

The cover features a central graphic composed of overlapping geometric shapes in various shades of blue and purple. A hand is shown interacting with a digital interface that includes a large blue cross, a heart with a pulse line, and various medical icons like a pill, a stethoscope, and a clipboard. Below this, a tablet displays a blue padlock icon, symbolizing security. The background is white with dark blue geometric shapes in the corners.

USER MANUAL

Provider Enrollment Applications

Individual Provider

Ohio | Department of
Medicaid

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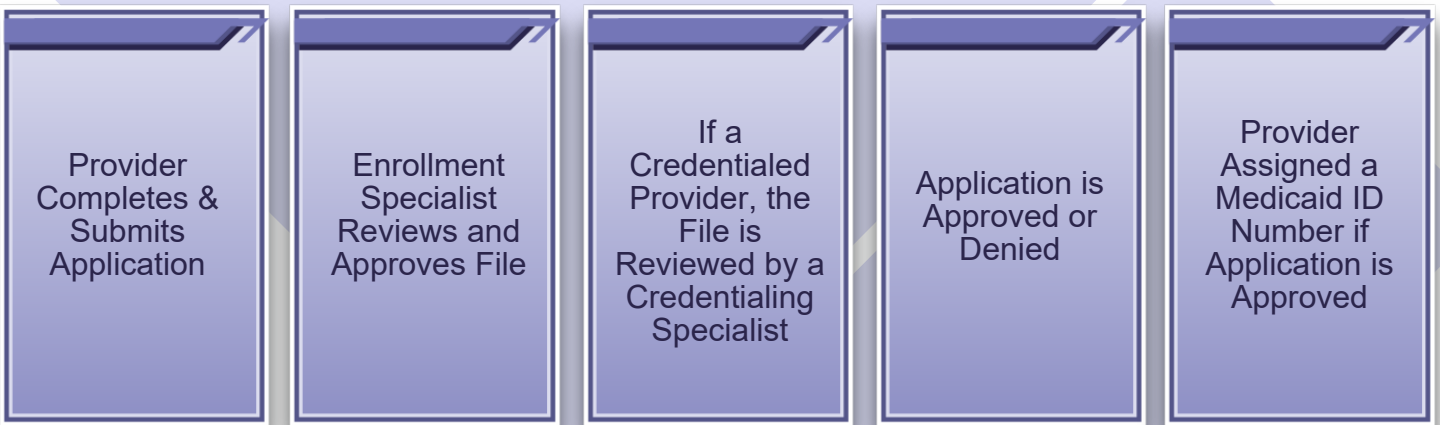
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Introduction

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.



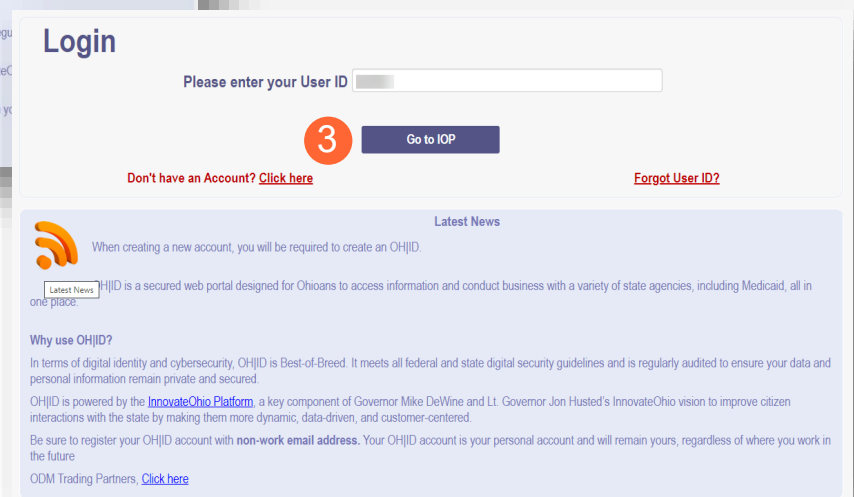
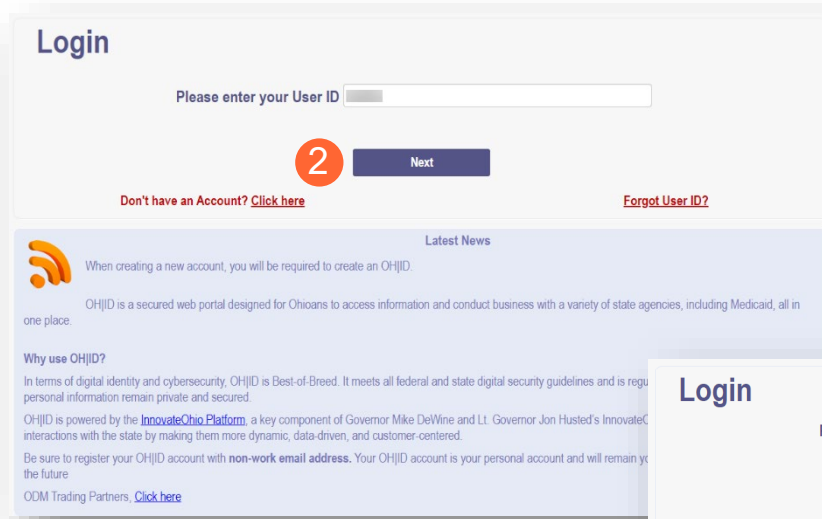
Provider Administrator Initial Login

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

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.

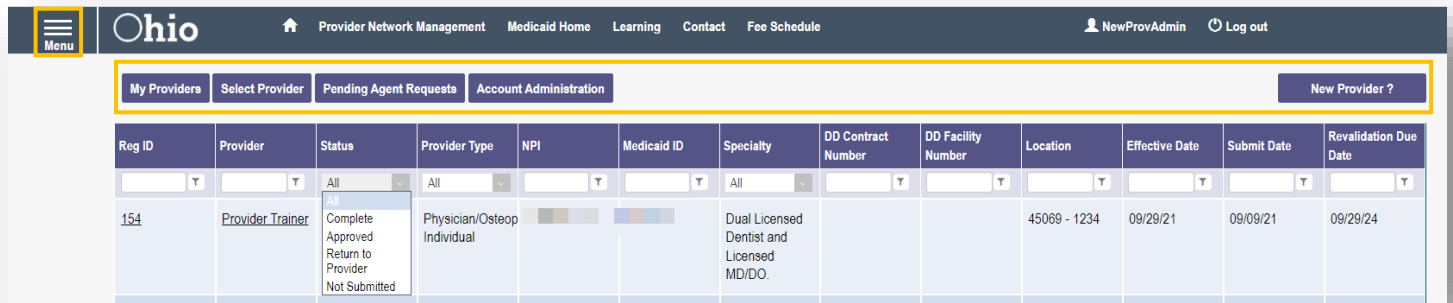
In the event that an unauthorized user is able to access information to which they are not entitled, the user should immediately contact the site administrator.

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.



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.

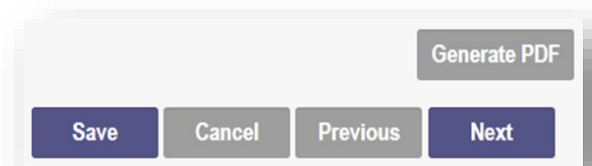
Save: Saves the current page and remains on the page.

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.



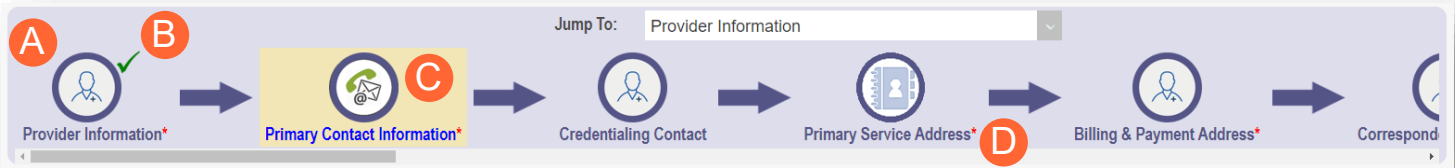
INDIVIDUAL PROVIDER

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

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

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

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



Primary Contact Information

This is a required section.

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

Credentialing Contact

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

Individual Provider - New Provider Entry

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

Step 1: Click 'New Provider'

The screenshot shows a navigation bar with tabs: 'My Providers', 'Select Provider', 'Pending Agent Requests', and 'Account Administration'. A red circle with the number '1' highlights a 'New Provider ?' button. Below the navigation bar is a table with the following columns: Reg ID, Provider, Status, Provider Type, NPI, Medicaid ID, Specialty, DD Contract Number, DD Facility Number, Location, Effective Date, Submit Date, and Revalidation Due Date. The table contains four rows of provider data.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
162	Training WheelChair Van	Complete	WHEELCHAIR VAN			Wheelchair Van			43214 - 1564	09/15/21	09/10/21	09/10/26
190	Vicki J Trainer	Approved	PHYSICIAN ASSISTANT			PHYSICIAN ASSISTANT			43231 - 7605		10/20/21	
195	Training J Pharmacist	Complete	Pharmacist			PHARMACIST			43231 - 7605	10/18/21	10/18/21	10/18/24
198	Test Pharmacy	Submitted	PHARMACY			Pharmacy			43085 - 4706		10/19/21	

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

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

Standard application

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

2 [Select](#)

Ordering, Referring, Prescribing

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

[Select](#)

Change of Operator

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

[Select](#)

MCP Single Case

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

[Select](#) ⓘ

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

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

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

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

2

Less...

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

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

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

3

Application Type [Change](#)

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

Key Identifier Information

Step 1: Enter key provider information for the Provider

Enter all required fields marked with an asterisk *

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

A screenshot of a web form for entering provider information. A red circle with the number '1' is positioned at the top left of the form. The form fields include: Application Type (Standard application), Category* (Individual), Provider Type*, First Name*, Middle Name, Last Name*, Tax ID Type* (EIN, SSN), Tax ID*, Are you requesting retro coverage? (checkbox), NPI*, DD Contract Number (If Applicable), Requested Effective Date* (10/21/2021), Gender* (Female, Male, Unknown), Date of Birth*, Zip Code*, and Zip Code Extension*. There are 'Change' links next to Application Type and Category*. At the bottom right, there are 'Save' and 'Cancel' buttons, with a red circle '2' highlighting the 'Save' button.

Step 2: Click 'Save' to save the information

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



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

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

A screenshot of the same web form as above, but with the 'Taxonomy*' field at the bottom highlighted by a red circle with the number '3'. The 'Save' and 'Cancel' buttons are visible at the bottom right.

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

The screenshot displays the 'Uploaded Documents' section of an application. At the top, there is a table with the following data:

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

Below the table is a form for uploading a new document. The form includes:

- A 'Choose File' button with the text 'No file chosen' (labeled 1).
- A 'Name' input field (labeled 2).
- A 'Description' input field (labeled 3).
- An 'Upload file' button (labeled 4).
- A confirmation message: 'File Uploaded: test.pdf_29.pdf'.
- At the bottom right, a set of navigation buttons: 'Save', 'Cancel', 'Previous', and 'Next' (labeled 6).

The text 'Primary Contact Information (480295)' is visible at the bottom left of the form area.

Provider Information Page (Individual)

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

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

For this page the following fields are required:

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

Additional fields for optional entry:

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

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

The screenshot shows a web form titled "Provider Information" with a sub-header "This is a required section." On the left is a circular icon of a person with a cross. The form fields are as follows:

- Name of Business Entity* (text input, highlighted with a red circle '1')
- DBA (text input)
- Practice Type* (dropdown menu)
- Ownership Type* (dropdown menu)
- First Name* (text input)
- Middle Initial (text input)
- Last Name* (text input)
- Title (dropdown menu)
- Tax ID* (text input, highlighted with a blue dot)
- NPI (text input, highlighted with a blue dot)
- NPI Start Date (text input, value: 09/20/2005)
- Gender* (radio buttons: Female, Male, Unknown)
- Date of Birth* (text input)
- Provider Type* (dropdown menu, value: Physician/Osteopath Individual, highlighted with a blue dot)
- Revalidation Date (text input, value: Not Set Yet)
- Enrollment Status (text input, value: Not Set Yet)
- Enrollment Status Reason (text input, value: Not Set Yet)
- Birth Country (dropdown menu)
- Birth State (text input)
- Birth City (text input)
- CAQH # (text input)

At the bottom right, there is a question: "Have you been a resident of the state OHIO for the last 5 years?" with radio buttons for "Yes" and "No" (the "No" button is selected).

Navigation buttons: "Generate PDF" (top right), "Save", "Cancel", and "Next" (bottom right, highlighted with a red circle '2').

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 or
- Click the 'Next' button to save and move to the next screen

USPS Address Search Pop-Up

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

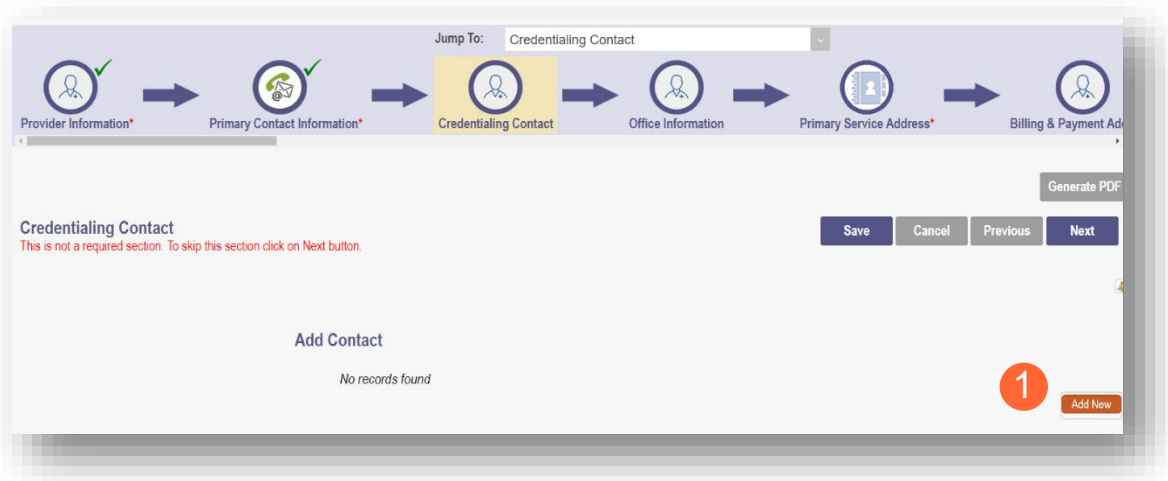
- Confirm the validation and accuracy of the address information
- Click 'Accept' on the USPS confirmation prompt
- Review the changes made to the address
- Click the 'Next' button again to proceed to the next page of the application
- **Note:** If 'Cancel' is selected, you will be taken back to the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

Credentialing Contact Page

Note: Credentialing contact information is not required for every Provider type. Click 'Next' to skip.

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

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

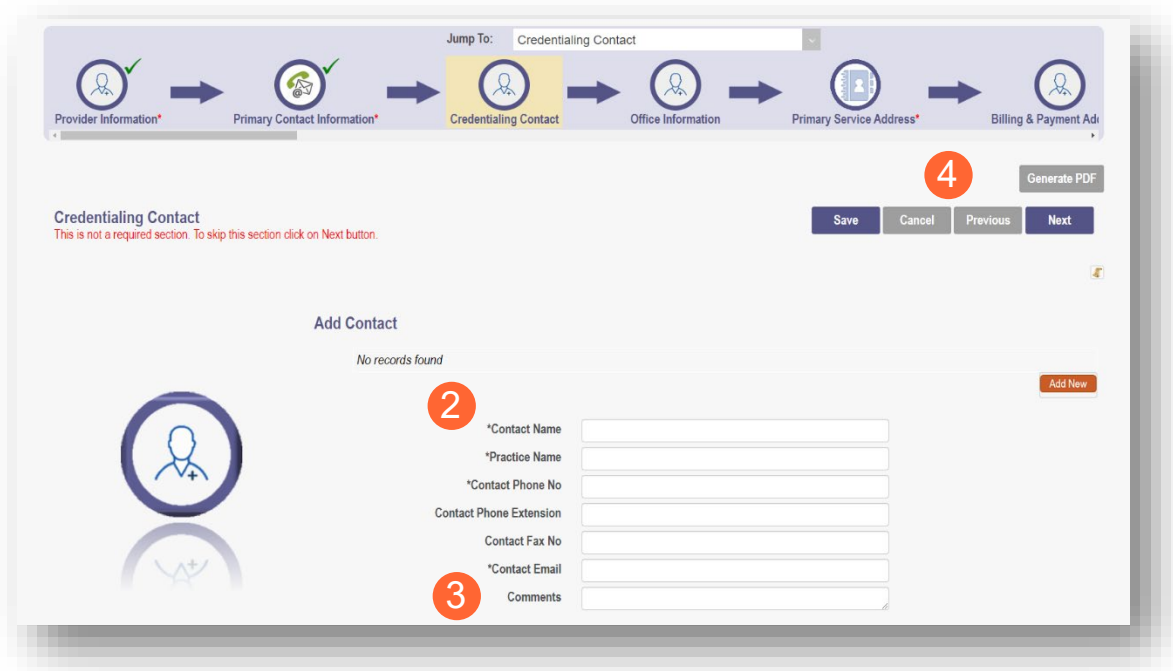


Step 2: Enter all required fields marked with an asterisk *

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



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:

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

1 Provider Name

Primary Service Address*

Address 2

City*

State*

County*

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

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

Provider Directory Opt-Out

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

- Cultural Competencies
- Languages Spoken
- Specialized Training

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

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

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

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

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

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

Step 6:

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

The screenshot shows a registration form with the following sections and callouts:

- 2** **Provider Information** *Only required for Individual registrations
 - Cultural Competencies
 - Languages Spoken
 - Specialized Training
- 3** **Hours of Operation** *Hours providers available for appointments
 - Monday through Sunday: Each day has two time selection dropdowns.
 - Open 24 Hours: A series of checkboxes for each day.
- 4** **Office Information**
 - Website
 - 24-hour telephone coverage
 - Public transportation access
 - Electronic billing
 - TDD/TTY
 - Cultural Competencies
 - Languages Spoken
 - Specialized Training
 - ADA Compliance* (dropdown: --Select ADA--)
 - ASL Offered* (dropdown: Yes)
 - Translation Services (checkboxes for Language Line and Translation)
- 5** **Patient Information**
 - Accept new patients (dropdown: No)
 - Accept new patients from referral only (dropdown: No)
 - Youngest patients accepted
 - Oldest patients accepted
 - Gender of patient Accepted
 - Accept newborn* (dropdown: No)
 - Accept pregnant women (dropdown: No)

Address Pages

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

Billing & Payment Address Page

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

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 *

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*

3 Save Cancel Previous Next

5 PDF

Other Service Locations

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

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

1 Add New

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

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 specialties page allows you to indicate any specialties for the Provider

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

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

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

The screenshot shows a progress bar at the top with icons for Service Locations, 1099 Address, Home Office Address, Specialties, Taxonomies, Professional Licenses, and CLIA Certifications. The 'Specialties' icon is highlighted in yellow. Below the progress bar, the 'Specialties' section is titled 'Specialties' with a red note 'This is a required section.' It includes a 'Generate PDF' button, 'Save', 'Cancel', 'Previous', and 'Next' buttons. A message states 'Primary Specialties are not editable by provider after application submission.' Below this, it says 'No records found' and an 'Add New' button with a red '1' in a circle next to it.

This screenshot shows the 'Add New' form for a specialty. It features a 'Generate PDF' button, 'Save', 'Cancel', 'Previous', and 'Next' buttons. A message states 'Primary Specialties are not editable by provider after application submission.' Below this, it says 'No records found' and an 'Add New' button. A checkbox labeled 'Designate a Primary Specialty' is checked. A red note says 'Designate a Primary Specialty and save first before secondary specialties can be entered.' A red '1' in a circle is next to the 'Specialty*' dropdown menu. Below the dropdown are 'Start Date*' (10/21/2021) and 'End Date' (12/31/2299) fields. A circular icon with a DNA helix and a magnifying glass is on the left.

INDIVIDUAL PROVIDER

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

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

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

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

Removing Specialties

Step 1: To Remove an added Specialty:

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

Jump To: Specialties

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

Taxonomies Page

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

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

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

Jump To: Taxonomies

Locations → 1099 Address* → Home Office Address* → Specialties* → **Taxonomies*** → Professional Licenses* → Medicare Number → Group, Facility & Hospital Affilia

Generate PDF

Save Cancel Previous Next

Taxonomies
This is a required section.

Taxonomy	Taxonomy Description	Primary	Start Date	End Date		
10410000X	Social Worker	Yes	07/26/2021	12/31/2299		
101YM0800X	Counselor Mental Health	No	10/06/2021			

Add New

INDIVIDUAL PROVIDER

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

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

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

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

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

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

Jump To: Taxonomies

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

Get PDF

Taxonomies
This is a required section.

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 your work and move to the next screen

Jump To: Taxonomies

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

5 Save **6** Get PDF

1

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

4

2 Taxonomy* Family Medicine (207Q00000X)

3 Is Primary Taxonomy

Start Date* 10/21/2021

End Date 12/31/2299

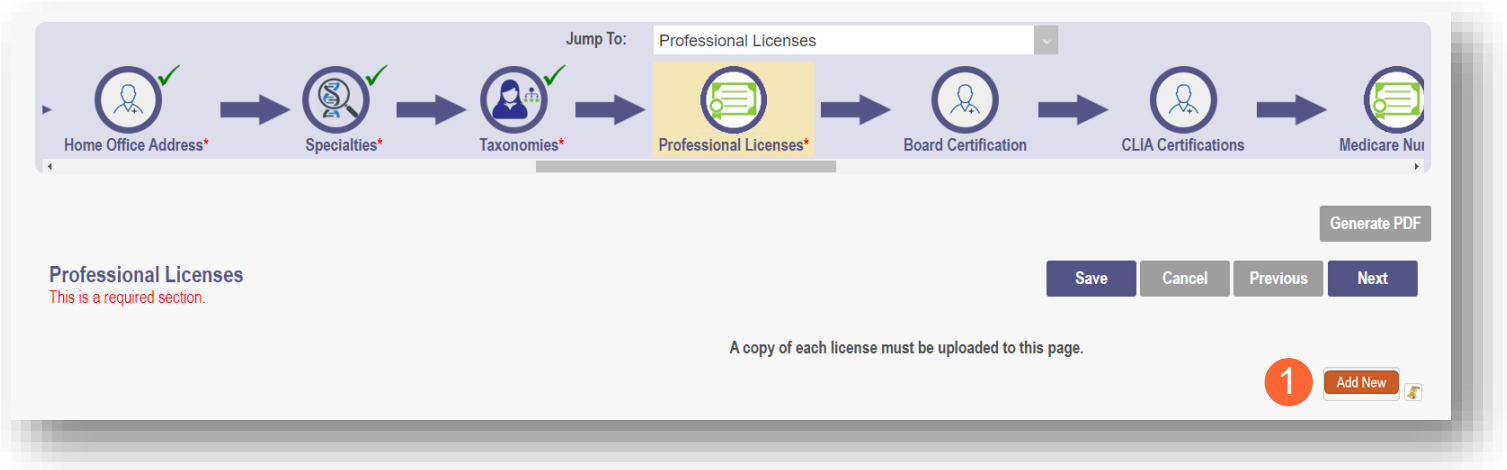
Add New

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'



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

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

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

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

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

Professional Licenses
This is a required section.

Get PDF

Save Cancel Previous Next

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

Add New

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

2

State*
License Board Name*
If Other, enter Board Name:
License Number*
Effective Date*
Expiration Date*
License Status
Address 1
Address 2
City
State OH
County
Zip
Endorsement Number ⓘ
Endorsement Status ⓘ
Endorsement Focus ⓘ
Endorsement Specialty ⓘ
Certifying Organization ⓘ
Certificate Date
Certificate Expiration

Uploaded Documents
Optional Document

Professional License

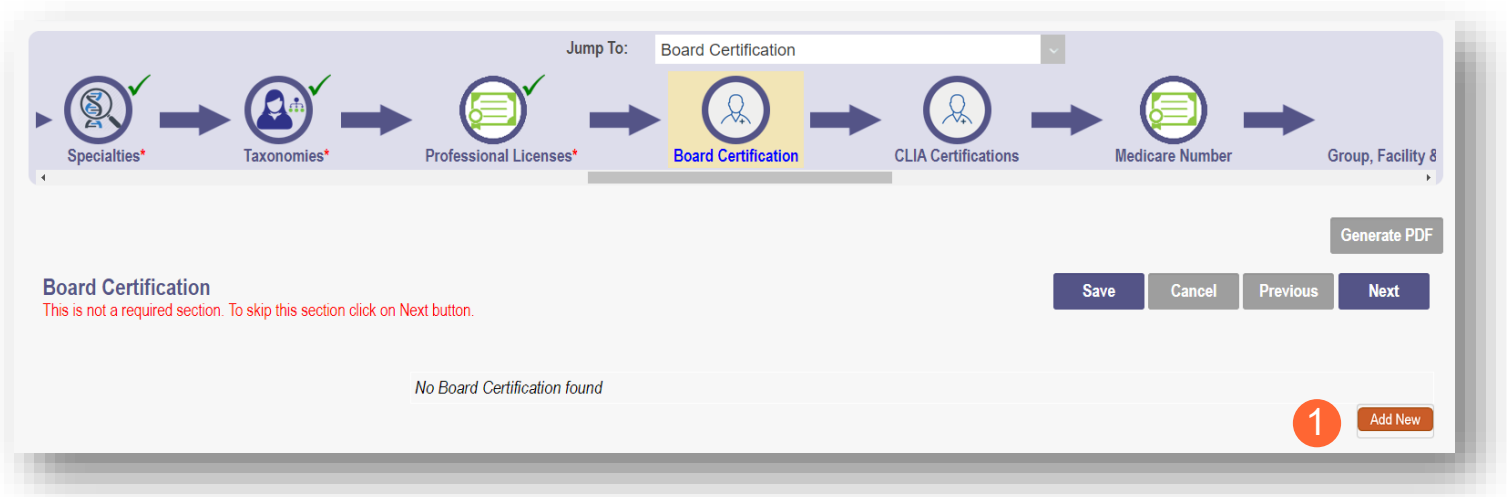
Browse 3

Board Certification Page

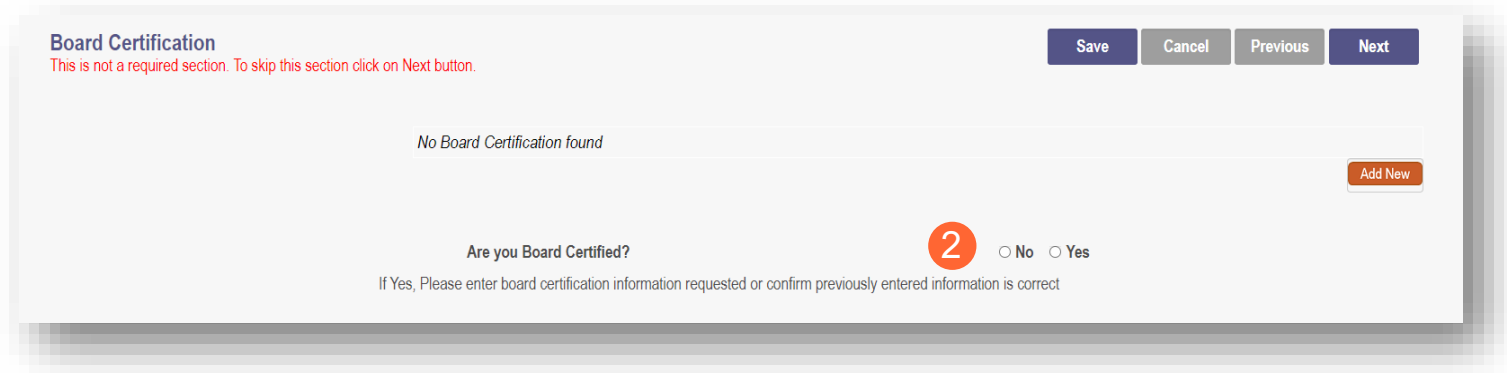
The Board Certification page allows you to add any recognized board certifications.

Note: Board Certification information is not required for every Provider type. Click 'Next' to skip, if not required.

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



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



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

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

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

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

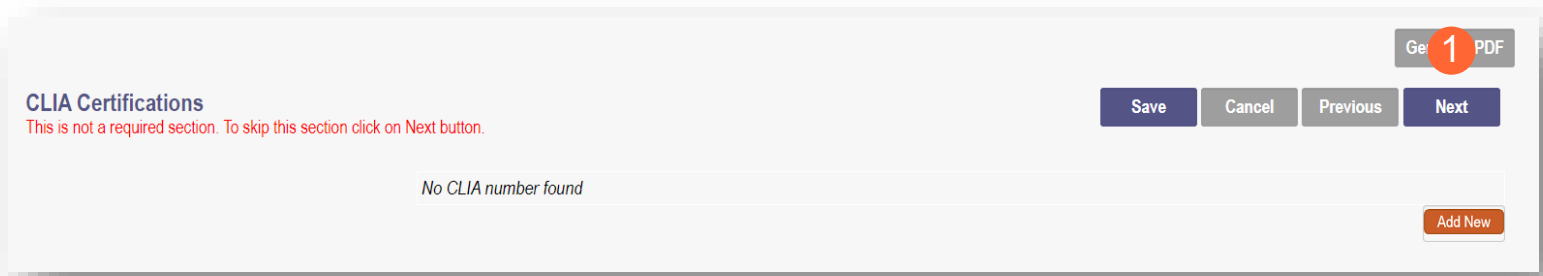
Step 5: Click 'Next' to save and move to the next screen

The screenshot shows a web form titled "Board Certification" with a sub-header "This is not a required section. To skip this section click on Next button." At the top right are buttons for "Save", "Cancel", "Previous", and "Next". A red circle with the number "4" is placed over the "Save" button. Below the buttons, the text "No Board Certification found" is displayed. To the right of this text is a red circle with the number "5" and an "Add New" button. Below this is a red circle with the number "4" and another "Add New" button. The main form area contains a question "Are you Board Certified?" with radio buttons for "No" and "Yes" (selected). Below this is a red circle with the number "3" and the text "If Yes, Please enter board certification information requested or confirm previously entered information is correct". The form fields are: "Board Certification*" (a dropdown menu), "Board Specialty*", "Certification Number", "Effective Date*", and "Expiration Date*". A dropdown menu is open under "Board Certification*", showing a list of medical boards including "American Board of Allergy and Immunology", "American Board of Anesthesiology", "American Board of Colon and Rectal Surgery", "American Board of Dermatology", "American Board of Emergency Medicine", "American Board of Family Medicine", "American Board of Internal Medicine", "American Board of Medical Genetics and Genomics", "American Board of Neurological Surgery", "American Board of Nuclear Medicine", "American Board of Obstetrics and Gynecology", "American Board of Ophthalmology", "American Board of Orthopaedic Surgery", "American Board of Otolaryngology – Head and Neck Surgery", "American Board of Pathology", and "American Board of Pediatrics". On the left side of the form is a circular icon with a person and a plus sign. At the bottom left is a section for "Uploaded Documents".

CLIA Certifications Page

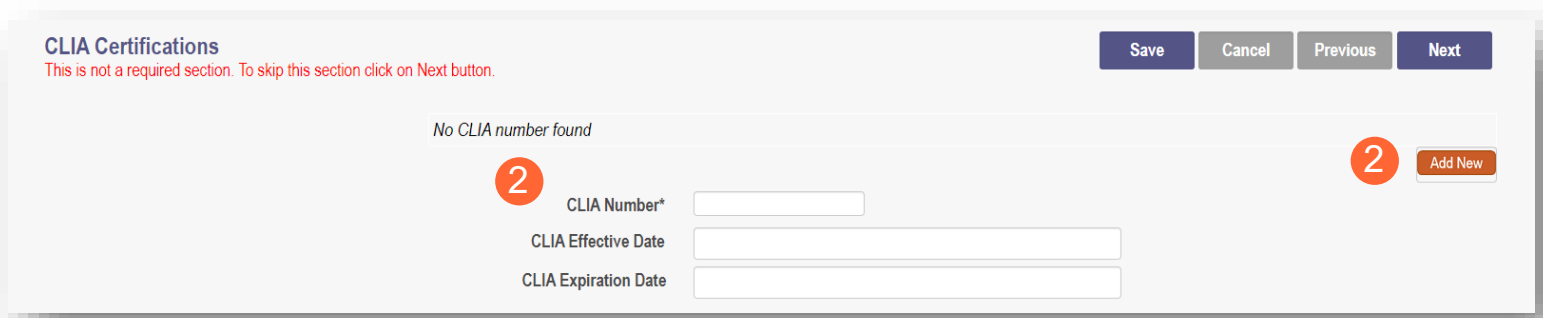
Step 1: For some Providers, this is not a required section

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



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



Medicare Number Page

Note: 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
- Secondary NPI (if applicable)
- Medicare State
- Medicare Enrollment Status (Required)
- Medicare Enrollment Date

Note: System uses Secondary NPI and Medicare State to look up and verify Provider is in PECOS

Step 2: Upload a Medicare Enrollment Certification document by clicking 'Browse' and locate the file on your computer

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

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

Step 4: Click 'Save' to save your work

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

Medicare Number

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

4

Save

Cancel

Previous

5

Next

Group, Facility & Hospital Affiliations (Individual) Page

This page will allow you to indicate any group, facility, or hospital affiliations you/your Provider may have.

Adding a Group Affiliation

Step 1: To add a Group Affiliation:

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

Medicaid Pop-Up

Step 2: Enter the Medicaid ID

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

Step 3: Click 'Save' to continue

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

Group, Facility & Hospital Affiliations (Individual)

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

Save Cancel Previous Next

Pending Group Affiliations

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

4

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address		
Medical Group			10/21/2021	12/31/2299	Pending Approval	2400 CORPORATE EXCHANGE DR STE 200 COLUMBUS, OH 43231		

Add New

Step 5: When the 'Pending Group Affiliations' are approved, they will move to the 'Confirmed Group Affiliations' section *(these are approved by the Group or Facility provider themselves)*

Group, Facility & Hospital Affiliations (Individual)

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

Save Cancel Previous Next

Pending Group Affiliations

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

Group Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address		
Medical Group			10/21/2021	12/31/2299	Pending Approval	2400 CORPORATE EXCHANGE DR STE 200 COLUMBUS, OH 43231		

Add New

5

Confirmed Group Affiliations

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

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

Adding a Hospital Affiliation

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

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

Step 2: Click 'Save' to continue

The screenshot shows a web form titled "Hospital Affiliation". At the top left, there is a red circle with the number "1". The form contains the following fields and controls:

- Question: "Do you practice exclusively within the inpatient setting?" with radio buttons for "Yes" and "No" (the "No" button is selected).
- Question: "Do you have hospital privileges?" with radio buttons for "Yes" and "No" (the "No" button is selected).
- Text input: "If 'No', please specify" with a text box.
- Form element: "This is my Primary Facility" with a checkbox.
- Text input: "Ohio Medicaid ID*" with a text box.
- Text input: "Facility Name*" with a text box.
- Text input: "Status of Privileges*" with a dropdown menu.
- Text input: "Staff Category*" with a dropdown menu.
- Text input: "Start Date*" with a text box.
- Text input: "End Date" with a text box containing the value "12/31/2299".
- Question: "Any past or present restriction of privileges?" with radio buttons for "Yes" and "No" (the "No" button is selected).
- Text input: "If 'Yes', please specify" with a text box.
- Buttons: "Save" and "Cancel" at the bottom right, with a red circle and the number "2" highlighting them.

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

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

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

Save Cancel Previous Next

4

Pending Group Affiliations

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

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

Add New

Confirmed Group Affiliations

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

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

3

Hospital Affiliations

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

Add New

Note: 'Delegated Credentialing' will also appear on this screen, if appropriate. Select the checkbox if you have delegated credentialing that does not display in the table. Information will be updated by the ODM Credentialing staff after submission.

Delegated Credentialing

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

Assigned Delegates	Delegate Name	Delegate MED ID
No delegates.		

MCP Affiliation

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

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

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

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

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

Confirmed MCP Affiliations

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

State CDS Number Page

If you have a state-registered Controlled Dangerous Substance number, enter that information on this page

- If you do not have a CDS number, you can bypass the page by clicking 'Next'

Step 1: If you have a CDS Number:

- Click 'Add New'
- Fill in the required fields

Step 2: Upload your State CDS document by clicking 'Browse'

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

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

Jump To: State CDS Number

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

Get PDF 3

State CDS Number

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

Save Cancel Previous Next

No records found

1 Add New

CDS Number

State

Date Issued

Expiration Date

Uploaded Documents

Required Document

State CDS Document Upload

Browse 2

Federal Drug Enforcement Administration (DEA) Registration Page

Note: Federal DEA Registration information is not required for every Provider type. Click 'Next' to skip, if not required.

Step 1: 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

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

Generate PDF

Save Cancel Previous Next

Federal DEA Registration

This is a required section.

DEA Question

Do you have a current DEA registration? **1** 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.

DEA Question

Do you have a current DEA registration? Yes No **1**

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

Save Cancel Previous Next

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 move to the next screen

Federal DEA Registration
This is a required section.

DEA Question

Do you have a current DEA registration? Yes No **3**

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

2 DEA Number

DEA State

Issue Date

Expiration Date

DEA Status

No records found

Save Cancel Previous Next **2** 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. Click 'Next' to skip.

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 H

Generate PDF

Professional Liability Insurance
This is a required section.

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? 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*

INDIVIDUAL PROVIDER

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

Education Page

On this page, indicate all education and training that has been completed beginning with an undergraduate degree through professional education and training.

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

The screenshot shows a navigation bar with a 'Jump To:' dropdown menu set to 'Education'. Below the menu are six icons representing different sections: Federal DEA Registration*, Professional Liability Insurance*, Education* (highlighted with a yellow box), Malpractice Claims History*, Work History*, and W9 Form*. Below the navigation bar, there are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', and 'Next'. The main content area is titled 'Education' and includes a red warning message: 'This is a required section.' Below this, there is a text prompt: 'Please enter all education and training you have completed beginning with your undergraduate degree through your professional education and training.' A message 'No records found' is displayed in the center. In the bottom right corner, there is a red circle with the number '1' and an 'Add New' button.

Step 2: Enter the required fields with an asterisk *

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

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

The screenshot shows the 'Education' form with a red circle containing the number '2' next to the first field. The form includes the following fields:

- *Education Type: (dropdown menu)
- *Name Of School: (text input)
- *Start Date: (text input)
- *End Date: (text input)
- *Degree/ Certificate Awarded: (dropdown menu)
- Speciality: (dropdown menu)
- *Address 1: (text input)
- Address 2: (text input)
- *City: (text input)
- *State: (dropdown menu)
- * Zip Code: (text input)
- *Country: (dropdown menu, currently set to UNITED STATES)
- Phone Number: (text input)
- Fax: (text input)
- Additional Information: (text input with a small icon at the end)

INDIVIDUAL PROVIDER

Step 3: Click 'Save' to continue

Step 4: Confirm that the Undergraduate School saved

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

Education
This is a required section.

3 Save Cancel Previous Next

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

School	Education	Specialty	Degree	Start Date	End Date	
4 UNDERGRADUATE SCHOOL	Undergraduate School		MB	08/01/2000	05/01/2004	5 Add New

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

Step 7: Click 'Next' to proceed to the next page once all education has been added

Education
This is a required section.

6 Save Cancel Previous Next 7

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

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

Add New

Malpractice Claims History Page

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

Note: This page will only display for required Providers

Step 1: Click the 'Yes' or 'No' radio button to indicate your answer

Yes/No Malpractice Claims History

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

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

No Yes

1 [Add New](#)

No MalpracticeClaim found.

Date of Occurrence*

Date Claim Filed*

Status of the claim*

If settled, the date the claim was settled

Professional liability carrier involved*

Carrier Address Line1*

Carrier Address Line2

City*

State*

Zip*

Phone Number 1*

Phone Ext 1

Policy Number

If settled, the amount of settlement

Method of Resolution

Describe the allegations against you*

Were You* Primary Defendant Co-Defendant

No of Other Defendants (if any)

Your role in case*

Describe the alleged injury to the patient

Did the alleged injury result in death?

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

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

Work History Page

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

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

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

Include a chronological work history for the past 5 years.

No records found

1
Add New

1

Current Employer

*Practice/ Employer Name:

* Start Date:

* End Date:

Organization Name*

Address 1*

Address 2

City*

State* ▼

County ▼

Zip*

Phone Number 1

Phone Ext 1

Fax Number 1

Contact Name

Email Address 1*

Email Address 2

Additional Information:

Reason for Departure(If Applicable):

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

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

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

Jump To: Work History

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

2 Generate PDF

Work History
This is a required section.

Save Cancel Previous Next

Include a chronological work history for the past 5 years.

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

3 Add New

Gaps in Work History

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

No records found

4 Add New

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

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

Step 5: Click 'Save' to save the work details then click 'Next' to continue

Gaps in Work History

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

No records found

4

*Gap Start Date:

*Gap End Date:

*Reason For Gap:

W9 Form Page

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

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

The screenshot shows a progress bar at the top with icons for: Professional Liability Insurance*, Education*, Malpractice Claims History*, Work History*, W9 Form* (highlighted), Required Documents, and Agreements*. Below the progress bar, there is a 'Jump To:' dropdown menu set to 'W9 Form'. A 'Generate PDF' button is on the right. Below that are 'Save', 'Cancel', 'Previous', and 'Next' buttons. The main section is titled 'W9 Form' with a red note: 'This is a required section.' Below this is a note: 'Information from the Identification page displayed below. Corrections to this information must be made in Organization/Individual Identification and Primary Contact sections of the Identification page.' There are two input fields: 'Individual Name:' with the value 'Training' and 'SSN:' with a masked value. Below these is the instruction 'Select the most appropriate category below:' followed by 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. A red circle with the number '1' is placed next to the 'Individual/sole proprietor of single-member LLC' option.

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' and 'Form 147'. A red circle with the number '2' is placed next to the 'W9' option. Below this is a note: '** Please visit <https://www.irs.gov/forms-pubs/about-form-w-9> to obtain a copy of the W9 with instructions.' The 'Required Document' section shows a file upload area with a blue header 'W-9'. Below the header, the text 'W9.pdf' is displayed in green, followed by 'Download' and 'Remove' links. A 'Browse' button is at the bottom. A red circle with the number '3' is placed next to the 'Browse' button.

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

EFT Banking Information Page

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

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

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

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

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

EFT Banking Information
This is a required section.

Generate PDF

Save Cancel Previous Next

1 Do you expect to receive payments directly from the State Medicaid Program (For example: Fee-for-Service Claims, Medicare Crossover Claims, Supplemental Pool Payments, Electronic Health Records Payments, etc.) as opposed to only payments from the Managed Care Contractors?
 Yes No

Instructions

2 **READ INSTRUCTIONS BEFORE COMPLETING**

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

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

Please enter your banking information below.

Banking Information

No banking information found.

3 Add New

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.

INDIVIDUAL PROVIDER

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'

The screenshot shows a 'Banking Information' form with a blue header. A red circle with the number '4' is positioned to the left of the 'Financial Institution Name*' field. The form contains the following fields and values:

Financial Institution Name*	Training Bank
Financial Institution Routing Number*	041215537
Confirm Financial Institution Routing Number*	041215537
Account Number*	25435345443
Confirm Account Number*	25435345443

Below the fields is the 'Account Type*' section with radio buttons for 'Checking' (selected) and 'Savings'. At the bottom, a red circle with the number '5' is next to a 'Save' button and a 'Cancel' button.

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

The screenshot shows the 'Banking Information' form with a table of banking information and an 'EFT Contact' section. A red circle with the number '6' is positioned to the left of the 'Add New' button.

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

Below the table is the 'EFT Contact' section with the text 'No EFT contact found.' and an 'Add New' button.

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.

INDIVIDUAL PROVIDER

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

Required

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

Optional

- Middle Name
- Phone Extension
- Fax Number

EFT Contact Information **7**

Provider Contact First Name*

Middle Name

Last Name*

Phone Number* () - -

Extension

Email Address*

Fax Number () - -

8 Save Cancel

Step 8: Click 'Save'

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

Confirm

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

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

I confirm the information provided is true and accurate.

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

EFT Banking Information **10**

This is a required section.

Generate PDF

Save Cancel Previous Next

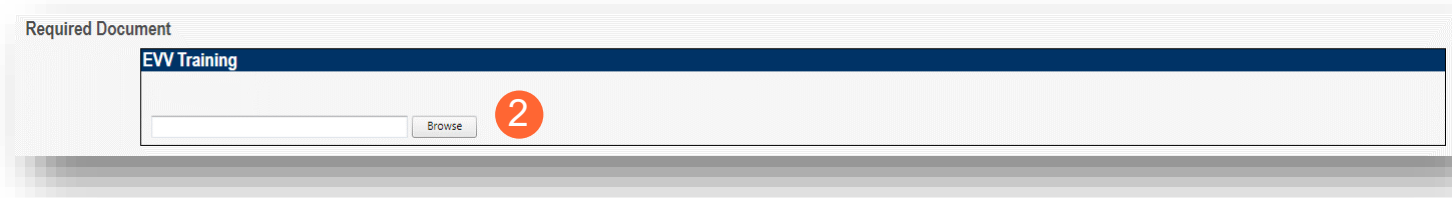
Required Documents Page

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

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

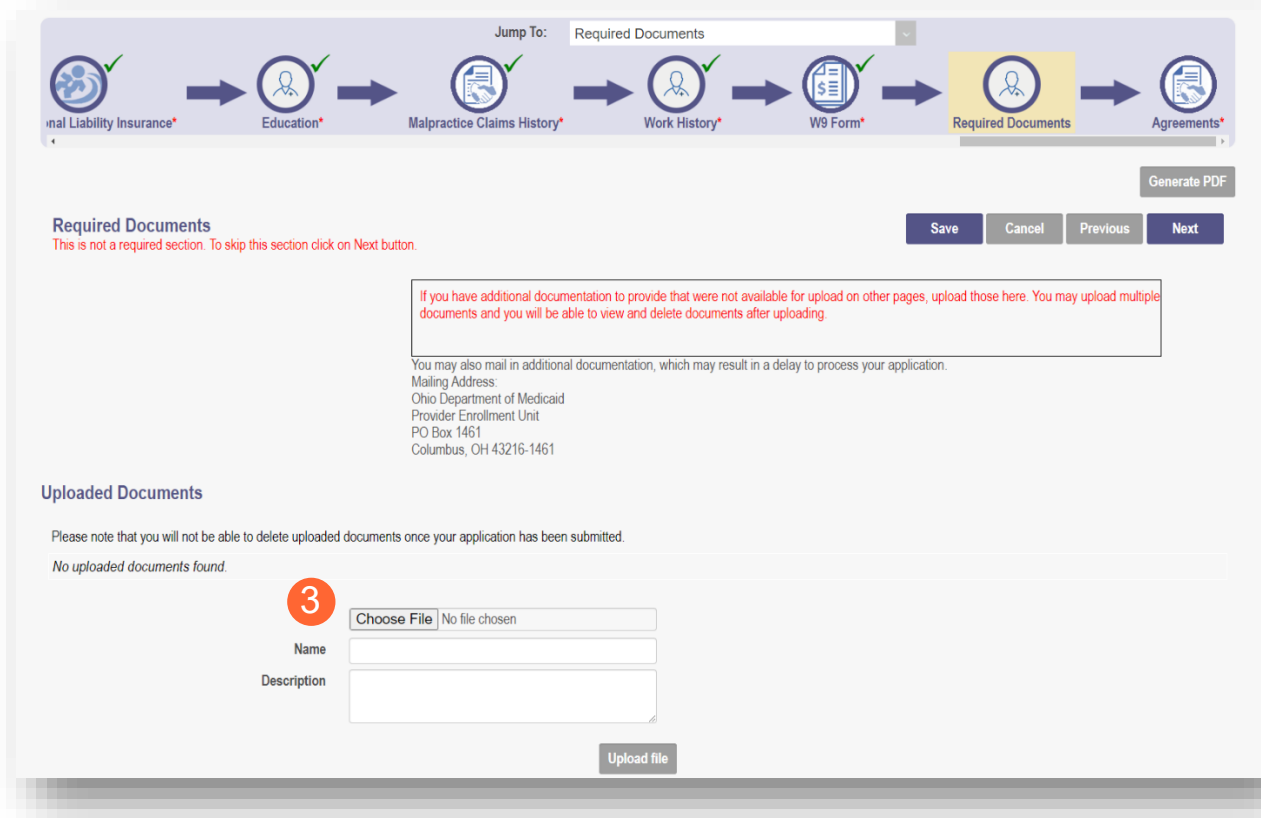
Step 2: If you are required to upload documents, blue upload boxes will be displayed under the Required Documents section

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



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



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'

Agreements
This is a required section.

Save Cancel Previous Next

Ohio Medicaid Provider Agreement

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

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

False Statement Agreement

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

1 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"

2 I agree to Terms and Conditions
Agreement Date: 5/5/2022

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'

3 If you meet this provision, please check this box

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

Possible 'Additional Credentialing Statement' questions:

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

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

Additional Credentialing Statement

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

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

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

No Yes If 'Yes' a comment is required.

Step 5: Complete the Individual Provider Questions

Possible Individual Provider Questions:

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

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

Individual Provider Questions

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

No Yes

If, 'Yes' a comment is required.

5

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

No Yes

If, 'Yes' a comment is required.

Step 6: Complete the Provider Agreement Attestation

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

Provider Agreement Attestation

6

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

Step 7: Complete the Provider Agreement Signature

- Enter your full name as the person attesting
- Confirm Provider Name and User ID auto-filled correctly

Step 8: Click 'Save'

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

Provider Agreement Signature

7 Name of Person Attesting*:

Provider Name:

User ID:

8

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

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

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

9

Submitting Application

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

Jump To: Agreements

Malpractice Claims History* Education* Work History* W9 Form* Required Documents Agreements*

Generate PDF

1 Submit for Review

Save Cancel Previous Next

Agreements
This is a required section.

Ohio Medicaid Provider Agreement

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

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

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

False Statement Agreement

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

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

Menu Ohio Provider Network Management Medicaid Home Learning Contact Fee Schedule Log out

2 Submission Confirmation

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

3 Return to Home Page

Resubmitting an Application

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

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

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

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

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

Reviewing Correspondence

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

Provider Management Home

Registration Information

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

Manage Application

Enrollment Actions + Enrollment Action Selections:

Programs + Program Selections:

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

My Current and Previous Applications

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

Step 2: Click the 'Provider Correspondence' hyperlink

Manage Application

Enrollment Actions + Enrollment Action Selections:

Programs + Program Selections:

Self Service - Self Service Selections:

2 [Provider Correspondence](#)

INDIVIDUAL PROVIDER

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'

* SEARCH CORRESPONDENCE

Correspondence TYPE: Enrollment Notifications

Date Available From: 01/01/2022

Date Available To: 04/11/2022

Search Clear

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

- CORRESPONDENCE SEARCH RESULT

Correspondence Search Results

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

1 2 3

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

Provider Communication

Subject: Provider Screening and Enrollment Registration-Action Required

Dear Provider:

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

Please see the return reasons below:

P021 - NPI # and Taxonomy not attached or incomplete

- Verify that NPI# and taxonomy correspond

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

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

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

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

Sincerely,

Completing Return to Provider (RTP) Process

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

Provider Management Home

Registration Information

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

Manage Application

Enrollment Actions **1** + Enrollment Action Selections:

Programs + Program Selections:

Self Service + Self Service Selections:

My Current and Previous Applications

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

Step 2: Click '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:

INDIVIDUAL PROVIDER

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

Professional Licenses
This is a required section.

5

Generate PDF

Save Cancel Previous Next

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

License Number	License Board	License State	Effective Date	Expiration Date	Address	Endorsement	
4 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)

Generate PDF

6 Submit for Review

Save Cancel Previous Next

Board Certification

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

No Board Certification found

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 Reg ID or Provider heading

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

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

Provider Management Home

Registration Information

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

Manage Application

Enrollment Actions **3** + Enrollment Action Selections:

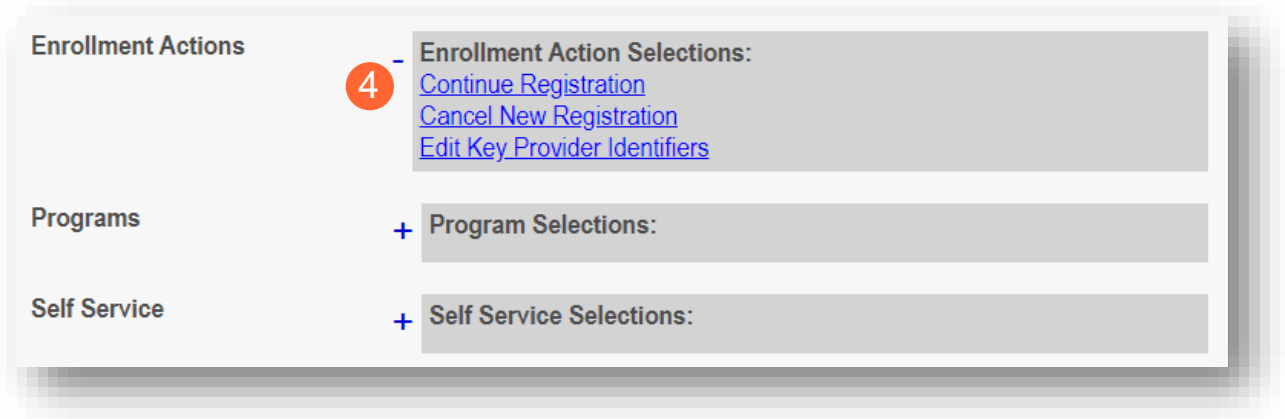
Programs + Program Selections:

Self Service + Self Service Selections:

My Current and Previous Applications

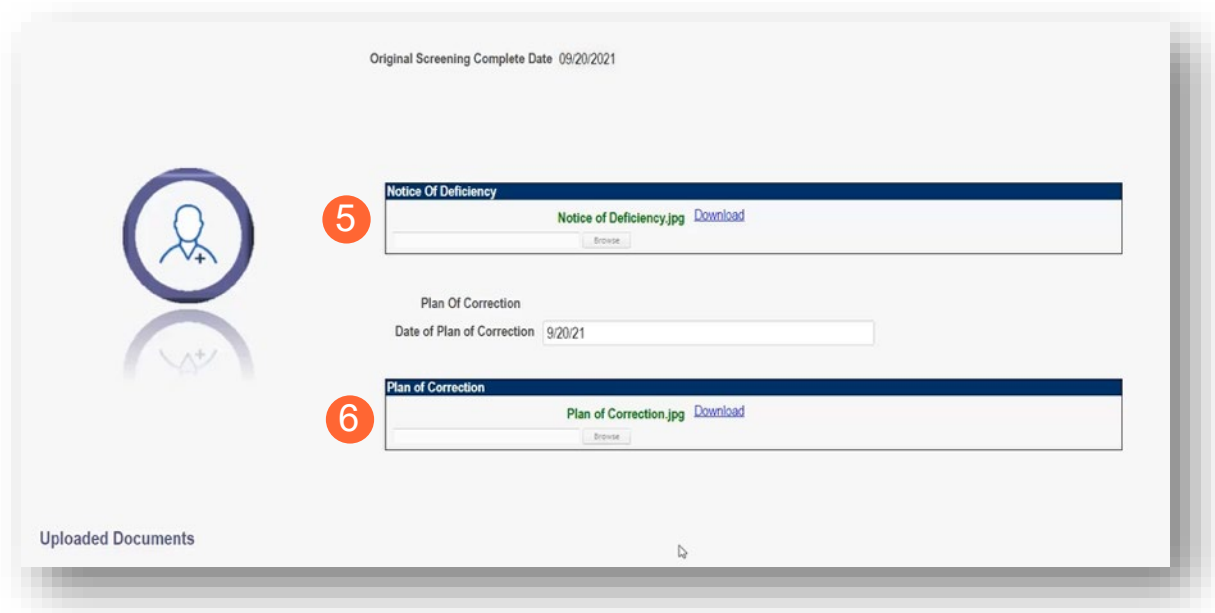
Reg ID	Enrollment Action	Program	Application Id	PNM Application Status	Other Agency Application Status	DD Legal Status	Status Date
519468	Application Flow - Standard - NEW REGISTRATION	Medicaid	608334	NOT PROCESSED			05/05/22

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

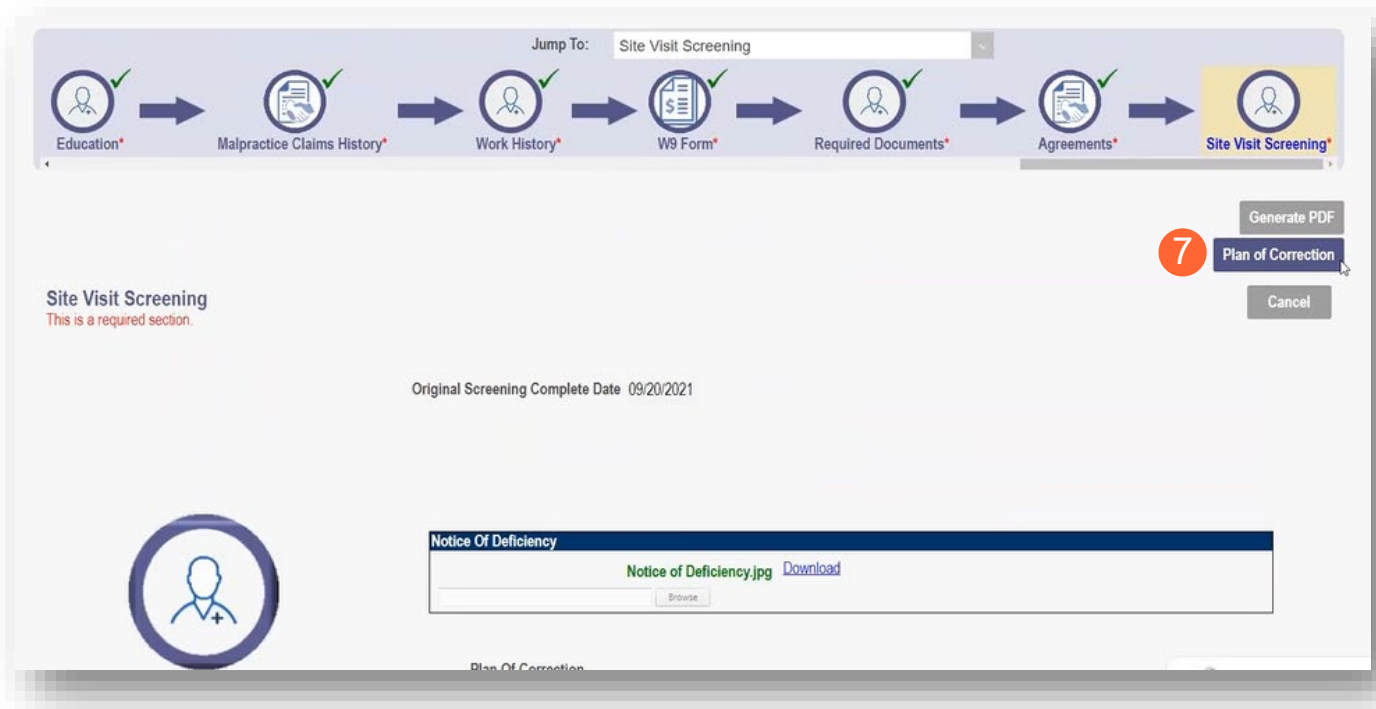


Step 5: You will be redirected to the 'Site Visit Screening' page where you will find the Notice of Operational Deficiency issued by the Compliance Specialist. To view the Deficiency, click 'Download'

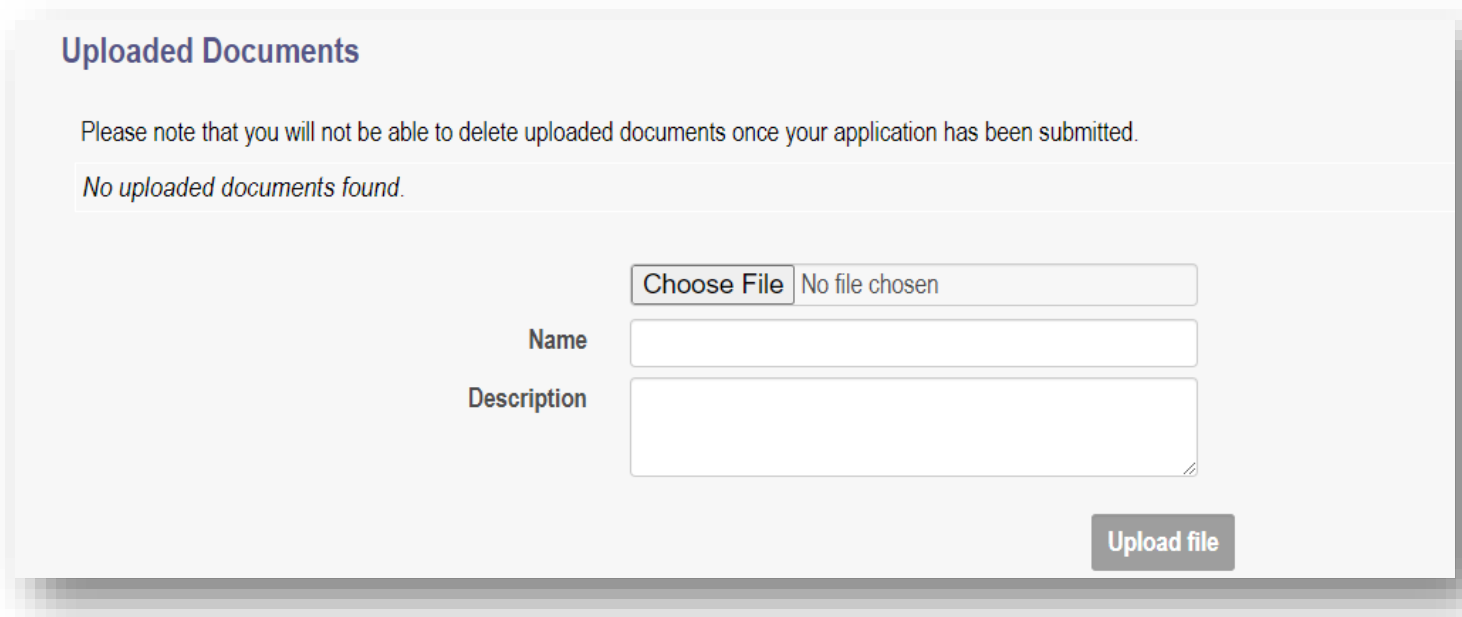
Step 6: To resolve the issue or issues, create a 'Plan of Correction' and once developed, upload the plan by clicking 'Browse' and choosing the file from your computer



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)



Review the Final Decision for Provider Submission

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

- 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

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
169	Donald Trainer	Complete	Physician/Oste Individual		0000134	Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706	09/29/21	09/16/21	09/29/24
170	Training Clinic	Complete	CLINIC		0000122	Primary Care Clinic			43085 - 4706	09/16/21	09/16/21	09/16/26
171	Kim Trainer	Complete	Chiropractor Individual		0000135	Chiropractic Services			43085 - 4706	09/29/21	09/16/21	09/29/24

Page size: 10 101 items in 11 pages

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

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

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID
169	Donald Trainer	Complete	Physician/Oste Individual		0000134
170	Training Clinic	Complete	CLINIC		0000122
171	Kim Trainer	Complete	Chiropractor Individual		0000135

Completing an Update

Step 1: Access the application in your dashboard by clicking on the link listed 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
169	Donald Trainer	Complete	Physician/Oste Individual		0000134	Dual Licensed Dentist and Licensed MD/DO.			43085 - 4706	09/29/21	09/16/21	09/29/24
170	Training Clinic	Complete	CLINIC		0000122	Primary Care Clinic			43085 - 4706	09/16/21	09/16/21	09/16/26
171	Kim Trainer	Complete	Chiropractor Individual		0000135	Chiropractic Services			43085 - 4706	09/29/21	09/16/21	09/29/24
178	Training Rural Health	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	Medicaid ID	Effective Date	Revalidation Due Date	Term Date
Sharon Aaron				

Manage Application

Enrollment Actions **2** + Enrollment Action Selections:

Programs + Program Selections:

Self Service + Self Service Selections:

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

Enrollment Actions


3 - Enrollment Action Selections:

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

Step 4: Choose which element on the 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](#) Professional Licenses

[Update](#) Group, Facility & Hospital Affiliations (Individual)

[Update](#) Required Documents


 Credentialing Information

[Update](#) Credentialing Contact

[Update](#) State CDS Number

[Update](#) Professional Liability Insurance

[Update](#) Malpractice Claims History

 Address Information

[Update](#) Office Information

[Update](#) Billing & Payment Address

[Update](#) Correspondence Address

[Update](#) Other Service Locations

[Update](#) 1099 Address

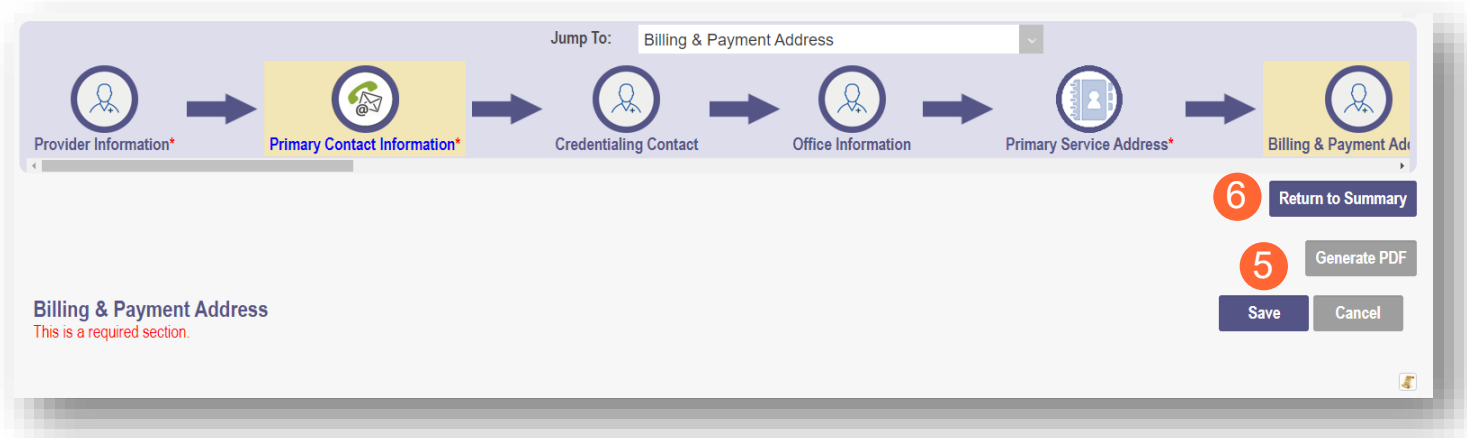
[Update](#) Home Office Address

INDIVIDUAL PROVIDER

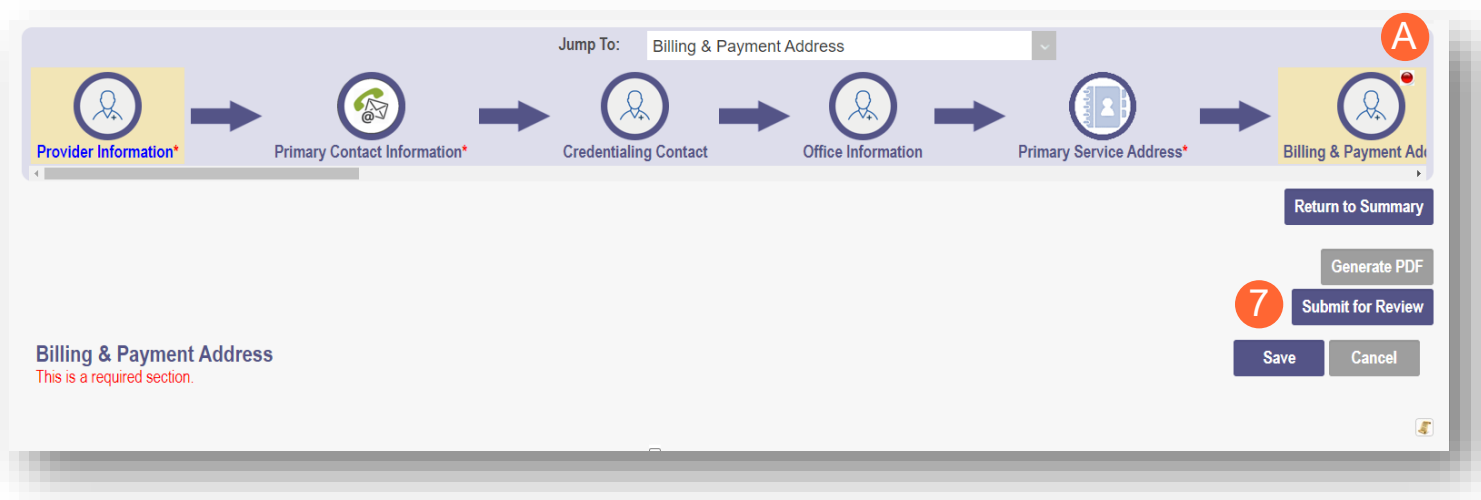
Step 5: Update the application page that you selected and click 'Save' once finished

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

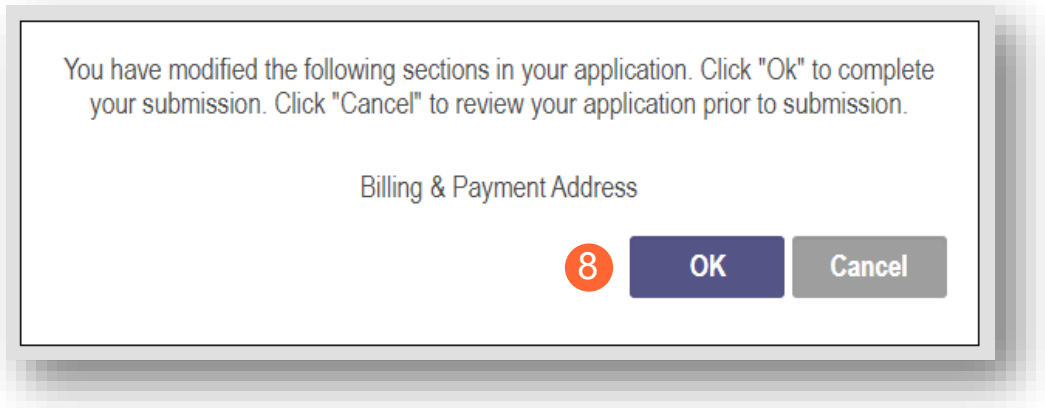
Step 6: If there are other pages that need to be updated, click 'Return to Summary' and select 'Update' for that section



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

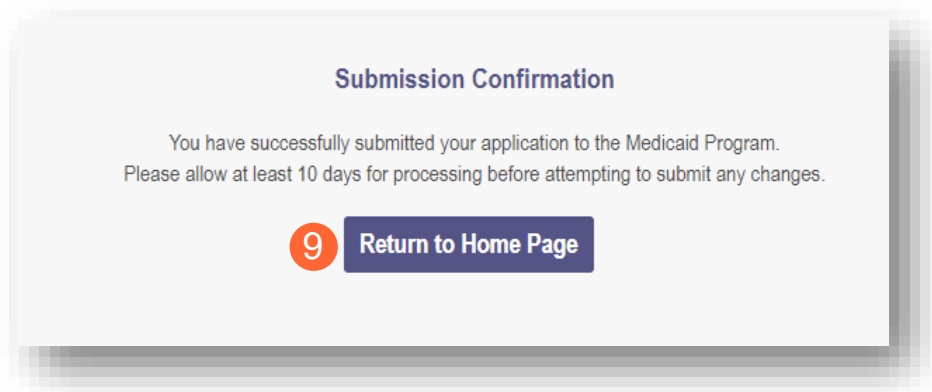


Step 8: A pop-up window displays confirming which page(s) received an update. Click 'OK' to complete the submission



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

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



Revalidation/Re-Enrollment Steps

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

Step 1: Access 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
517960	Test Training	Complete	69 - Pharmacist	1790794972	9999882	INTERNAL MEDICINE				03/11/19	03/17/19	03/17/22

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

Provider Management Home

Registration Information

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

Manage Application

Enrollment Actions **2** + Enrollment Action Selections:

Programs + Program Selections:

Self Service + Self Service Selections:

Step 3: Click the 'Begin Revalidation' hyperlink

Enrollment Actions

3 - Enrollment Action Selections:

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

INDIVIDUAL PROVIDER

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, Medicare Information, Required Documents, and Agreements. A red circle with the number '5' highlights the 'Agreements' step. Below the progress bar, a table lists sections and their status:

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

Below the table, the 'Agreements' section is expanded, showing the 'Ohio Medicaid Provider Agreement' with a note: 'Note: The Provider Agreement in the scroll box. All Providers must read the statements below.' The 'Submit for Review' button is highlighted with a red circle and the number '4'. Other buttons include 'Save', 'Cancel', 'Previous', 'Next', and 'Generate PDF'.

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

This close-up shows the bottom navigation area of the application. It features a 'Generate PDF' button at the top right, followed by a 'Submit for Review' button highlighted with a red circle and the number '6'. Below these are four 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'

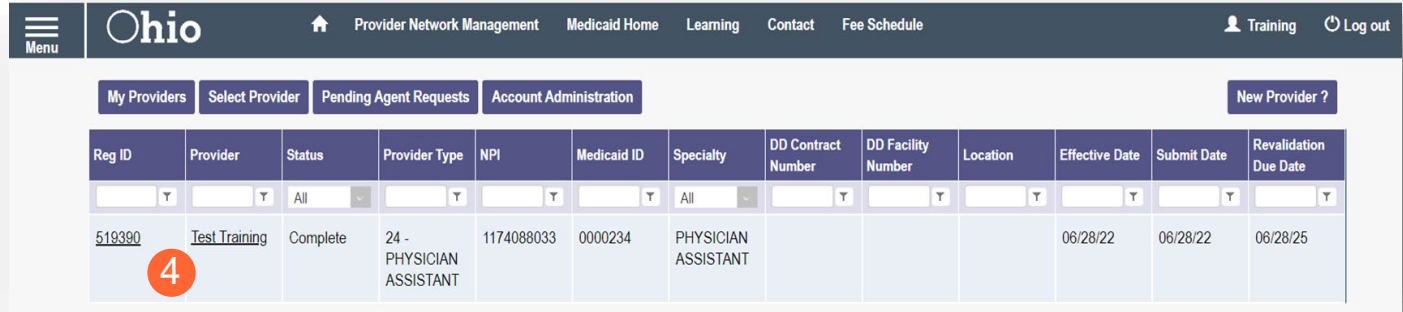
2 Medicaid ID
 NPI
 Tax ID

3

INDIVIDUAL PROVIDER

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



The screenshot shows the Ohio Provider Network Management dashboard. The header includes the Ohio logo, navigation links (Provider Network Management, Medicaid Home, Learning, Contact, Fee Schedule), and user options (Training, Log out). Below the header are tabs for 'My Providers', 'Select Provider', 'Pending Agent Requests', and 'Account Administration', along with a 'New Provider ?' button. The main content is a table with the following columns: Reg ID, Provider, Status, Provider Type, NPI, Medicaid ID, Specialty, DD Contract Number, DD Facility Number, Location, Effective Date, Submit Date, and Revalidation Due Date. A single row is visible with the following data: Reg ID 519390, Provider Test Training, Status Complete, Provider Type 24 - PHYSICIAN ASSISTANT, NPI 1174088033, Medicaid ID 0000234, Specialty PHYSICIAN ASSISTANT, Effective Date 06/28/22, Submit Date 06/28/22, and Revalidation Due Date 06/28/25. A red circle with the number 4 is overlaid on the 'Test Training' provider name.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
519390	Test Training	Complete	24 - PHYSICIAN ASSISTANT	1174088033	0000234	PHYSICIAN ASSISTANT				06/28/22	06/28/22	06/28/25