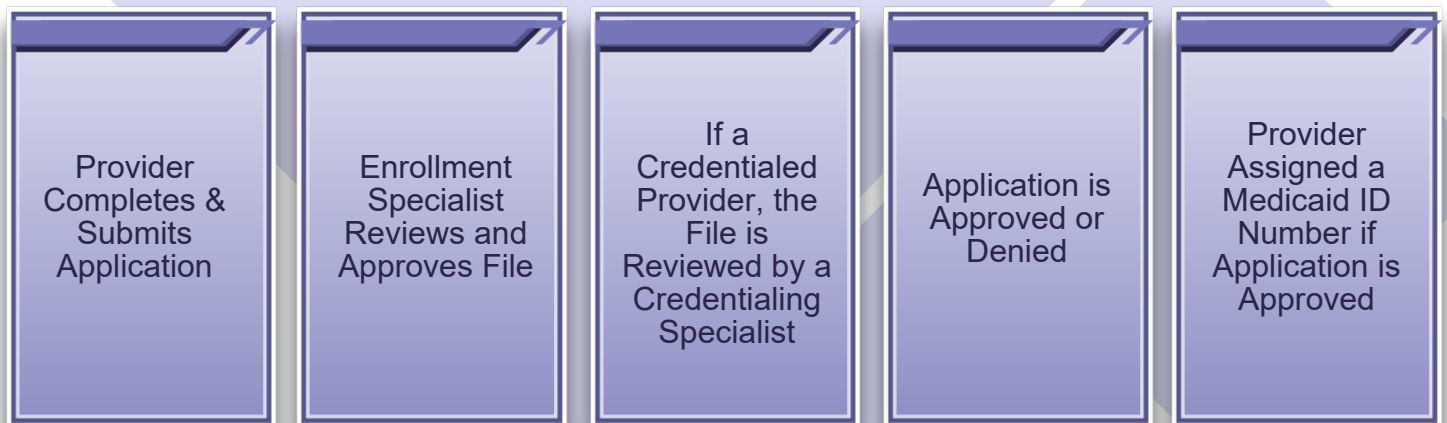
Submitting Application.....	50
Resubmitting an Application	51
Reviewing Correspondence	52
Completing Return to Provider (RTP) Process	54
Submitting a Plan of Correction	57
Review the Final Decision for Provider Submission	60
Completing an Update	61
Affiliating Individuals to Your Organization.....	65
Revalidation/Re-Enrollment Steps.....	69
Select and Transfer Providers	71

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, 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.

The steps listed below are for Provider Type 84 – Community Mental Health and Provider Type 95 – Substance Use Disorder, which would have a specific Behavioral Health page appear.



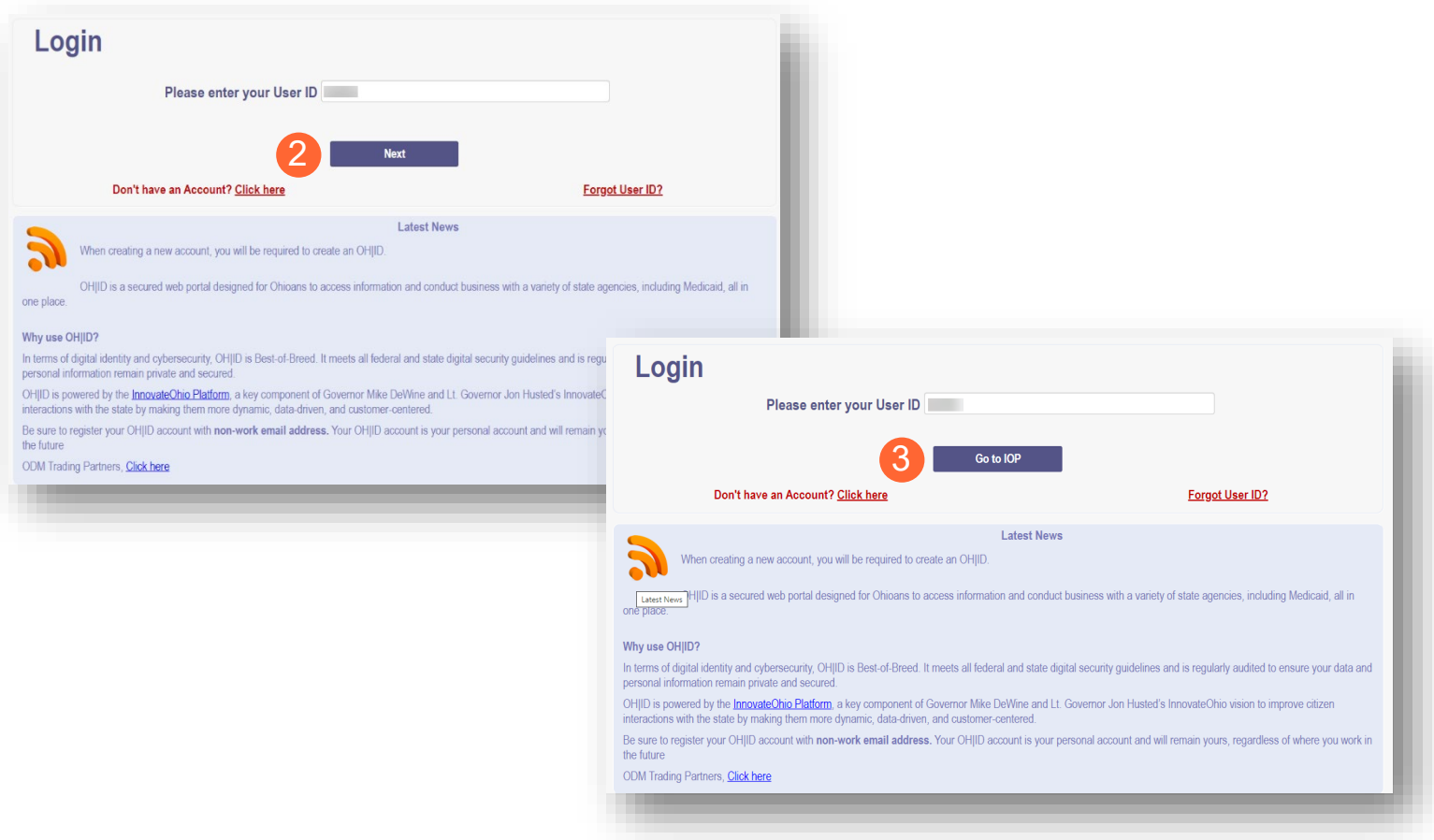
Provider Administrator Initial Login

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.

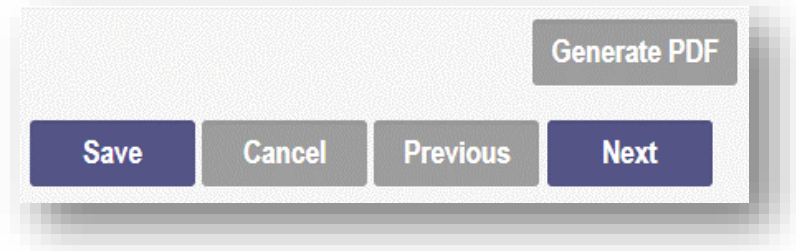
Cancel: Clears the work entered and does not save the page.

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.

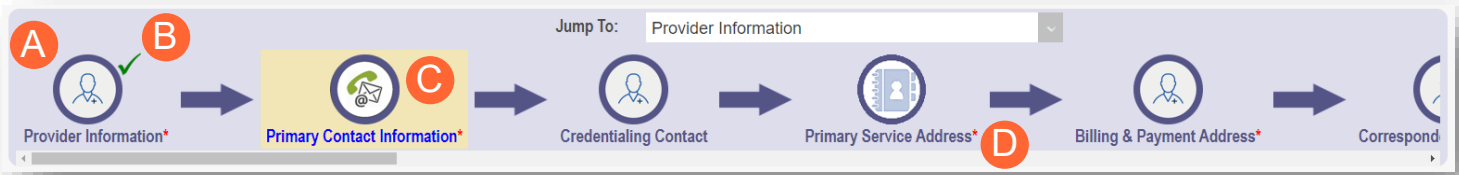


Navigational Bar: A workflow at the top of the page that shows the progress made throughout your application. Click the icon to review a specific page and jump to other pages for entry into the application (A).

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 your are actively working or viewing (C).

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



Primary Contact Information
This is a required section.

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

Credentialing Contact

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

Organization Provider - New Provider Entry

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

Step 1: Click 'New Provider'

The screenshot shows the 'Organization Provider' interface. At the top, there are four tabs: 'My Providers', 'Select Provider', 'Pending Agent Requests', and 'Account Administration'. To the right of these tabs is a red circle with the number '1' and a button labeled 'New Provider?'. Below the tabs is a table with 14 columns: 'Reg ID', 'Provider', 'Status', 'Provider Type', 'NPI', 'Medicaid ID', 'Specialty', 'DD Contract Number', 'DD Facility Number', 'Location', 'Effective Date', 'Submit Date', and 'Revalidation Due Date'. The table contains four rows of data:

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

The screenshot shows the application type selection screen. At the top, there is a warning message: "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." Below the warning are four application type buttons:

- 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. (Button: Select)
- Ordering, Referring, Prescribing**: Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing. (Button: 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. (Button: Select)
- MCP Single Case**: Use this application if you are entering into a Single Case agreement with a Managed Care Plan. (Button: Select)

At the bottom left, there is a button labeled "Click here for more application types..." with a red circle and the number '2' next to it.

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

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

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

2

Less...

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

Step 3: Next, click 'Organization' to begin an Organization 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."

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

Step 2: Click 'Save' to save the information and advance

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



The NPI entered is not in the NPPES list.

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 a 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'

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 (Organization)

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 in the required fields marked with an asterisk*

For this page the following fields are required:

- Name of Business Entity
- Practice Type
- Ownership Type
- Tax ID
- Provider Type

The screenshot shows the 'Provider Information' page. At the top, a progress bar indicates the sequence of steps: Provider Information* (highlighted), Primary Contact Information*, Primary Service Address*, Billing & Payment Address*, Correspondence Address*, and Other S. A 'Jump To:' dropdown menu is set to 'Provider Information'. Below the progress bar, the 'Provider Information' section is titled, with a note 'This is a required section.' A red circle with the number '1' highlights the 'Name of Business Entity*' field, which contains 'Training Mental Health Provider'. Other fields include 'DBA', 'Practice Type*', 'Ownership Type*', 'Tax ID*' (564564564), 'NPI' (1164846499), 'NPI Start Date' (02/06/2014), 'Provider Type*' (84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER), 'Revalidation Date' (Not Set Yet), 'Enrollment Status' (Not Set Yet), and 'Enrollment Status Reason' (Not Set Yet). A red circle with the number '2' highlights the 'Next' button. The 'Save', 'Cancel', and 'Next' buttons are located at the bottom right of the form.

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 on the page to proceed to the next page of the application

Step 1: Complete the Primary Service Address information.

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

Note: Steps 2 – 4 are optional. If you select ‘Provider Directory Opt-Out,’ Provider information will not be included in the public facing Provider Directory.

14

Step 2: 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 3: 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 4: 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

☐ 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

2
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours
☐ Open 24 Hours

Office Information 3

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 4

Accept new patients
Accept new patients from referral only
Youngest patients accepted
Oldest patients accepted
Gender of patient Accepted
Accept newborn*
Accept pregnant women

No
No

No
No

Step 5:

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

15

Address Pages

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

<div><div>Billing & Payment Address Page</div><div><p>If the Billing & Payment Address is the same as the Primary Service Address, select the check box to indicate it is the ‘Same as the Practice Location.’ This will pre-populate information that was entered on the previous screen into the fields.</p><p>If a different address, enter the required fields marked with an asterisk *</p><p>Click ‘Save’ or ‘Next’ to save the contact to the record</p></div></div>	<div><div>Billing & Payment Address</div><div><div><div>Save</div><div>Cancel</div><div>Previous</div><div>Next</div></div><div>History</div><div><div>Same as Practice Location</div><div><div>Address Type</div><div><div>Individual</div><div>Organization</div></div></div><div><div>Organization Name*</div><div>Title</div><div>Address 1*</div><div>Address 2</div><div>City*</div><div>State*</div><div>County</div><div>Zip*</div><div>Ext Zip*</div><div>Phone Number 1*</div><div>Phone Ext 1</div><div>Phone Number 2</div><div>Phone Ext 2</div><div>Fax Number 1</div><div>Fax Number 2</div><div>Contact Name</div><div>Email Address 1*</div></div></div></div></div>
<div><div>Correspondence Address Page</div><div><p>If the Correspondence Address is the same as the Primary Service Address, select the check box to indicate it is the ‘Same as the Practice Location.’ This will pre-populate information that was entered on the previous screen into the fields.</p><p>If a different address, enter the required fields marked with an asterisk *</p><p>Click the ‘Save’ or ‘Next’ buttons to save the contact to the record</p></div></div>	<div><div>Correspondence Address</div><div><div><div>Save</div><div>Cancel</div><div>Previous</div><div>Next</div></div><div>History</div><div><div>Same as Practice Location</div><div><div>Address Type</div><div><div>Individual</div><div>Organization</div></div></div><div><div>Organization Name*</div><div>Address 1*</div><div>Address 2</div><div>City*</div><div>State*</div><div>County</div><div>Zip*</div><div>Ext Zip*</div><div>Phone Number 1*</div><div>Phone Ext 1</div><div>Phone Number 2</div><div>Phone Ext 2</div><div>Fax Number 1</div><div>Fax Number 2</div><div>Contact Name</div><div>Email Address 1*</div></div></div></div></div>

1099 Address Page

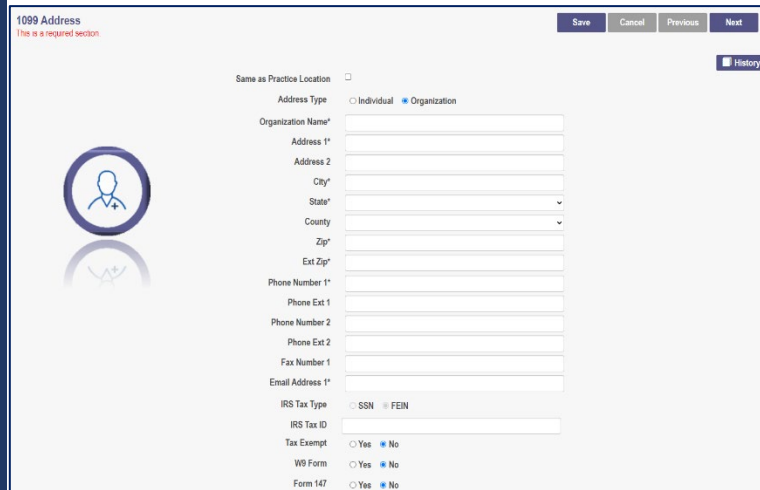
If the 1099 Address is the same as the Primary Service Address, select the check box to indicate it is the 'Same as the Practice Location.' This will pre-populate information that was entered on the previous screen into the fields.

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

Save Cancel Previous Next History

Same as Practice Location ☐

Address Type ☐ Individual ☒ Organization

Organization Name*

Address 1*

Address 2

City*

State*

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Email Address 1*

IRS Tax Type ☐ SSN ☒ FEIN

IRS Tax ID

Tax Exempt ☐ Yes ☒ No

W9 Form ☐ Yes ☒ No

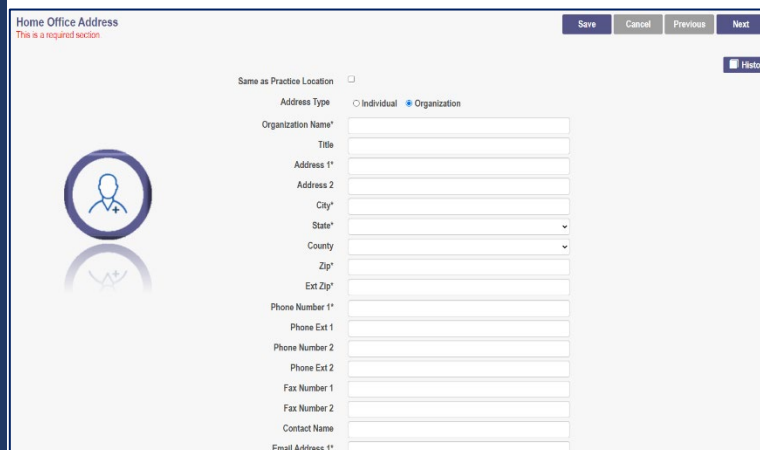
Form 147 ☐ Yes ☒ No

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

Save Cancel Previous Next History

Same as Practice Location ☐

Address Type ☐ Individual ☒ Organization

Organization Name*

Title

Address 1*

Address 2

City*

State*

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

Other Service Locations

This page allows you to enter any other locations where you provide services.

Behavioral Health Providers should be entering all OHMAS certified locations to the record

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

Jump To: Other Service Locations

Billing & Payment Address* Correspondence Address* Other Service Locations 1099 Address* Home Office Address* Specialties*

3 Save Cancel Previous Next 5 Get PDF

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

*Please enter Other Service locations that bill/will bill under the same Medicaid ID
No additional practice locations found.

1 Add New History

2

Name

Address 1*

Address 2

City*

State*

County

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

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

Patient Information

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

Specialties Page

The specialty page allows you to indicate any specialties

Note: A Primary Specialty must be designated on one Specialty.

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 is a progress indicator with icons for 'Primary Service Locations', '1099 Address*', 'Home Office Address*', 'Specialties*', 'Taxonomies*', 'Professional Licenses*', and 'CLIA Certifications'. The 'Specialties*' icon is highlighted. Below the progress bar, the 'Specialties' section is titled with a red note: 'This is a required section.' To the right are buttons for 'Save', 'Cancel', 'Previous', 'Next', and 'Generate PDF'. Below these buttons, a message states: 'Primary Specialties are not editable by provider after application submission.' Below this message is a table with the text 'No records found'. In the bottom right corner, there is a red circle with the number '1' and an 'Add New' button.

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

Step 3: Click 'Add New' and repeat the process to enter any Additional Specialties

The screenshot shows the 'Specialties' form. At the top, there is a 'Save' button highlighted with a red circle '2'. Below the navigation bar, the 'Specialties' section is titled with a red note: 'This is a required section.' Below this, a message states: 'Primary Specialties are not editable by provider after application submission.' Below this message is a table with the text 'No records found'. In the bottom right corner, there is a red circle with the number '3' and an 'Add New' button. On the left side, there is a large icon of a magnifying glass over a DNA helix. In the center, there is a checkbox labeled 'Designate a Primary Specialty' which is checked. Below this checkbox is a red note: 'Designate a Primary Specialty and save first before secondary specialties can be entered.' Below the checkbox is a form with three fields: 'Specialty*' (with a dropdown menu and a red circle '1' next to it), 'Start Date*' (with the value '5/6/2022'), 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

Jump To: Other Service Locations

Service Locations → 1099 Address* → Home Office Address* → **Specialties*** → Taxonomies* → Medicare Number → Behavioral Health Informa

Generate PDF 4

Specialties
This is a required section.

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status		
842 Community Mental Health Professional Medicare Cro	Yes	05/06/2022	12/31/2299	INACTIVE		
840 ODMH Community Health Agency	No	05/06/2022	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

Jump To: Other Service Locations

Service Locations → 1099 Address* → Home Office Address* → **Specialties*** → Taxonomies* → Medicare Number → Behavioral Health Informa

Generate PDF

Specialties
This is a required section.

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status		
842 Community Mental Health Professional Medicare Cro	Yes	05/06/2022	12/31/2299	INACTIVE		
840 ODMH Community Health Agency	No	05/06/2022	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.

Jump To: Other Service Locations

1099 Address*

Home Office Address*

Specialties*

Taxonomies*

Medicare Number

Behavioral Health Information*

Group,

Generate PDF

Save

Cancel

Previous

Next

Taxonomies

This is a required section.

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
251S00000X	COMMUNITY/BEHAVIORAL HEALTH	Yes	05/06/2022	12/31/2299		

Add New

History

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.

Save

Cancel

Previous

Next

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
251S00000X	COMMUNITY/BEHAVIORAL HEALTH	Yes	05/06/2022	12/31/2299		

1

Add New

History

2

Taxonomy*

3

Start Date*

4

End Date

☐ Is Primary Taxonomy

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 'Next' to save and proceed to the next page

Taxonomies
This is a required section.

SaveCancelPreviousNext

5

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
251S00000X	COMMUNITY/BEHAVIORAL HEALTH	Yes	05/06/2022	12/31/2299	<div>1</div>	<div>Add New</div>

History

2

Taxonomy*

Community/Behavioral Health (251S00000X)

3

Start Date*

05/06/2022

4

End Date

12/31/2299

☒ Is Primary Taxonomy

Professional Licenses

Note: License information and a copy of a valid license are not required for every Provider type.

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

This page will appear for Provider Type 95 – Substance Use Disorder

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

The screenshot shows a multi-step navigation bar at the top with icons and labels: Home Office Address*, Specialties*, Taxonomies*, Professional Licenses* (highlighted in yellow), Board Certification, CLIA Certifications, and Medicare Nui. A 'Jump To:' dropdown menu is set to 'Professional Licenses'. Below the navigation bar, the 'Professional Licenses' section is titled, with a red note stating 'This is a required section.' To the right of the title are buttons for 'Save', 'Cancel', 'Previous', 'Next', and 'Generate PDF'. A message below the buttons states 'A copy of each license must be uploaded to this page.' In the bottom right corner, there is a red circle with the number '1' and an 'Add New' button with a document icon.

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

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

Add New

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

2

State*

License Board Name*

If Other, enter Board Name:

License Number*

Effective Date*

Expiration Date*

License Status

Address 1

Address 2

City

State

County

Zip

Endorsement Number

Endorsement Status

Endorsement Focus

Endorsement Specialty

Certifying Organization

Certificate Date

Certificate Expiration

3

Professional License

Browse

Medicare Number Page

This is not a required section to complete. 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

The screenshot shows the 'Medicare Number' form. At the top, it says 'Medicare Number' and 'No records found'. On the right, there is a red circle with the number '1' and an 'Add New' button. The form contains several fields: 'Medicare Number Type' with radio buttons for 'CCN (CMS Certification Number)' and 'PTAN (Provider Transaction Access Number)', each with a 'What is this?' link; 'Medicare Number' (text input); 'Secondary NPI' (text input); 'Medicare State' (dropdown menu); 'Medicare Enrollment Status*' (dropdown menu); and 'Medicare Enrollment Date' (text input). Below these fields is an 'Optional Document' section with a header 'Medicare Enrollment Certification Required for Dialysis Facilities (Only if approved)' and a 'Browse' button. A red circle with the number '2' is placed over the 'Browse' button.

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

The screenshot shows the 'Medicaid' form. At the top, it says 'Medicaid' and 'No Other State Medicaid Number found'. On the right, there is a red circle with the number '3' and an 'Add New' button. The form contains two fields: 'Other State Medicaid Enrollment Status' (dropdown menu) and 'State' (dropdown menu).

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

Behavioral Health Information Page

This page is required to complete and allows you to indicate specific information about your Behavioral Health Organization.

Step 1: Enter a Behavioral Health Certification Date typing or by clicking on the blank line to open a calendar

Step 2: Select a Certification Type from the drop-down menu

- Interim
- Full Certification

Step 3: Click the proper radio button to answer each question 'Yes' or 'No'

Note: For the final two questions on the page, if 'Yes' is answered, a bed capacity number need to be entered

Step 4: Type in the average waiting time to obtain an appointment in the space provided

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

Behavioral Health Information

This is a required section.

Save

Cancel

Previous

Next

5

Behavioral Health Information

Community Behavioral Health Centers that provide mental health services are certified by the Ohio Department of Mental Health and Addiction Services (ODMHAS), if the CBHC provides substance use disorder services the facility must be licensed by ODMHAS.

1

Behavioral Health Certification Date

2

Certification Type

Interim

3

Do you offer emergency appointments (within 24 hours of call)?

☐ No ☐ Yes

Do you treat younger children (age 0-5)?

☐ No ☐ Yes

Do you treat older children (age 6-12)?

☐ No ☐ Yes

Do you treat adolescents (age 13-20)?

☐ No ☐ Yes

Do you treat adults (age 21-65)?

☐ No ☐ Yes

Do you treat geriatric patients (age 65 and older)?

☐ No ☐ Yes

Do you provide family therapy?

☐ No ☐ Yes

Do you provide group therapy?

☐ No ☐ Yes

Do you provide crisis evaluation/intervention services?

☐ No ☐ Yes

Are you available to see clients at least 4 full days a week?

☐ No ☐ Yes

What is the average waiting time to obtain an appointment?

4

☐ No ☐ Yes

Do you provide residential treatment for Substance Use Disorder?

If yes, please provide bed capacity (# of beds) at the facility.

☐ No ☐ Yes

Do you provide residential treatment for serious Mental Health conditions?

If yes, please provide bed capacity (# of beds) at the facility.

29

Group, Organizations & Hospital Affiliations Page

This page will allow you to indicate any individual Providers who are affiliated with your organization.

Adding an Individual Provider Associated with Your Organization

Step 1: To add an Individual Affiliation, click ‘Add New’

Medicare Number

Behavioral Health Information*

Group, Organizations & Hospital Affiliations*

Professional Liability Insurance*

W9 Form*

Jump To:

Behavioral Health Information

Generate PDF

Group, Organizations & Hospital Affiliations

This is a required section.

Save

Cancel

Previous

Next

Individual Providers Associated with Your Group

In the table below, enter or confirm each individual provider that is associated with your group. For Active affiliations, click on the Individual provider's name to update the Individual's enrollment profile.

Note: If the affiliation status displays as 'Individual Enrollment Pending Approval' or as 'Individual Requires Revalidation', the individual provider must create an account in PNM and complete their application for enrollment or re-validation.

Always verify that NPI you enter for Individuals are correct.

Display Active Only

☐ Yes

☒ No

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status	Revalidation Due Date	Medicaid ID	Rendering Location	Directory OptOut		
No affiliations found.												

Display 50

Display 100

Total Count: 0

1

Add New

30

ORGANIZATION PROVIDER

Step 2: Enter the information for the individual provider, including the Rendering Location

- Note: You will need the NPI for the Provider and enter that information
- The State Date will default to the date of application, but is an editable field

Step 3: Click 'Save' to continue

Add Group Member

2

First Name*

Last Name*

NPI*

Rendering Location*

☐ Click here to NOT include this provider in directory for this location.

Start Date* 5/6/2022 [What is this?](#)

End Date 12/31/2299

Medicaid ID

Affiliation Status Member Not Found

3 Save Cancel

Step 4: Confirm the affiliation is listed on the screen

Group, Organizations & Hospital Affiliations

This is a required section.

Save Cancel Previous Next

6

Individual Providers Associated with Your Group

In the table below, enter or confirm each individual provider that is associated with your group. For Active affiliations, click on the Individual provider's name to update the Individual's enrollment profile.

Note: If the affiliation status displays as 'Individual Enrollment Pending Approval' or as 'Individual Requires Revalidation', the individual provider must create an account in PNM and complete their application for enrollment or re-validation.

Always verify that NPI you enter for Individuals are correct.

Display Active Only ☐ Yes ☒ No

4

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status	Revalidation Due Date	Medicaid ID	Rendering Location	Directory OptOut		
Dale Ada	1437827268	CLINICAL COUNSELING	COUNSELOR TRAINEE	5/2/2022	12/31/2299	Confirmed	2026-09-06	0998021	2400 CORPORATE EXCHANGE DR			

5 Add New History

Display 50 | Display 100

Total Count: 1

A

Step 5: Click 'Add New' to add additional affiliations

Note: The individual Providers will have a different affiliation status. The definitions of that status are shown at the bottom of this section (A)

Note: If you are viewing a previously submitted application and there are numerous affiliations listed, you can use the Affiliate Search to locate a specific Provider from your affiliations list (B)

Affiliate Search

Partial or Full search using Name and/or NPI. When both fields are used to search, the grid will be filtered by both Name and NPI.

Display Active Only ☐ Yes ☒ No

Name

Affiliation Status

NPI

B

Step 6: Once all affiliations are added, click 'Next'

A

Affiliation Status Definitions

Individual Enrollment Pending Approval - The Individual application has not been approved in PNM.

Confirmed - The group confirmed the individual as an affiliate. No further actions are necessary at this time.

Active - The Individual provider is active and affiliated with your organization. No further actions are necessary.

Pending Removal - The group entered an End Date for the affiliation. No further actions are necessary.

Removed - The group entered an End Date. No further actions are necessary.

Individual Requires Revalidation - The individual provider exists in the system but is currently inactive. The Individual needs to complete a revalidation before being confirmed within your organization.

Pending Approval - The individual provider has requested affiliation with the group. The group is required to approve the affiliation request.

Member Not Found - The individual provider cannot be found.

Transaction Rejected - The transaction has been rejected by the SI. Resubmit Affiliation.

Professional Liability Insurance Page

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

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

Jump To: Professional Liability Insurance

Health Information* → Group, Organizations & Hospital Affiliations* → **Professional Liability Insurance*** → W9 Form* → EFT Banking* → Application Fee*

Generate PDF

Save Cancel Previous Next

History

Professional Liability Insurance
This is a required section.

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*

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

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	4565432113	08/03/2021	08/03/2023	Test Policy Holder	1,000,000	30,000,000	

Add New

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 organization type by clicking on the appropriate radio button category

The screenshot shows the 'W9 Form' page in a web application. At the top, there is a progress bar with icons for 'Organizations & Hospital Affiliations', 'Professional Liability Insurance', 'W9 Form' (highlighted), 'EFT Banking', 'Application Fee', and 'Owner Information'. A 'Jump To:' dropdown menu is set to 'Professional Liability Insurance'. Below the progress bar, there are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', and 'Next'. The main section is titled 'W9 Form' with a red note: 'This is a required section.' Below this, it says '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.' There are input fields for 'Legal Business Name' (filled with 'Training Mental Health Provider') and 'EIN' (filled with '564564564'). Below these, it says 'Select the most appropriate category below:' and lists several radio button options. A red circle with the number '1' is next to the first option: 'Individual/sole proprietor of single-member LLC'. Other options include '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 of the W9 Form page. It says 'Indicate the form you are uploading' and has two radio button options: 'W9' (selected, with a red circle and number '2') and 'Form 147'. Below this, there is a note: '** Please visit <https://www.irs.gov/forms-pubs/about-form-w-9> to obtain a copy of the W9 with instructions.' The 'Required Document' section shows a table with one row: 'W-9'. Below the table, there are links for 'W9.pdf', 'Download', and 'Remove'. A 'Browse' button is at the bottom right of the document list. A red circle with the number '3' is next to the 'Browse' button.

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

EFT Banking Information Page

This page requires 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

Save

Cancel

Previous

Next

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.

Please enter your banking information below.

Banking Information

No banking information found.

3

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.

Generate PDF
10
Save
Cancel
Previous
Next

Application Fee

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

Paying The Fee

Step 1: Select the 'Credit Card' radio button

Step 2: Click 'Select Payment'

Application Fee

This is a required section.

Save

Cancel

Previous

Next

Application Fee

All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$595.00

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

Fee Amount	\$595.00
Fee Status	Pending
Payment Type	<div>1</div> <div> <input checked="" type="radio"/> Credit Card <div>2</div> <input type="radio"/> Request Waiver of Application Fee </div>

Authorize Payment

Select Payment

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

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

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

The screenshot shows a web form titled "Enter New Account" with a red circle containing the number "3" in the top left corner. The form is part of the CBOSS system, as indicated by the logo in the top left and a "BETA" label in the top right. The form fields are as follows:

- Name on Card:** A single-line text input field.
- Card Number:** A single-line text input field.
- MM/YY:** A single-line text input field for the expiration date.
- Card Type:** A row of four icons representing different credit card brands: American Express, Discover, Mastercard, and Visa.
- Address Line 1:** A single-line text input field.
- Address Line 2:** A single-line text input field.
- City:** A single-line text input field.
- State:** A single-line text input field.
- Zip:** A single-line text input field.
- Country:** A single-line text input field.
- Phone Number:** A single-line text input field.
- Email Address:** A single-line text input field.
- Remember For Future Use:** A checkbox with the label "Remember For Future Use".
- Buttons:** At the bottom, there are two buttons: "Cancel" on the left and "Submit" on the right. The "Submit" button has a red circle containing the number "4" next to it.

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

Application Fee

This is a required section.

Save

Cancel

Previous

Next

Application Fee

All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$595.00

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

Fee Amount

\$595.00

Fee Status

Waived

Payment Type

☒ Credit Card

☐ Request Waiver of Application Fee

5

Authorize Payment

Select Payment

Please note your Registration ID on the check.

Amount*

\$595.00

Waiver Reason

Comments

Waiving the Fee

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


Application Fee
This is a required section.

Save

Cancel

Previous

Next



Application Fee

All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$595.00

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

Fee Amount

\$595.00

Fee Status

Pending

Payment Type

☐ Credit Card
☒ Request Waiver of Application Fee

Authorize Payment

Select Payment

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

Please note your Registration ID on the check.

Amount*

\$595.00

2

Waiver Reason

Comments

Medicare Enrolled
Paid in Another State
Paid in the past 5 years
Medicare Enrollment Pending

Fee Payment History

Step 3: If needed, type comments in the box

Please note your Registration ID on the check.

Amount*

\$595.00

Waiver Reason

Paid in the past 5 years

3

Comments

Paid 1/2/2021

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

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

Browse

4

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

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

Proof of Payment_2.pdf

Download

Remove

Browse

Owner Information

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

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

- **Note:** If additional sections such as 'Real Estate Owners' or 'Additional Disclosure' apply to you, please complete those sections as well

Step 3: To add Owner Information, click 'Add New'

The screenshot shows the 'Owner Information' form. At the top right, there is a 'Generate PDF' button and a navigation bar with 'Save', 'Cancel', 'Previous', and 'Next' buttons. The form title is 'Owner Information' with a note 'This is a required section.' Below the title, a instruction says 'Click on the section header to expand or collapse the panel.' The form is divided into several sections, each with a plus icon to expand and a minus icon to collapse. Section 1 (callout 1) is 'Instructions'. Section 2 (callout 2) is 'Definitions & Requirements'. Section 3 (callout 3) is 'Owner, Managing Employee and Controlling Interest Information', which is currently expanded and shows a message 'No owner information found.' with an 'Add New' button. Below this are sections for 'Real Estate Owners', 'Additional Disclosure', and 'Questions' (callout 2). The 'Questions' section contains several yes/no questions related to ownership, residency, and business transactions.

Owner Information
This is a required section.

Generate PDF

Save Cancel Previous Next

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

+ Instructions

+ Definitions & Requirements

- Owner, Managing Employee and Controlling Interest Information

No owner information found.

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

+ Real Estate Owners

+ Additional Disclosure

- Questions

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

Step 4: Enter the detailed Owner Information for any Individuals, Managing Employees, or Organizations who have ownership interests in your Organization

Step 5: Click 'Save'

Owner Information

4

Owner Type*

Owner Title

Affiliation Type

Address 1*

Address 2

City*

State*

County

Zip*

Percentage of Ownership*

Owner End Date

Individual

Managing Employee

Organization

12/31/2299

5

Save

Cancel

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

- Owner, Managing Employee and Controlling Interest Information

6

Type	Name	Title	Percentage		
Individual	Travis Trainer	President	100.00		

Add New

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

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

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

- Questions

7

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

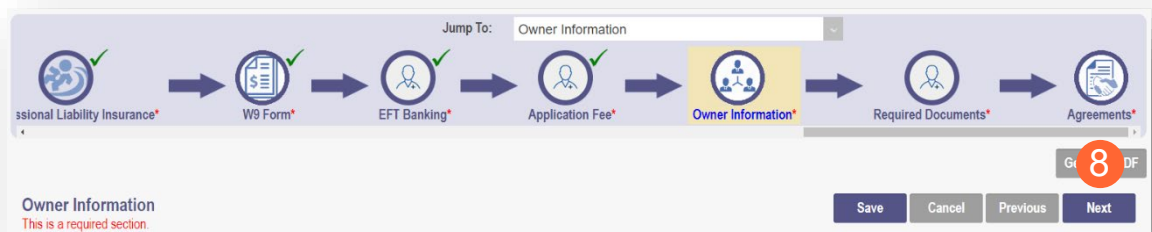
☐ No

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

☐ Yes

☐ No

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



Required Documents Page

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

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

Generate PDF

Required Documents


This is a required section.

Save

Cancel

Previous

Next



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

You may also mail in additional documentation, which may result in a delay to process your application.

Mailing Address:
Ohio Department of Medicaid
Provider Enrollment Unit
PO Box 1461
Columbus, OH 43216-1461

Required Document

ODI (Ohio Department of Insurance) Attestation

Browse

Required Document

Site Visit/Accreditation

Browse

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,' then select the file and open

Required Document

ODI (Ohio Department of Insurance) Attestation

Browse 2

Required Document

Site Visit/Accreditation

Browse 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

Generate PDF


Required Documents
This is a required section.

Save

Cancel

Previous

Next



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

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

Uploaded Documents

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

3

Choose File

No file chosen

Name

Description

Upload file

47

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 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 **4**

☐ 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 5: Complete the Provider Agreement Signature

- Select or Enter the Name of the Person Attesting

Provider Agreement Signature

5 Name of Person Attesting*:

Provider Name:

User ID:

6

Step 6: Click 'Save'

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

Step 7: 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.**

7

Submitting Application

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

The screenshot shows a progress bar at the top with steps: Professional Liability Insurance*, W9 Form*, EFT Banking*, Application Fee*, Owner Information*, Required Documents*, and Agreements*. The 'Agreements' step is highlighted with a red circle and the number 1. Below the progress bar, the 'Agreements' section is titled 'Ohio Medicaid Provider Agreement'. A note states: 'Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step.' Below this, it says 'All Providers must read the statements below and agree to the terms'. The main content area contains the 'Ohio Revised Code 2921.42 and 2921.43 Agreement' and a 'False Statement Agreement' section. On the right side, there are buttons: 'Generate PDF', 'Submit for Review' (highlighted with a red circle and the number 1), 'Save', 'Cancel', 'Previous', and 'Next'.

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

The screenshot shows the 'Submission Confirmation' page. At the top, there is a navigation bar with the Ohio logo and links: 'Provider Network Management', 'Medicaid Home', 'Learning', 'Contact', 'Fee Schedule', and 'Log out'. The main content area has a red circle with the number 2 and the title 'Submission Confirmation'. Below this, it says: 'You have successfully submitted your application to the Medicaid Program. Please allow at least 10 days for processing before attempting to submit any changes.' At the bottom, there is a red circle with the number 3 and a button labeled 'Return to Home Page'.

Resubmitting an Application

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

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
519460	Training Mental Health Provider	Not Submitted	95 - OMHAS CERTIFIED/LI TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program						
519470	Training Mental Health Provider	Return to Provider	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro						

Reviewing Correspondence

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

Provider Management Home

Registration Information

Provider Name Training Mental Health Provider	Medicaid ID	Effective Date	Revalidation Due Date	Term Date
--	-------------	----------------	-----------------------	-----------

Manage Application

Enrollment Actions + Enrollment Action Selections:

Programs + Program Selections:

Self Service **1** + Self Service Selections:

My Current and Previous Applications

Reg ID	Enrollment Action	Program	Application Id	PNM Application Status	Other Agency Application Status	DD Legal Status	Status Date
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

Training Mental Health Provider

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

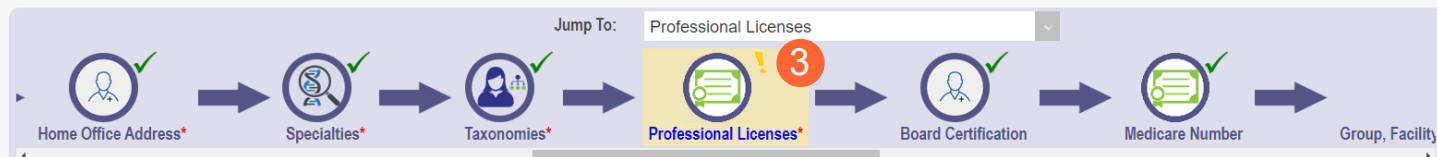
- Rejected pages are marked with a yellow exclamation point
- Messaging will appear at the top of the page indicating the reason the application was rejected

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



Generate PDF

Professional Licenses

This is a required section.

Save

Cancel

Previous

Next

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 horizontal progress bar with seven steps: Home Office Address*, Specialties*, Taxonomies*, Professional Licenses*, Board Certification, Medicare Number, and Group, Facility. The 'Professional Licenses*' step is highlighted in yellow and marked with a green checkmark. Above the progress bar is a 'Jump To:' dropdown menu set to 'Professional Licenses'. Below the progress bar, the 'Professional Licenses' section is active, displaying the text 'This is a required section.' On the right side, there are several buttons: 'Generate PDF', 'Submit for Review' (with a red circle containing the number 6), 'Save', 'Cancel', 'Previous', 'Next', and 'History' (with a document icon).

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

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

The screenshot shows a confirmation message box. At the top, there is a red circle with the number 7 followed by the heading 'Submission Confirmation'. The message text reads: 'You have successfully submitted your application to the Medicaid Program. Please allow at least 10 days for processing before attempting to submit any changes.' At the bottom, there is a red circle with the number 8 followed by a blue button labeled 'Return to Home Page'.

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

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	Approved	Physician/Oste Individual			Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706		09/16/21		
170	Training Clinic	Submitted	CLINIC			Primary Care Clinic			43085 - 4706		09/16/21		
171	Kim Trainer	Return to Provider	Chiropractor Individual			Chiropractic Services			43085 - 4706		09/16/21		

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

Provider Management Home

Registration Information

Provider Name

Training Mental Health Provider

Medicaid ID

Effective Date

Revalidation Due Date

Term Date

Manage Application

Enrollment Actions

3 + Enrollment Action Selections:

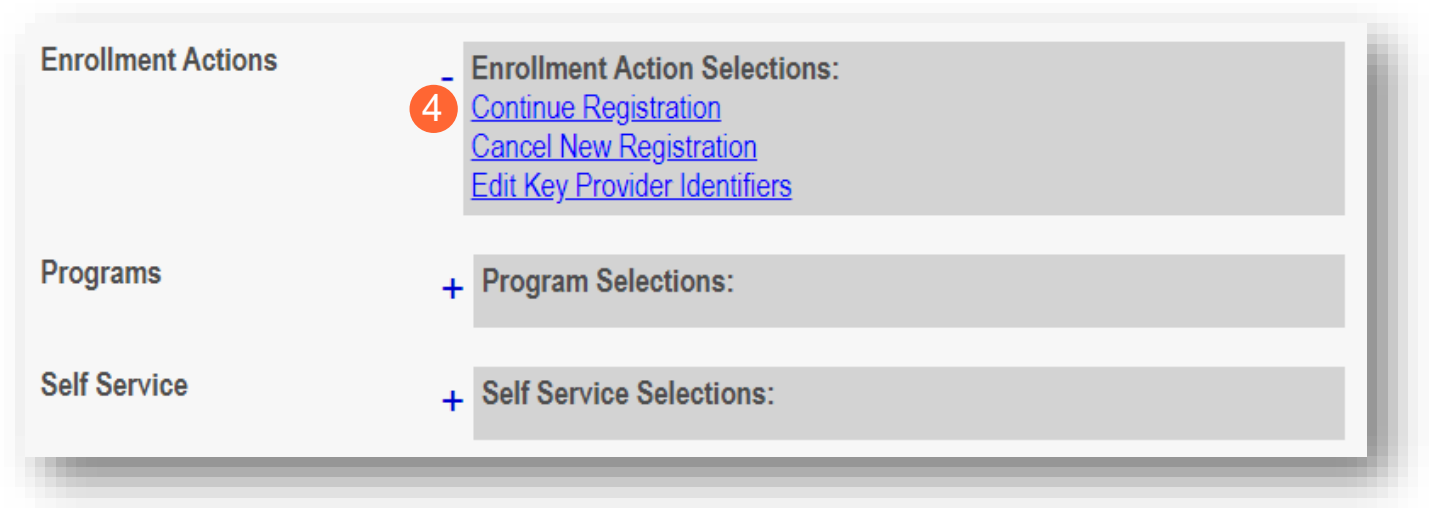
Programs

+ Program Selections:

Self Service

+ Self Service Selections:

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 the 'Enrollment Actions' item is a grey box containing a minus sign and a red circle with the number '4'. To the right of the 'Programs' item is a grey box containing a plus sign. To the right of the 'Self Service' item is a grey box containing a plus sign. The main content area on the right is titled 'Enrollment Action Selections:' and contains three hyperlinks: 'Continue Registration', 'Cancel New Registration', and 'Edit Key Provider Identifiers'.

Enrollment Actions

4 - Enrollment Action Selections:

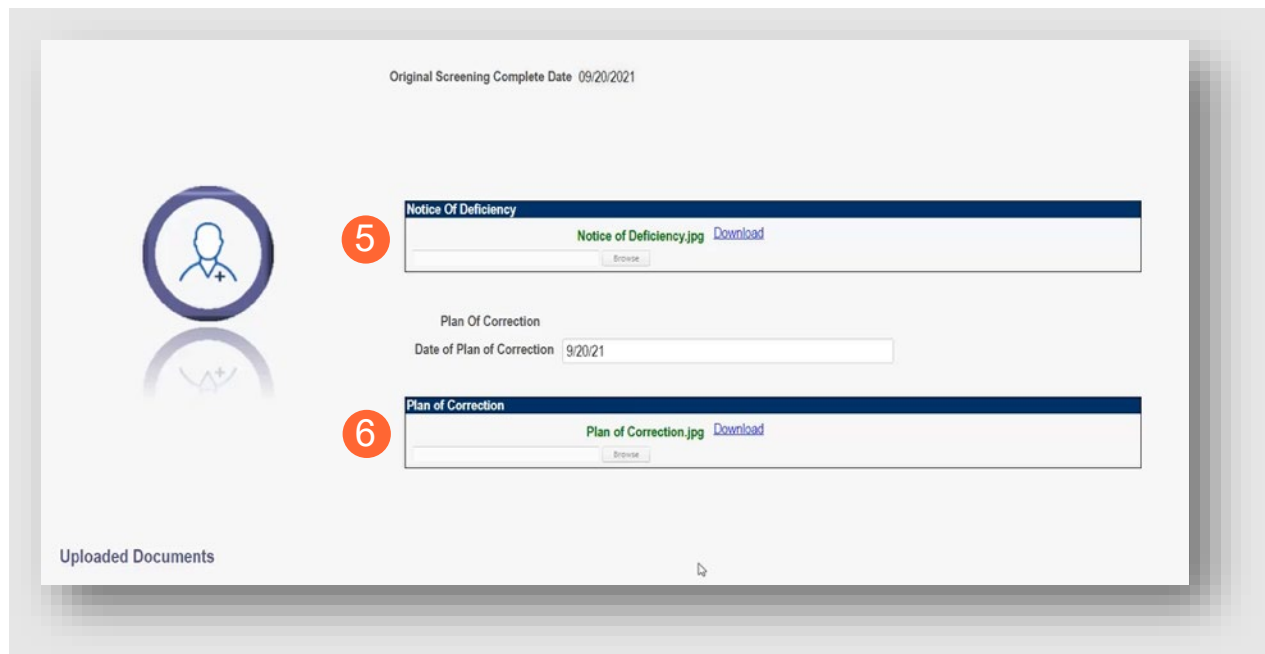
- [Continue Registration](#)
- [Cancel New Registration](#)
- [Edit Key Provider Identifiers](#)

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, there is a circular icon with a person silhouette and a plus sign. The main content area has two sections. The first section is titled 'Notice Of Deficiency' and contains a red circle with the number '5'. It shows a file named 'Notice of Deficiency.jpg' with a 'Download' link and a 'Browse' button. The second section is titled 'Plan Of Correction' and contains a red circle with 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

Description

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	

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								

Provider Management Home

Registration Information

Provider Name	Medicaid ID	Effective Date	Revalidation Due Date	Term Date
Training Mental Health Provider				

Manage Application

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

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						
519470	Training Mental Health Provider	Complete	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro				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

Training Mental Health Provider

Medicaid ID

Effective Date

Revalidation Due Date

Term Date

Manage Application

Enrollment Actions

+

Enrollment Action Selections:

Programs

+

Program Selections:

Self Service

+

Self Service Selections:

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

Enrollment Actions

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

Group, Organizations & Hospital Affiliations

Update

Required Documents



Identification

Update

Provider Information



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

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

Specialties
This is a required section.

6 Return to Summary
5 Generate PDF
Save Cancel

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

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

Specialties
This is a required section.

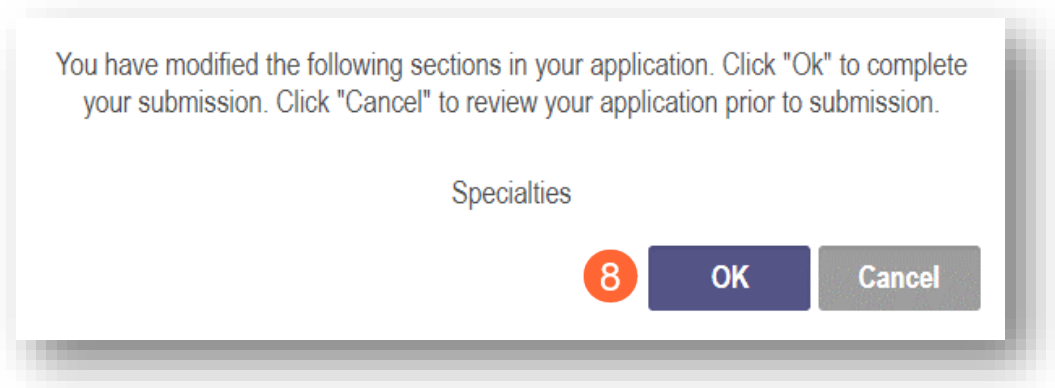
Return to Summary
Generate PDF
7 Submit for Review
Save Cancel

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	

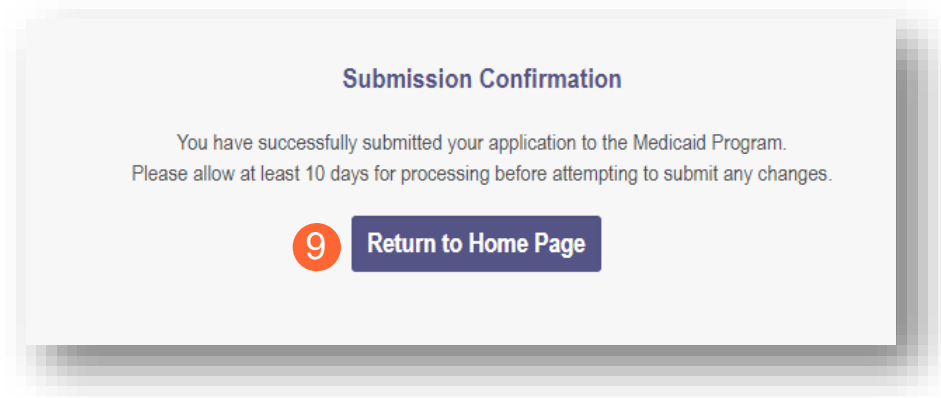
Add New
History

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



Affiliating Individuals to Your Organization

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

<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	
519460	Training Mental Health Provider	Not Submitted	95 - OMHAS CERTIFIED/LI TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program							
519470	Training Mental Health Provider	Complete	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro				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

Manage Application

Enrollment Actions
+ Enrollment Action Selections:

Programs
+ Program Selections:

Self Service
+ Self Service Selections:

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

Enrollment Actions
- Enrollment Action Selections:

3
[Begin ODM Enrollment Profile Update](#)
[Edit Key Provider Identifiers](#)
[Request Disenrollment](#)

Step 4: Click 'Update' next to Group, Organizations & Hospital Affiliations

Provider Update - Lets keep your information current !

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

Most Common Updates



4

Update

Primary Contact Information

Update

Primary Service Address

Update

Group, Organizations & Hospital Affiliations

Update

Required Documents

Identification



Update

Provider Information

Address Information



Update

Office Information

Update

Billing & Payment Address

Update

Correspondence Address

Update

Other Service Locations

Update

1099 Address

Update

Home Office Address

Step 5: The Providers who are Pending Approval will be highlighted in yellow

Step 6: Click on the 'pencil' icon to edit the Provider affiliation

Individual Providers Associated with Your Group



In the table below, enter or confirm each individual provider that is associated with your group. For Active affiliations, click on the Individual provider's name to update the Individual's enrollment profile.

Note: If the affiliation status displays as 'Individual Enrollment Pending Approval' or as 'Individual Requires Revalidation', the individual provider must create an account in PNM and complete their application for enrollment or re-validation.

Always verify that NPI you enter for Individuals are correct.

Display Active Only ☐ Yes ☒ No

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status	Revalidation Due Date	Medicaid ID	Rendering Location			
Dean Training				10/21/2021	12/31/2299	Pending Approval						
		Non-Agency Home Care Attendant	ODA WAIVER	6/29/2021	12/31/2299	Active	2026-06-23		2400 CORPORATE EXCHANGE DR			
Provider Trainer		Physician/Osteopath Individual	Dual Licensed Dentist and Licensed MD/DO.	9/30/2021	12/31/2299	Active	2024-09-29		2400 CORPORATE EXCHANGE DR			
Training J Pharmacist				10/18/2021	12/31/2299	Pending Approval						
Training Trainer				10/15/2021	12/31/2299	Pending Approval						

Add New



ORGANIZATION PROVIDER

Step 7: Choose the appropriate Rendering Location for the Provider from the drop-down menu

Step 8: Click 'Save'

Step 9: Continue this process for all Providers with a 'Pending Approval' affiliation status

Step 10: Once all Pending Approval Providers have been updated, they will no longer display in yellow. Click 'Submit for Review' to update the file

Always verify that NPI you enter for Individuals are correct

Edit Group Member

First Name*

Last Name*

NPI*

7 Rendering Location*

2400 CORPORATE EXCHANGE DR, STE 200, COLUMBUS ▾

Start Date*

[What is this?](#)

End Date

Medicaid ID

Affiliation Status

Pending Approval

8

Save

Cancel

Generate PDF

10

Submit for Review

Save

Cancel

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status	Revalidation Due Date	Medicaid ID	Rendering Location		
Dean Training				11/16/2021	12/31/2299	Individual Enrollment Pending Approval			2400 CORPORATE EXCHANGE DR		✖
		Non-Agency Home Care Attendant	ODA WAIVER	6/29/2021	12/31/2299	Active	2026-06-23		2400 CORPORATE EXCHANGE DR		
Provider Trainer		Physician/Osteopath Individual	Dual Licensed Dentist and Licensed MD/DO.	9/30/2021	12/31/2299	Active	2024-09-29		2400 CORPORATE EXCHANGE DR		
Training J Pharmacist		Pharmacist	PHARMACIST	11/16/2021	12/31/2299	Confirmed	2024-10-18		2400 CORPORATE EXCHANGE DR		
Training Trainer				11/16/2021	12/31/2299	Individual Enrollment Pending Approval			2400 CORPORATE EXCHANGE DR		✖

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

<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
<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/LIC TREATMENT PROGRAM	1215345327		ODADAS Certified/Licens Treatment Program						
519470	Training Mental Health Provider	Complete	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro				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
Training Mental Health Provider				

Manage Application

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

Step 3: Click the 'Begin Revalidation' hyperlink

Enrollment Actions

3

Enrollment Action Selections:

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

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

Jump To:

Section Name	Status
Provider Information*	✓
Primary Contact Information*	5 ✓
Office Information	✓
Primary Service Address*	✓
Billing & Payment Address*	✓
Correspondence Address*	✓
Other Service Locations	✓
1099 Address*	✓
Home Office Address*	✓
Specialties*	✓
Taxonomies*	✓
Medicare Number	✓
Group, Organizations & Hospital Affiliations	✓
MCP Affiliation	✓
W9 Form*	✓
Owner Information*	✓
Required Documents	✓
Agreements*	✓

Agreements
This is a required section.

Ohio Medicaid Provider Agreement
Note: The Provider Agreement in the scroll box
All Providers must read the statements below
Ohio Revised Code 2921.42 and 2921.43 Agre
In accordance with Chapter 102, and Sections 2
understands Chapter 102, and Sections 2921.42
action inconsistent with those laws and this orde
is, in itself, grounds for termination of this contr

by signature on this document, certifies: (1) it has reviewed and
understands the Ohio ethics and conflict of interest laws, and (3) will take no
chapter 102, and Sections 2921.42 and 2921.43 of the Ohio Revised Code
th the State of Ohio.

Generate PDF
Submit for Review
Save Cancel Previous Next

4

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

Generate PDF

6 Submit for Review

Save Cancel Previous Next

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'

Medicaid ID: 0000234
 NPI: 1174088033
 Tax ID: 117408803

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

Ohio												
Provider Network Management Medicaid Home Learning Contact Fee Schedule Training Log out												
Menu												
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
519390	Test Training	Complete	24 - PHYSICIAN ASSISTANT	1174088033	0000234	PHYSICIAN ASSISTANT				06/28/22	06/28/22	06/28/25

4