

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

USER MANUAL

# Provider Enrollment Applications

Group/Organization Provider

**Ohio** | Department of  
Medicaid

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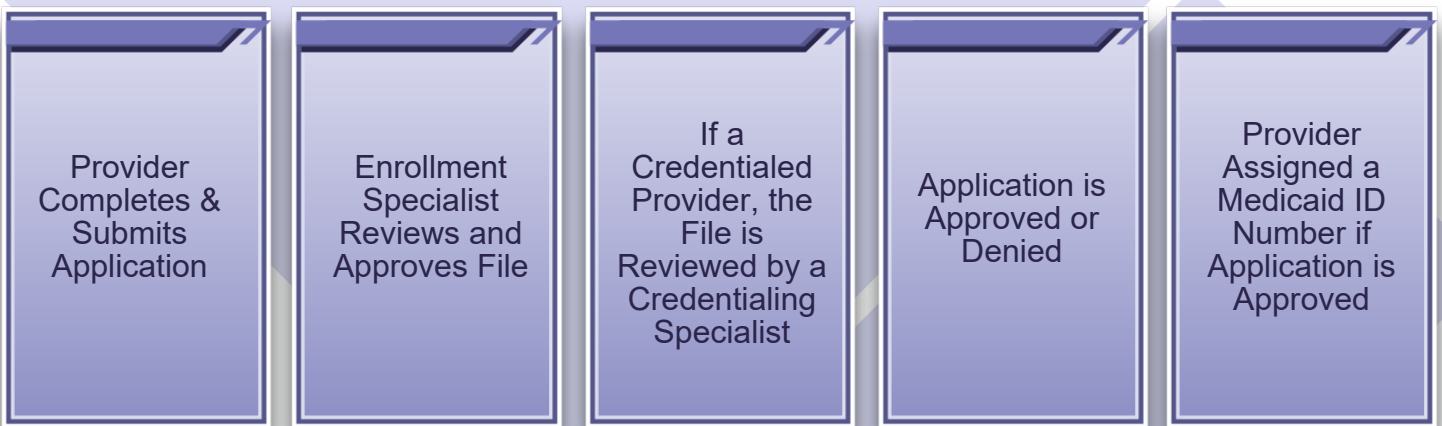
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## Introduction

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

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



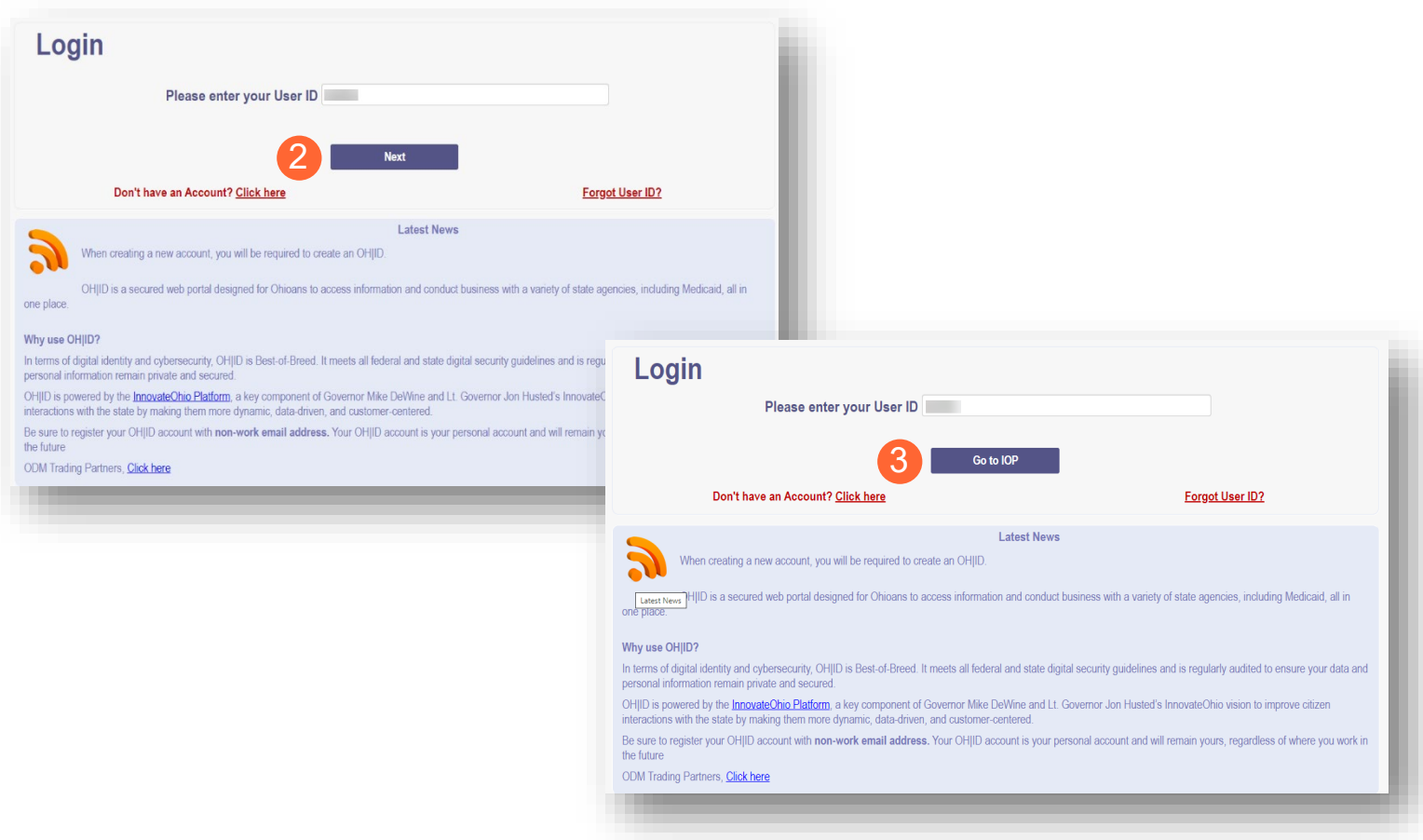
## Provider Administrator Initial Login

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

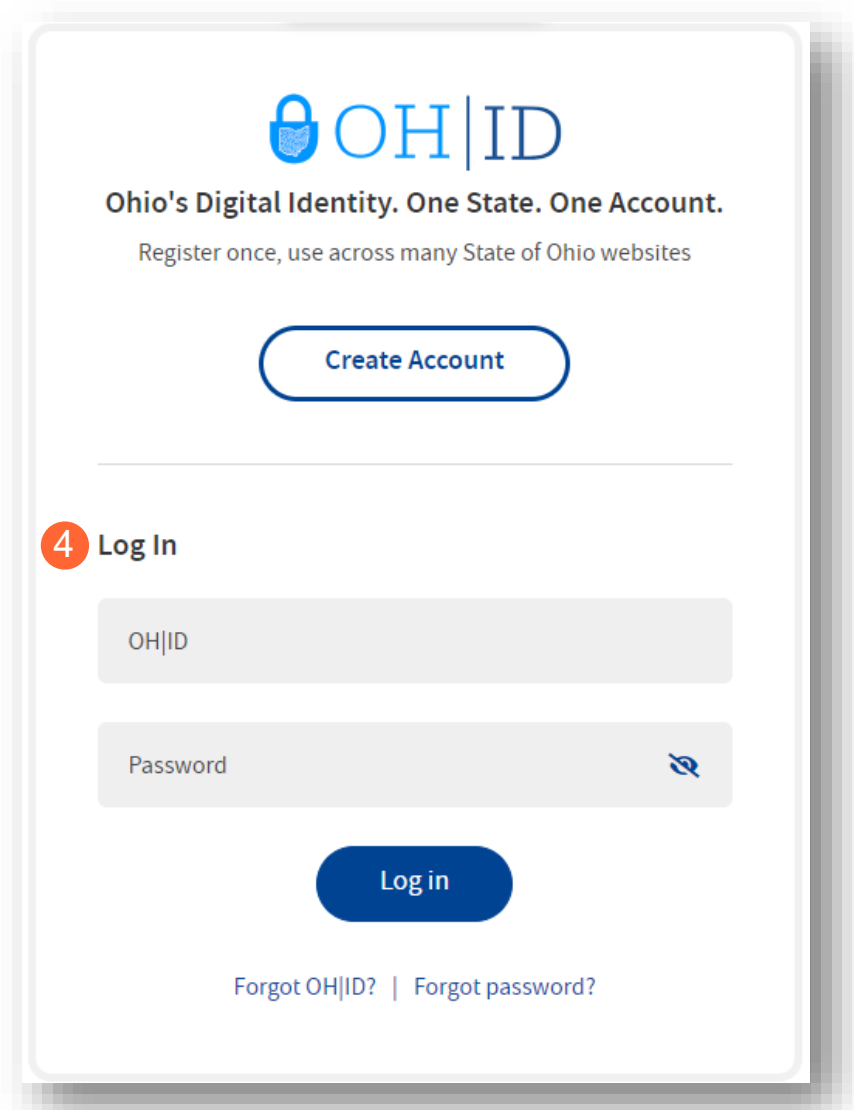
**Step 1:** Visit the PNM web address: [https://ohpnm.omes.maximus.com/OH\\_PNM\\_PRD/Account/Login.aspx](https://ohpnm.omes.maximus.com/OH_PNM_PRD/Account/Login.aspx)

**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**

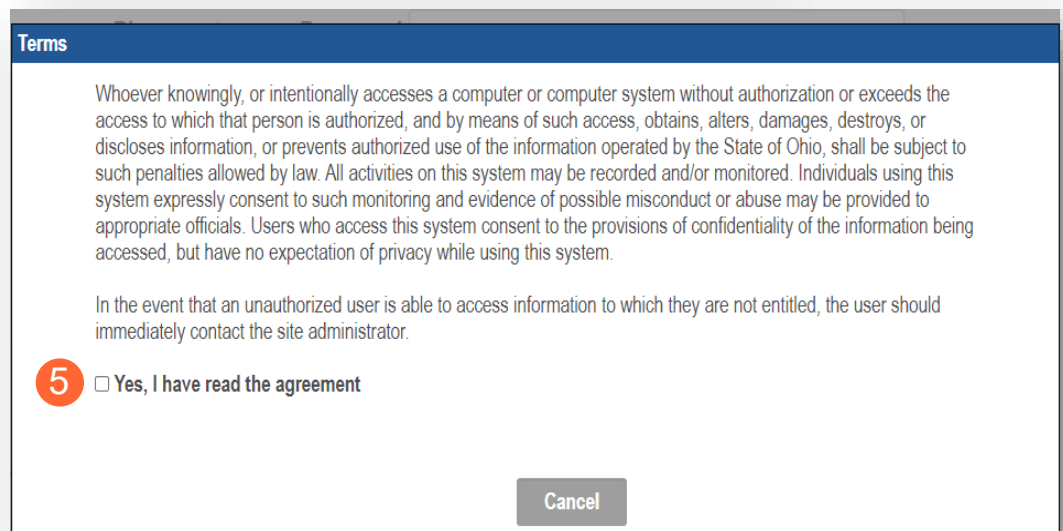
OH|ID

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	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-hand corner of the screen. This will provide you with access to the Provider Directory, Learning Resources, Provider Financials, My Profile, Contact Us, and other key information for the Provider.

**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 New Ohio Medicaid Providers that you will be responsible for administering.

## Page Navigation

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

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

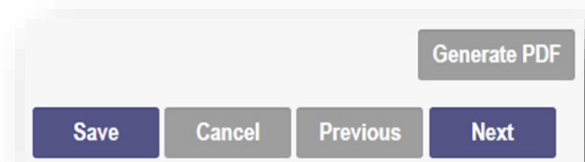
**Cancel:** Clears the work entered and does not save the page.

**Previous:** Returns to the previous page

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

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

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

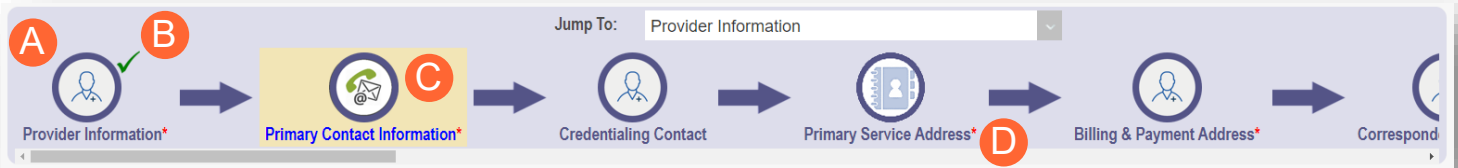


**Navigational Bar:** A workflow at the top of the page that shows the progress made throughout your application. Click the icon to review a specific page and jump to other pages for entry into the application (A).

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

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

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



### Primary Contact Information

This is a required section.

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

### Credentialing Contact


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



## Group/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 top navigation bar with four tabs: 'My Providers', 'Select Provider', 'Pending Agent Requests', and 'Account Administration'. A red circle with the number '1' highlights the 'New Provider ?' button located to the right of the 'Account Administration' tab.

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	All	<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"/>
<a href="#">162</a>	<a href="#">Training WheelChair Van</a>	Complete	WHEELCHAIR VAN			Wheelchair Van			43214 - 1564	09/15/21	09/10/21	09/10/26
<a href="#">190</a>	<a href="#">Vicki J Trainer</a>	Approved	PHYSICIAN ASSISTANT			PHYSICIAN ASSISTANT			43231 - 7605		10/20/21	
<a href="#">195</a>	<a href="#">Training J Pharmacist</a>	Complete	Pharmacist			PHARMACIST			43231 - 7605	10/18/21	10/18/21	10/18/24
<a href="#">198</a>	<a href="#">Test Pharmacy</a>	Submitted	PHARMACY			Pharmacy			43085 - 4706		10/19/21	

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

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

#### Standard application

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

2

#### Ordering, Referring, Prescribing

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

#### 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.

#### MCP Single Case

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

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

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

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

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

**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 'Group' to begin a Group Provider application or 'Organization' to begin an Organization Provider application. For a Pharmacy application, click 'Pharmacy'

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

Application Type  [Change](#)

3	3
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' to advance to the next page

**Uploaded Documents**

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

1 Choose File No file chosen

2 Name

3 Description

4 Upload file

File Uploaded: test.pdf\_29.pdf

6 Save Cancel Previous Next

Primary Contact Information (480295)

## Provider Information Page (Group/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
- NPI (National Provider Identifier)
- Provider Type

Jump To: Provider Information

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

1

2

Generate PDF

Save Cancel Next

**Provider Information**  
This is a required section.

Name of Business Entity\* Training Treatment

DBA

Practice Type\*

Ownership Type\*

Tax ID\* 160985797

NPI 1609857978

NPI Start Date 11/14/2005

Provider Type\* CLINIC

Revalidation Date Not Set Yet

Enrollment Status Not Set Yet

Enrollment Status Reason Not Set Yet

**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

## Credentialing Contact Page

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

**Note:** This is not a required section. Click 'Next' to skip the section and proceed in the application

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

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

Generate PDF

Save Cancel Previous Next

History

Add Contact

No records found

1 Add New

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

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

**Step 4:**

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

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

Save Cancel Previous Next

History

Add Contact

No records found

Add New

2 \*Contact Name

\*Practice Name

\*Contact Phone No

Contact Phone Extension

Contact Fax No

\*Contact Email

3 Comments

4


## Primary Service Address Page

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

**Step 1:** Complete the Primary Service Address information.

Required fields include:

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



1 Organization Name\*

Primary Service Address\*

Address 2

City\*

State\*

County

Zip\*

Ext Zip\*

Phone Number 1\*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1\*

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

☐ Provider Directory Opt-Out



**Step 2:** Indicate specific 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

The screenshot shows a web form with three main sections: 'Hours of Operation', 'Office Information', and 'Patient Information'. Each section is marked with a red circle containing a number (2, 3, and 4 respectively).

**Hours of Operation** (Step 2): This section is titled 'Hours of Operation' with a subtitle '\*Hours providers available for appointments'. It contains a table with days of the week (Monday through Sunday) and two columns of drop-down menus for selecting hours. To the right of the table are seven checkboxes, each labeled 'Open 24 Hours'.

**Office Information** (Step 3): This section is titled 'Office Information'. It contains several fields: 'Website' (a text input field), '24-hour telephone coverage' (a 'Yes' checkbox), 'Public transportation access' (a 'Yes' checkbox), 'Electronic billing' (a 'Yes' checkbox), and 'TDD/TTY' (a 'Yes' checkbox). Below these are 'Cultural Competencies' (a drop-down menu), 'Languages Spoken' (a drop-down menu), 'Specialized Training' (a drop-down menu), 'ADA Compliance\*' (a drop-down menu with '--Select ADA--' as an option), 'ASL Offered\*' (a 'Yes' checkbox), and 'Translation Services' (two checkboxes: 'Language Line' and 'Translation').

**Patient Information** (Step 4): This section is titled 'Patient Information'. It contains several fields: 'Accept new patients' (a 'No' checkbox), 'Accept new patients from referral only' (a 'No' checkbox), 'Youngest patients accepted' (a text input field), 'Oldest patients accepted' (a text input field), 'Gender of patient Accepted' (a drop-down menu), 'Accept newborn\*' (a 'No' checkbox), and 'Accept pregnant women' (a 'No' checkbox).

**Step 5:**

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

## Address Pages

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

**Note:** Additional address pages may appear for certain Providers (Ex. Hospital Address for Hospital Providers)

### Billing & Payment Address Page

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

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

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

### Correspondence Address Page

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

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

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

## 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

## 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 \*

## Hospital Address Page (Hospital Providers Only)

This address page will appear for Hospital Providers only and is required to be completed. Repeat the process below to add more than one location.

**Step 1:** Click 'Add New' to enter details for the Hospital location

**Step 2:**

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

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

- Hospital Cost Report Address
- Hospital Care Assurance Program (HCSAP)
- Hospital Franchise Fee (HFF)

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

The screenshot shows the 'Hospital Address' form. At the top left, the title 'Hospital Address' is followed by a red note: 'This is a required section.' In the top right corner, there are four buttons: 'Save', 'Cancel', 'Previous', and 'Next'. Below these, on the right side, is a 'History' button with a document icon. A red circle with the number '4' is placed over the 'History' button. On the left side of the form, there is a large circular icon containing a person silhouette with a plus sign. Below this icon is a smaller, fainter version of the same icon. The main content area of the form is titled 'No records found.' and contains a list of input fields. A red circle with the number '2' is placed over the 'Same as Practice Location' checkbox. A red circle with the number '3' is placed over the 'Location Type\*' dropdown menu. A red circle with the number '1' is placed over the 'Add New' button, which is located at the bottom right of the form. The form fields include: 'Same as Practice Location' (checkbox), 'Location Type\*' (dropdown), 'Address Type' (radio buttons for 'Individual' and 'Organization'), 'Organization Name\*' (text field), 'Address 1\*' (text field), 'Address 2' (text field), 'City\*' (text field), 'State\*' (dropdown menu showing 'OH'), 'County' (dropdown menu), 'Zip\*' (text field), 'Ext Zip\*' (text field), 'Phone Number 1\*' (text field), 'Phone Ext 1' (text field), 'Phone Number 2' (text field), 'Phone Ext 2' (text field), 'Fax Number 1' (text field), 'Fax Number 2' (text field), 'Contact Name' (text field), and 'Email Address 1\*' (text field).

## Other Service Locations

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

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

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

**Step 5:**

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

Jump To: Other Service Locations

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

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

Save Cancel Previous Next

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

Add New

**2**

Name

Address 1\*

Address 2

City\*

State\* OH

County

Zip\*

Ext Zip\*

Phone Number 1\*

Phone Ext 1

Phone Number 2

Phone Ext 2

**1**

**4** **Provider Information** \*Only required for Individual registrations

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

**Hours of Operation** \*Hours providers available for appointments

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

**Office Information**

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

**Patient Information**

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

## Specialties Page

The specialty page allows 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 displays the 'Specialties' page in a web application. At the top, a navigation bar shows a sequence of steps: 'My Service Locations', '1099 Address\*', 'Home Office Address\*', 'Specialties\*' (highlighted), 'Taxonomies\*', 'Professional Licenses\*', and 'CLIA Certifications'. A 'Jump To:' dropdown menu is set to 'Specialties'. Below the navigation bar, the page title 'Specialties' is followed by a red note: 'This is a required section.' To the right are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', and 'Next'. A message states: 'Primary Specialties are not editable by provider after application submission.' Below this, it says 'No records found'. A red circle with the number '1' and an 'Add New' button are visible. The main content area shows a large circular icon with a DNA helix and a magnifying glass. To the right of the icon, there is a checkbox labeled 'Designate a Primary Specialty' which is checked. Below this, a red note says: 'Designate a Primary Specialty and save first before secondary specialties can be entered.' A red circle with the number '1' is next to the 'Specialty\*' dropdown menu. Below the dropdown are input fields for 'Start Date\*' (11/8/2021) and 'End Date' (12/31/2299). An 'Add New' button is at the bottom right.

Jump To: Specialties

My Service Locations → 1099 Address\* → Home Office Address\* → Specialties\* → Taxonomies\* → Professional Licenses\* → CLIA Certifications

**Specialties**  
This is a required section.

Generate PDF

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

No records found

1 Add New

**Specialties**  
This is a required section.

Generate PDF

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

No records found

1 Add New

☒ Designate a Primary Specialty .

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

1 Specialty\*

Start Date\* 11/8/2021

End Date 12/31/2299

Add New

**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

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

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

Jump To: Specialties

Service Locations → 1099 Address\* → Home Office Address\* → **Specialties\*** → Taxonomies\* → Professional Licenses\* → Board Certification

**Specialties**  
This is a required section.

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date		
Family Practice	Yes	05/01/2008	12/31/2299		
Internal Medicine/Pediatrics	No	05/01/2008	12/31/2299		

Add New

Save Cancel Previous Next

## Removing Specialties

**Step 1:** To Remove an added specialty:

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

Jump To: Specialties

Service Locations → 1099 Address\* → Home Office Address\* → **Specialties\*** → Taxonomies\* → Professional Licenses\* → Board Certification

**Specialties**  
This is a required section.

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date		
Family Practice	Yes	05/01/2008	12/31/2299		
Internal Medicine/Pediatrics	No	05/01/2008	12/31/2299		
Physician/Osteopath Individual	No	05/01/2008	12/31/2299		

Add New

Generate PDF

Save Cancel Previous Next



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.

Locations

1099 Address\*

Home Office Address\*

Specialties\*

Taxonomies\*

Professional Licenses\*

Medicare Number

Group, Facility & Hospital Affilia

Jump To:

Taxonomies

Generate PDF

Save

Cancel

Previous

Next

Taxonomies

This is a required section.

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
104100000X	Social Worker	Yes	07/26/2021	12/31/2299		
101YM0800X	Counselor Mental Health	No	10/06/2021			

Add New

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

Jump To: Taxonomies

1099 Address\* Home Office Address\* Specialties\* Taxonomies\* Professional Licenses\* Board Certification CLIA Certification

**Taxonomies**  
This is a required section.

Get PDF

Save Cancel Previous Next

Taxonomy	Taxonomy Description	Primary	Start Date	End Date	
207Q00000X	FAMILY MEDICINE	Yes	10/21/2021	12/31/2299	

1 Add New

Taxonomy\*

2 ☐ Is Primary Taxonomy

3 Start Date\*

4 End Date

## Editing or Changing Primary Taxonomy

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

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

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

**Step 4:** Confirm your changes have been adjusted

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

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

Jump To: Taxonomies

1099 Address\* Home Office Address\* Specialties\* Taxonomies\* Professional Licenses\* Board Certification CLIA Certification

**Taxonomies**  
This is a required section.

Get PDF

Save Cancel Previous Next

Taxonomy	Taxonomy Description	Primary	Start Date	End Date
207Q00000X	FAMILY MEDICINE	Yes	10/21/2021	12/31/2299

Add New

**2** Taxonomy\* Family Medicine (207Q00000X)

**3** ☒ Is Primary Taxonomy

Start Date\* 10/21/2021

End Date 12/31/2299

Professional Licenses

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

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

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

Jump To:

Professional Licenses

Home Office Address\*

Specialties\*

Taxonomies\*

Professional Licenses\*

Board Certification

CLIA Certifications

Medicare Nui

Generate PDF

Save

Cancel

Previous

Next

Professional Licenses

This is a required section.

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

1

Add New

**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.

Save Cancel Previous Next

Get PDF

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

3

Uploaded Documents

Optional Document

Professional License

Browse

CLIA Certifications Page

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

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

CLIA Certifications

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

Get PDF

1

Save

Cancel

Previous

Next

No CLIA number found

Add New

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

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

CLIA Certifications

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

Save

Cancel

Previous

Next

No CLIA number found

2

CLIA Number\*

CLIA Effective Date

CLIA Expiration Date

2

Add New

## Medicare Number Page

Depending on your Provider type, this may not be a required section. Click 'Next' to skip, if not required.

**Step 1:** If you need to complete this section, click 'Add New' and enter the relevant information:

- Medicare Number type

*If you need further clarification, click 'What is this?' for help*

- Medicare number based on type selected
- Medicare State
- Medicare Enrollment Status (Required)
- Medicare Enrollment Date

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 has two radio buttons for 'Medicare Number Type': 'CCN (CMS Certification Number)' and 'PTAN (Provider Transaction Access Number)', each with a 'What is this?' link. Below these are input fields for 'Medicare Number', 'Secondary NPI', 'Medicare State' (a dropdown menu), 'Medicare Enrollment Status\*' (a dropdown menu), and 'Medicare Enrollment Date'. At the bottom, there 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' and locate the file on your computer

**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 has two dropdown menus: 'Other State Medicaid Enrollment Status' and 'State'.

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

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

**Medicare Number**

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

4

Save

Cancel

Previous

5

Next



Group, Organizations & Hospital Affiliations Page

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

Adding an Individual Provider Associated with Your Group

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

Jump To: 

Group, Organizations & Hospital Affiliations

ies\*

CLIA Certifications

Medicare Number

Group, Organizations & Hospital Affiliations\*

MCP Affiliation

Federal DEA Registration

Generate PDF

Save

Cancel

Previous

Next

Group, Organizations & Hospital Affiliations

This is a required section.

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		
No affiliations found.											

Display 50 | Display 100

Total Count: 0

1

Add New

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

- Note: You will need the NPI for the Provider and will have to enter that information

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

2

First Name\*

Last Name\*

NPI\*

Rendering Location\*

Start Date\* 11/8/2021 [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

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

Group, Organizations & Hospital Affiliations

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.

4

Display Active Only ☐ Yes ☒ No

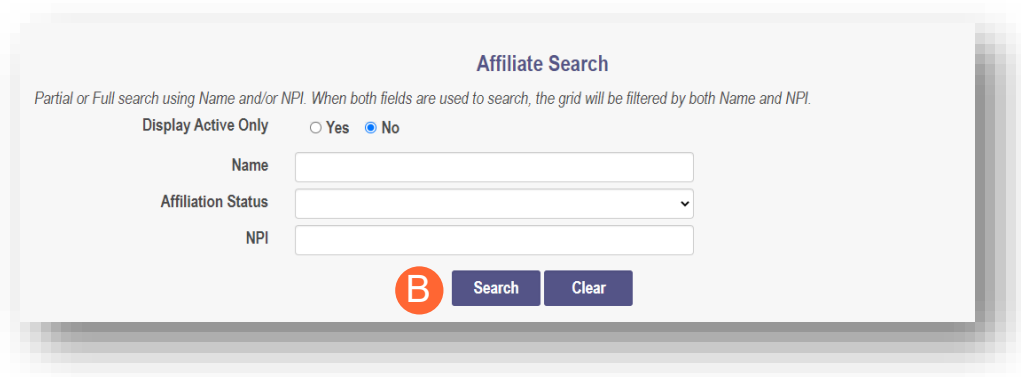
A

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status	Revalidation Due Date	Medicaid ID	Rendering Location		
Donald Trainer		Physician/Osteopath Individual	Licensed MD/DO	11/8/2021	12/31/2299	Confirmed	2027-10-19	0000134	DISCOVERY DR		

5 Add New

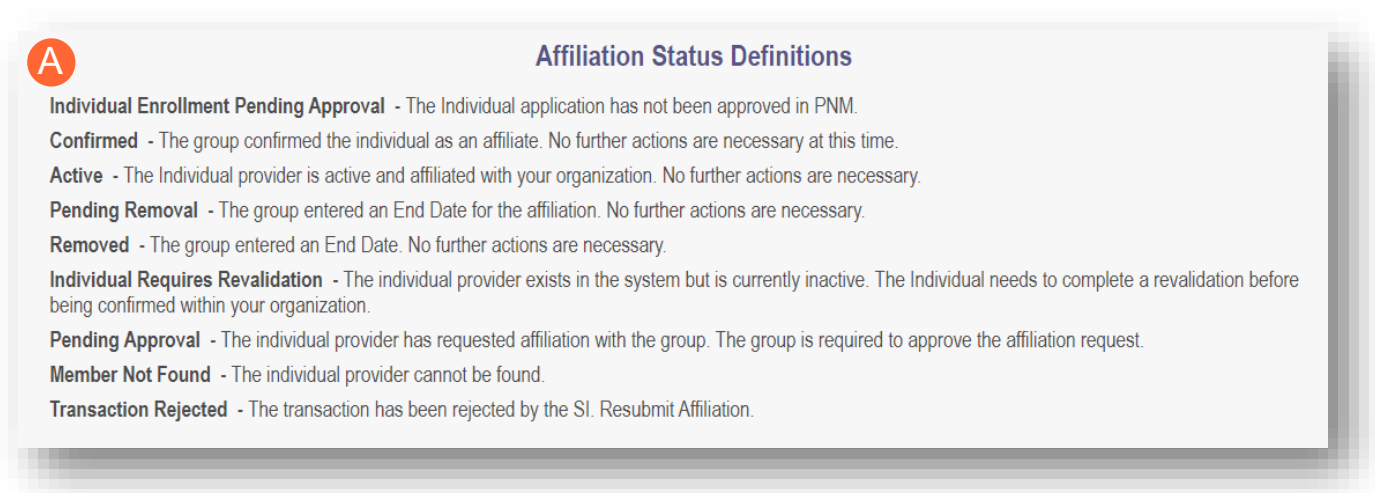
**Note:** The individual Providers will have a different affiliation status. The definitions of that status are shown at the bottom of this section (A)

**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)



The screenshot shows a web form titled "Affiliate Search". Below the title is a subtitle: "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." The form includes a "Display Active Only" section with radio buttons for "Yes" and "No", where "No" is selected. There are three input fields: "Name" (a text box), "Affiliation Status" (a dropdown menu), and "NPI" (a text box). At the bottom of the form are two buttons: "Search" and "Clear". A red circle with the letter "B" is positioned to the left of the "Search" button.

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



The screenshot shows a section titled "Affiliation Status Definitions" with a red circle containing the letter "A" in the top left corner. The section lists several 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.

## MCP Affiliation

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

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

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

The screenshot shows a progress bar at the top with six steps: Medicare Number, Group, Facility & Hospital Affiliations (Individual), MCP Affiliation (highlighted), State CDS Number, Federal DEA Registration\*, and Professional. Below the progress bar, the 'MCP Affiliation' section is active. It includes a 'Generate PDF' button and navigation buttons: Save, Cancel, Previous, and Next. The main question is 'Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans?' with a red circle containing the number '1' next to the 'No' radio button. A 'Please Note' message states: 'This indication does not ensure a contract with the Ohio Medicaid Managed Care Plans. Providers must still go thru the plan's contracting process, if applicable'. Below this is a table titled 'Confirmed MCP Affiliations' with columns: Name, Start Date, End Date, and Provider Type. The table is currently empty, with the text 'No MCP affiliations found.' below it.

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

This screenshot shows the same 'MCP Affiliation' section as the previous one, but with the 'Yes' radio button selected. The 'Please Note' message is repeated. Below the note is a list of Managed Care Plans, each with an unchecked checkbox. A red circle containing the number '2' is next to the first item. The list includes: AmeriHealth Caritas, Anthem Blue Cross, Aetna, Buckeye, CareSource, Humana, Molina, and United Health Care. The 'Confirmed MCP Affiliations' table is still empty, with 'No MCP affiliations found.' below it.

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

### Confirmed MCP Affiliations

Name	Start Date	End Date	Provider Type	Tracking Number	MITs Specialty
No MCP affiliations found.					

## Federal DEA Registration Page

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

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

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

Jump To: Federal DEA Registration

ions (Individual) → MCP Affiliation → State CDS Number → Federal DEA Registration\* → Professional Liability Insurance\* → Education\* → Malpr

Federal DEA Registration  
This is a required section.

Save Cancel Previous Next

Get PDF

**DEA Question**

Do you have a current DEA registration?

☒ Yes ☐ No

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

No records found

## Yes/No DEA Number

**Step 1:** If you select 'No', you will be prompted to enter the representative's information

Federal DEA Registration  
This is a required section.

Save Cancel Previous Next

[DEA Question](#)

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

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

Name of Provider that prescribes on your behalf

DEA Number of the prescribing Provider

DEA State of the prescribing Provider

Prescribing Comments

No records found

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

- DEA Number
- DEA State
- Issue Date
- Expiration Date

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

Federal DEA Registration  
This is a required section.

Save Cancel Previous Next

[DEA Question](#)

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

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

DEA Number

DEA State

Issue Date

Expiration Date

DEA Status

No records found

Add New

## Professional Liability Insurance Page

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

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

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

Jump To: Professional Liability Insurance

State CDS Number Federal DEA Registration\* Professional Liability Insurance\* Education\* Malpractice Claims History\* Work History

Professional Liability Insurance  
This is a required section.

Generate PDF

Save Cancel Previous Next

No records found

1 Add New

## Yes/No Professional Liability Insurance

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

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

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

Do you carry malpractice insurance? 2 Yes No

Self Insured? Yes

Policy Number\*

Effective Date\*

Original Effective Date\*

Expiration Date\*

Type of Coverage\*

Do you have unlimited coverage?

Policy includes tail coverage\*

Carrier or Self-Insured Name\*

Carrier address 1

Carrier address 2

City\*

State\* OH

County\*

Zip\*

Policy Holder\*

Coverage Amount Per Occurrence\*

Coverage Amount Per Aggregate\*

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

Do you carry malpractice insurance?

☐ Yes ☒ No

If No, please provide explanation below.

3

Please provide an explanation regarding malpractice insurance

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

Professional Liability Insurance

This is a required section.

Get PDF 4

Save Cancel Previous Next

History

Carrying malpractice insurance?	Policy Number	Effective Date	Expiration Date	Policy Holder	Coverage Account Per Occurrence	Coverage Account Per Aggregate	Explanation regarding malpractice insurance
Yes	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. At the top, a navigation bar includes icons for 'Professional Liability Insurance\*', 'Education\*', 'Malpractice Claims History\*', 'Work History\*', 'W9 Form\*' (highlighted), 'Required Documents', and 'Agreements\*'. A 'Jump To:' dropdown menu is set to 'W9 Form'. Below the navigation bar, there are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', and 'Next'. The main section is titled 'W9 Form' with a note 'This is a required section.' Below this, it states 'Information from the Identification page displayed below. Corrections to this information must be made in Organization/Individual Identification and Primary Contact sections of the Identification page.' The 'Individual Name' field contains 'Training' and the 'SSN' field is masked. A red circle with the number '1' points to the 'Select the most appropriate category below:' section, which contains a list of radio button options: Individual/sole proprietor of single-member LLC, C Corporation, S Corporation, Partnership, Trust/Estate, Limited Liability C Corporation, Limited Liability S Corporation, Limited Liability Partnership, and Other.

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

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

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

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

**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

SaveCancelPreviousNext

1

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

☐ Yes
 ☐ No

2

Instructions

READ INSTRUCTIONS BEFORE COMPLETING

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

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

3

Banking Information

No banking information found.

Add New

EFT Contact

No EFT contact found.

Add New

Confirm

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

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

☐ I confirm the information provided is true and accurate.

**Step 4:** Complete the required information

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

**Step 5:** Click 'Save'

**Banking Information**

4 Financial Institution Name\* Training Bank

Financial Institution Routing Number\* 041215537

Confirm Financial Institution Routing Number\* 041215537

Account Number\* 25435345443


Confirm Account Number\* 25435345443

Account Type\* ☒ Checking ☐ Savings

5 Save Cancel

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

**Banking Information**

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

**EFT Contact**

No EFT contact found.

6 Add New

**Confirm**

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

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

☐ I confirm the information provided is true and accurate.

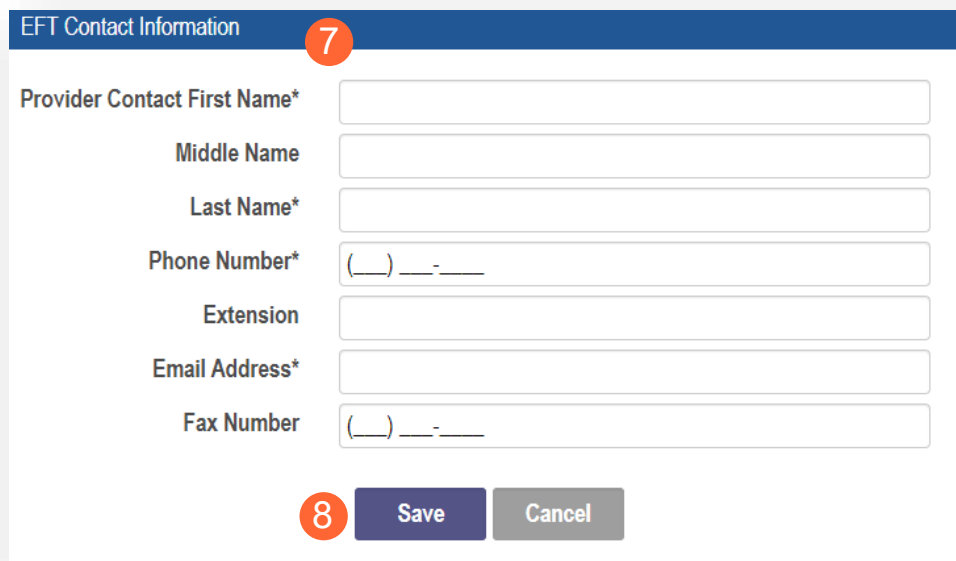
**Step 7:** Enter the following contact information for the person who will handle the Electric Funds Transfer account

Required

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

Optional

- Middle Name
- Phone Extension
- Fax Number

A form titled "EFT Contact Information" with a blue header. It contains input fields for "Provider Contact First Name\*", "Middle Name", "Last Name\*", "Phone Number\*" (with a format of ( ) - -), "Extension", "Email Address\*", and "Fax Number" (with a format of ( ) - -). At the bottom right, there are "Save" and "Cancel" buttons. A red circle with the number 7 is in the top right corner, and a red circle with the number 8 is in the bottom left corner.

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

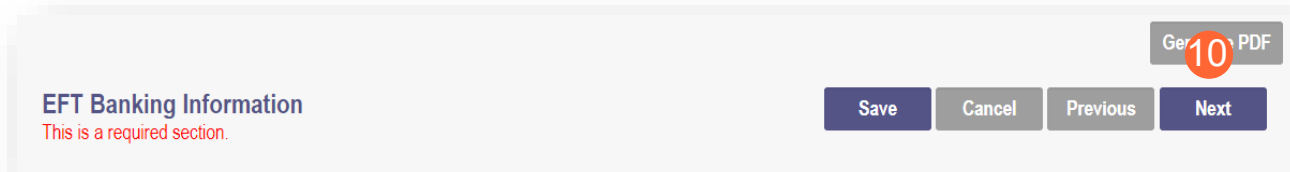
**Confirm**

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

A form titled "EFT Banking Information" with a blue header. It contains a "Generate PDF" button in the top right corner. At the bottom, there are "Save", "Cancel", "Previous", and "Next" buttons. A red circle with the number 10 is in the top right corner.

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 by certain Providers 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.

**Note:** This page will only appear if you are required to pay the Application Fee

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

1

☒ Credit Card

2

☐ Request Waiver of Application Fee

Authorize Payment

Select Payment

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

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

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

**CBOSS** BETA

### Enter New Account

3

Name on Card

Card Number

MM/YY

MasterCard Discover American Express Visa

Address Line 1

Address Line 2

City State

Zip Country

Phone Number

Email Address



☐ Remember For Future Use

Cancel 4 Submit

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

Application Fee  
This is a required section.

SaveCancelPreviousNext



### 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.

**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

**1**

[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**

**Fee Payment History**

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

**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'

Jump To: Owner Information

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

Generate PDF

Save Cancel Previous Next

Owner Information  
This is a required section

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

+ 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 Group or Organization

**Step 5:** Click 'Save'

Owner Information

4

Owner Type\*

Owner Title

Affiliation Type

Address 1\*

Address 2

City\*

State\*

County

Zip\*

Percentage of Ownership\*

Owner End Date

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

Jump To: Owner Information

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

Owner Information  
This is a required section.

Save Cancel Previous Next

8 DF

## Required Documents Page

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

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

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

- To upload a document, click 'Browse,' then select the file and open

Required Document

EWV Training

Browse

2

**Note:** Organizations and Facilities may have specific documents that need to be uploaded in the Required Documents section. An example of those document types is listed below:

Optional Document

ODH Bed Registration for all Instate

Browse

Optional Document

Verification of Bed Size Doc for Outstate Type 2

Browse

Optional Document

Home State Psychiatric License for Outstate Type 2

Browse

Optional Document

ODI Application-Please Upload a Completed and signed ODI Standardized Credentialing

Browse

Required Document

Maternity License

Browse

Required Document

Site Visit/Accreditation

Browse

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

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

Jump To: Required Documents

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

Generate PDF

Save Cancel Previous Next

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

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

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

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

3 Choose File No file chosen

Name

Description

Upload file

## Agreements Page

The Agreements page will ask for you to agree and attest to information that you have provided on 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 the Name of the Person Attesting

**Step 6:** Click 'Save'

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

**Provider Agreement Signature**

5 Name of Person Attesting\*: Tom Trainer

Provider Name: Test Test

User ID: trainingprov

6 Save

**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 OK





## Submitting Application

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

The screenshot shows a progress bar at the top with icons for: Personal Liability Insurance\*, Education\*, Malpractice Claims History\*, Work History\*, W9 Form\*, Required Documents, and Agreements\*. A 'Jump To:' dropdown menu is set to 'Agreements'. Below the progress bar, the 'Agreements' section is highlighted with a red circle and the number '1'. The section title is 'Agreements' with a note: 'This is a required section.' To the right of the title are buttons: 'Generate PDF', 'Submit for Review' (highlighted with a red circle and '1'), 'Save', 'Cancel', 'Previous', and 'Next'. The main content area is titled 'Ohio Medicaid Provider Agreement' and contains a note: '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 is a scrollable box with the text: 'All Providers must read the statements below and agree to the terms'. The scrollable box contains two sections: 'Ohio Revised Code 2921.42 and 2921.43 Agreement' and 'False Statement Agreement'. A circular icon of a hand holding a document is on the left side of the scrollable box.

**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 is a navigation bar with the 'Ohio' logo, a home icon, and links: 'Provider Network Management', 'Medicaid Home', 'Learning', 'Contact', 'Fee Schedule', a user icon, and 'Log out'. The main content area has a red circle with the number '2' and the title 'Submission Confirmation'. Below the title is a message: '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 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 under the Reg ID or Provider heading

<div> <div>Menu</div> <div>Ohio</div> <div> <a href="#">Provider Network Management</a> <a href="#">Medicaid Home</a> <a href="#">Learning</a> <a href="#">Contact</a> <a href="#">Fee Schedule</a> </div> <div>Log out</div> </div>													
<div> <a href="#">My Providers</a> <a href="#">Select Provider</a> <a href="#">Pending Agent Requests</a> <a href="#">Account Administration</a> </div>													<a href="#">New Provider ?</a>
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date	
<a href="#">169</a>	<a href="#">Donald Trainer</a>	Approved	Physician/Oste Individual			Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706		09/16/21		
<a href="#">170</a>	<a href="#">Training Clinic</a>	Submitted	CLINIC			Primary Care Clinic			43085 - 4706		09/16/21		
<a href="#">171</a>	<a href="#">Kim Trainer</a>	Return to Provider	Chiropractor Individual			Chiropractic Services			43085 - 4706		09/16/21		
<div> <div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> </div> <div>Page size: 10</div> </div>													93 items in 10 pages

## Reviewing Correspondence

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

Provider Management Home

Registration Information

Provider Name	Medicaid ID	Effective Date	Revalidation Due Date	Term Date
Training Clinic	0000004	04/25/2022	04/25/2027	

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
517991	Application Flow - Standard - NEW REGISTRATION	Medicaid	606135				04/25/22

**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
<a href="#">Send Additional Information (RTP Notice)</a>	ENROLLMENT	03/21/2022		✓
<a href="#">Ohio Medicaid Provider Application Received</a>	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 Clinic	0000004	04/25/2022	04/25/2027	

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
517991	Application Flow - Standard - NEW REGISTRATION	Medicaid	606135				04/25/22

**Step 2:** Click '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 on the page

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

3

Jump To: Professional Licenses

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

5

Generate PDF

Save Cancel Previous Next

**Professional Licenses**  
This is a required section.

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

4

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

Add New

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

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

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

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

5 OK

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

Jump To: Professional Licenses

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

Board Certification

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

No Board Certification found

Generate PDF

6 Submit for Review

Save Cancel Previous Next

Add New

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

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

7 Submission Confirmation

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

8 Return to Home Page

## Submitting a Plan of Correction

**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 under 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		

Page size: 10 93 items in 10 pages

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

Provider Management Home

Registration Information

Provider Name

Training Clinic

Medicaid ID

0000004

Effective Date

04/25/2022

Revalidation Due Date

04/25/2027

Term Date

Manage Application

Enrollment Actions

3 + Enrollment Action Selections:

Programs

+ Program Selections:

Self Service

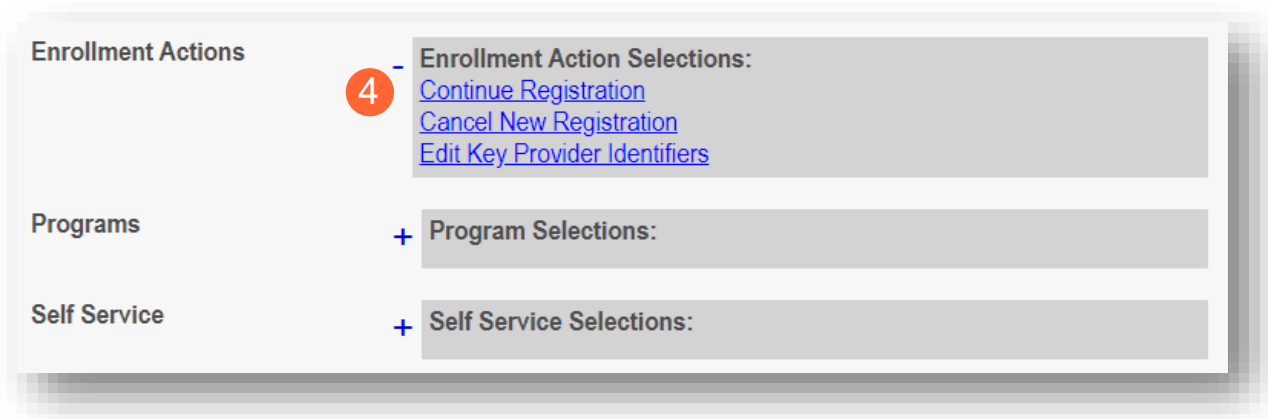
+ Self Service Selections:

My Current and Previous Applications

Reg ID	Enrollment Action	Program	Application Id	PNM Application Status	Other Agency Application Status	DD Legal Status	Status Date
517991	Application Flow - Standard - NEW REGISTRATION	Medicaid	606135				04/25/22



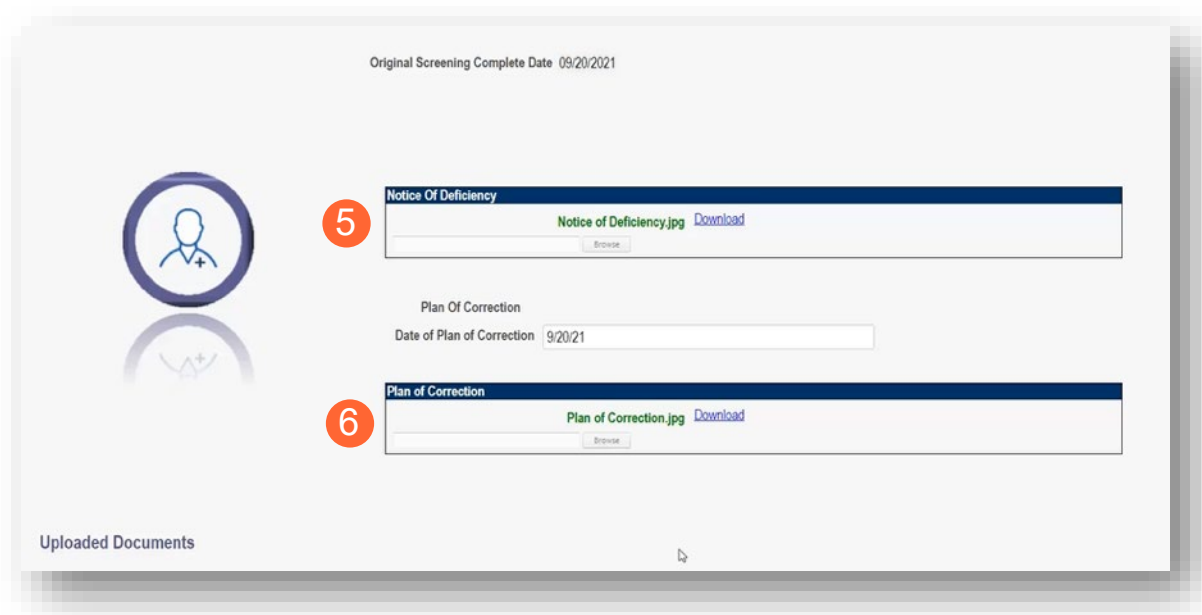
**Step 4:** To access the application, click 'Continue Registration'



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 red circle with the number '4' and a minus sign. To the right of the 'Programs' item is a plus sign. To the right of the 'Self Service' item is a plus sign. The main content area on the right has three sections: 'Enrollment Action Selections:' with links for 'Continue Registration', 'Cancel New Registration', and 'Edit Key Provider Identifiers'; 'Program Selections:'; and 'Self Service Selections:'.

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

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



The screenshot shows the 'Site Visit Screening' page. At the top, it says 'Original Screening Complete Date 09/20/2021'. On the left is a circular icon with a person 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, it says 'Uploaded Documents'.

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

**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.*

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

## Review the Final Decision for Provider Submission

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

- Locate your newly assigned Medicaid ID number next to your application in the table
- If the provider does not appear, use number timeline at the bottom to navigate to the correct page

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	<a href="#">Donald Trainer</a>	Complete	Physician/Oste Individual		0000134	Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706	09/29/21	09/16/21	09/29/24	
170	<a href="#">Training Clinic</a>	Complete	CLINIC		0000122	Primary Care Clinic			43085 - 4706	09/16/21	09/16/21	09/16/26	1
171	<a href="#">Kim Trainer</a>	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

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	<a href="#">Donald Trainer</a>	Complete	Physician/Oste Individual		0000134	
170	<a href="#">Training Clinic</a>	Complete	CLINIC		0000122	
171	<a href="#">Kim Trainer</a>	Complete	Chiropractor Individual		0000135	

<div> <div>My Providers</div> <div>Select Provider</div> <div>Pending Agent Requests</div> <div>Account Administration</div> </div> <div>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" value=""/>	<input type="text" value=""/>	<input type="text" value="All"/>	<input type="text" value="All"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value="All"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>
<a href="#">169</a>	<a href="#">Donald Trainer</a>	Complete	Physician/Oste Individual	<input type="text" value=""/>	0000134	Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706	09/29/21	09/16/21	09/29/24
<a href="#">170</a>	<a href="#">Training Clinic</a>	Complete	CLINIC	<input type="text" value=""/>	0000122	Primary Care Clinic			43085 - 4706	09/16/21	09/16/21	09/16/26
<a href="#">171</a>	<a href="#">Kim Trainer</a>	Complete	Chiropractor Individual	<input type="text" value=""/>	0000135	Chiropractic Services			43085 - 4706	09/29/21	09/16/21	09/29/24
<a href="#">178</a>	<a href="#">Training Rural Health</a>	Submitted	Rural Health Clinic	<input type="text" value=""/>		Rural Health Clinic Medical			43085 - 4706		09/22/21	

Provider Management Home

Registration Information

Provider Name

Training Clinic

Medicaid ID

0000004

Effective Date

04/25/2022

Revalidation Due Date

04/25/2027

Term Date

Manage Application

Enrollment Actions

2 + Enrollment Action Selections:

Programs

+ Program Selections:

Self Service

+ Self Service Selections:

**Enrollment Actions**

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

**Step 4:** Choose which element on the application you wish to update from the provided list and click ‘Update’

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

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

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

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

Jump To: Billing & Payment Address

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

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

6 Return to Summary  
5 Generate PDF  
Save Cancel

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

Jump To: Billing & Payment Address

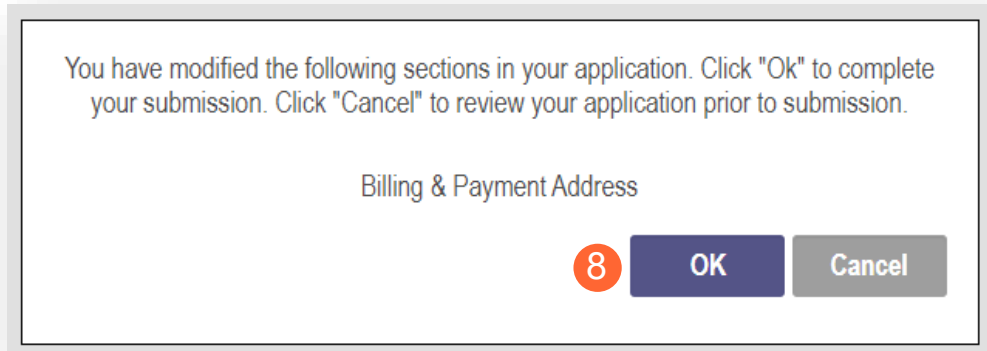
Provider Information\* → Primary Contact Information\* → Credentialing Contact → Office Information → Primary Service Address\* → Billing & Payment Address

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

Return to Summary  
Generate PDF  
7 Submit for Review  
Save Cancel

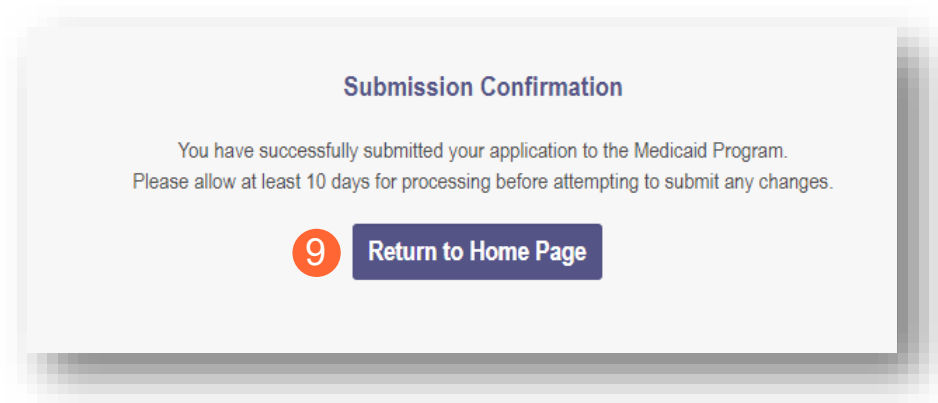
A

**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 Group/Organization

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

My Providers   Select Provider   Pending Agent Requests   Account Administration <span>New Provider ?</span>												
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<a href="#">169</a>	<a href="#">Donald Trainer</a>	Complete	Physician/Oste Individual		0000134	Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706	09/29/21	09/16/21	09/29/24
<a href="#">170</a> <b>1</b>	<a href="#">Training Clinic</a>	Complete	CLINIC		0000122	Primary Care Clinic			43085 - 4706	09/16/21	09/16/21	09/16/26
<a href="#">171</a>	<a href="#">Kim Trainer</a>	Complete	Chiropractor Individual		0000135	Chiropractic Services			43085 - 4706	09/29/21	09/16/21	09/29/24
<a href="#">178</a>	<a href="#">Training Rural Health</a>	Submitted	Rural Health Clinic			Rural Health Clinic Medical			43085 - 4706		09/22/21	

Page size: 10   102 items in 11 pages

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

Provider Management Home

Registration Information

Provider Name

Training Clinic

Medicaid ID

0000004

Effective Date

04/25/2022

Revalidation Due Date

04/25/2027

Term Date

Manage Application

Enrollment Actions

**2** +

Enrollment Action Selections:

Programs

+

Program Selections:

Self Service

+

Self Service Selections:

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

Enrollment Actions

**3** -

Enrollment Action Selections:

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


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**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

<a href="#">Update</a>	Primary Contact Information
<a href="#">Update</a>	Primary Service Address
<a href="#">Update</a>	Group, Organizations & Hospital Affiliations
<a href="#">Update</a>	Required Documents

**Step 5:** The Providers who are Pending Approval will be highlighted in yellow**Step 6:** Click on the 'pencil and paper' 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		
<a href="#">Provider Trainer</a>		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

**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\*  [What is this?](#)

Start Date\*

End Date

Medicaid ID

Affiliation Status

**8**

Generate PDF

**10**

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		
<a href="#">Provider Trainer</a>		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 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/re-enrollment.

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

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<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"/>
<a href="#">517946</a>	<a href="#">Training Medical Group</a>	Complete	21 - Professional Medical Group	1245585009	9999876	Professional Medical Group				02/09/22	02/09/22	02/09/27

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

### Provider Management Home

#### Registration Information

Provider Name	Medicaid ID	Effective Date	Revalidation Due Date	Term Date
Training Clinic	0000004	04/25/2022	04/25/2027	

#### Manage Application

Enrollment Actions	<b>2</b> +	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 application. Click 'Next' to save and proceed to the next page

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

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

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

The screenshot displays the application review interface. At the top, a progress bar shows five steps: Medicare Number, Group, Organizations & Hospital Affiliations, MCP Affiliation, Required Documents, and Agreements. A red circle with the number 5 is next to the 'Agreements' step. Below the progress bar, a table lists the sections and their status:

Section Name	Status
Provider Information*	✓
Primary Contact Information*	✓
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*	✓

Below the table, the 'Agreements' section is expanded, showing the 'Ohio Medicaid Provider Agreement'. A red note states: 'Note: The Provider Agreement in the scroll box'. The agreement text is partially visible. At the bottom right, there is a 'Submit for Review' button and a 'Generate PDF' button. A red circle with the number 4 is next to the 'Submit for Review' button.

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

This close-up shows the bottom right corner of the application interface. It features a 'Generate PDF' button, a red circle with the number 6, and a prominent 'Submit for Review' button. Below these are four navigation buttons: 'Save', 'Cancel', 'Previous', and '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'

2

Medicaid ID: 0000234

NPI: 1174088033

Tax ID: 117408803

3 Save Cancel

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

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

Menu

Ohio

Home

Provider Network Management

Medicaid Home

Learning

Contact

Fee Schedule

Training

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
<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"/>
519390	Test Training	Complete	24 - PHYSICIAN ASSISTANT	1174088033	0000234	PHYSICIAN ASSISTANT				06/28/22	06/28/22	06/28/25

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