

PNM Enrollment Application Support Guide

Personal Care Aide

Last Updated: February 2024

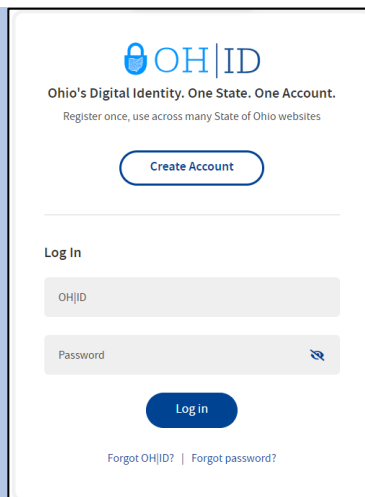
Quick Reference Guide: Creating OH|ID Account for PNM

Steps:

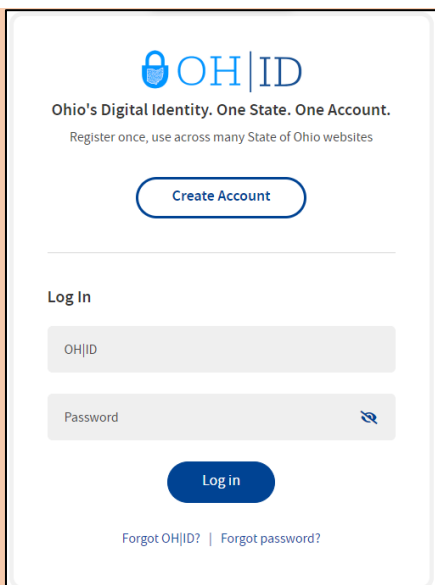
1

Access the OH|ID login page for the InnovateOhio Platform by accessing this link:

<https://ohid.ohio.gov/wps/portal/gov/ohid/login/>



2



On the OH|ID page, click 'Create Account'

3

Complete the 6-step account creation process, including the Email Verification step, where an email with a PIN will be sent to the email address listed

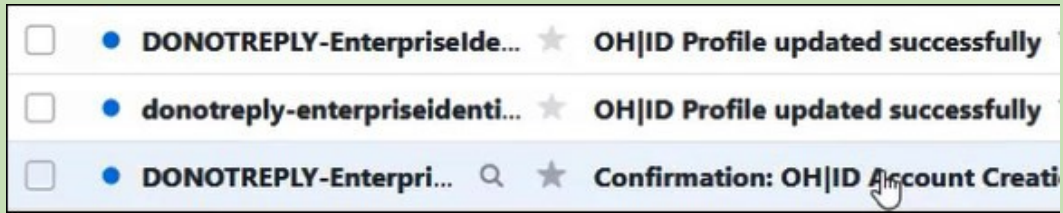
Create OH|ID Account

- 1 Email Verification
- 2 Personal Info
- 3 Pick a Username
- 4 Create Password
- 5 Account Recovery
- 6 Terms & Conditions

Quick Reference Guide: Creating OH|ID Account for PNM

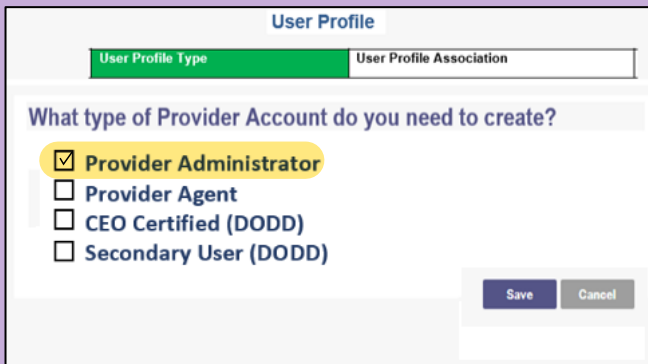
Steps:

4



Continually check the email listed on the account creation page for email updates and PIN numbers to verify your identity

5

A screenshot of a web form titled 'User Profile'. At the top, there are two dropdown menus: 'User Profile Type' (set to 'Provider Administrator') and 'User Profile Association'. Below this is the question 'What type of Provider Account do you need to create?'. There are four radio button options: 'Provider Administrator' (checked), 'Provider Agent', 'CEO Certified (DODD)', and 'Secondary User (DODD)'. At the bottom right of the form are 'Save' and 'Cancel' buttons.

You should be automatically directed back to the PNM system.

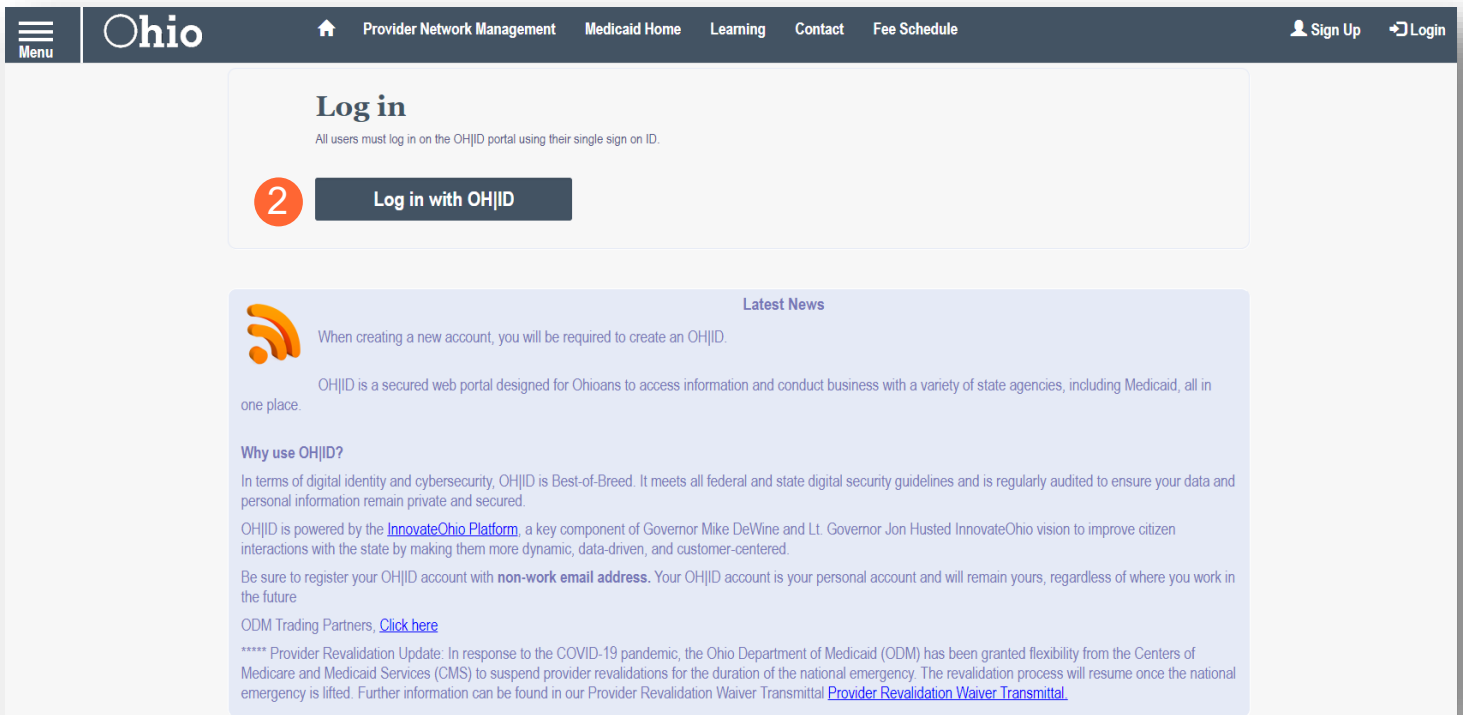
During your initial login, you may be asked for what type of Provider Account (role) you need to create for PNM. Select the proper option and click Save.

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_PROD/Account/Login.aspx

Step 2: Click 'Log in with OH|ID'



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

Tips

- Log in or click 'Create Account' if you do not have an OH ID and Password.
- If you are creating a new account, you may need to log back into https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx once your account

OH|ID
Ohio's Digital Identity. One State. One Account.
Register once, use across many State of Ohio websites

Create Account

Log In

3

OH|ID

Password

Log in

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

Step 4: You will be redirected to the PNM system. Read the Terms of Use and click "Yes, I have read the agreement" to proceed into PNM

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.

4 Yes, I have read the agreement

Cancel

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'

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...](#)

Personal Care Aide

- 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...

Personal Care Aide

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.”

Application Type: [Change](#)

3

[Individual](#) [Group](#) [Organization](#) [Facility/Institution](#) [Pharmacy](#)

Key Identifier Information

Step 1: Enter key provider information for the Provider

Enter all required fields marked with an asterisk *

- **Provider Type**
- 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

Non-Agency Personal Care

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.

Note: Taxonomy will be the same as you entered in NPI registration.

Note: Taxonomy should be 25 - Non-Agency Personal Care Aide

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 = OTHER
- Ownership Type = SOLE PROPRIETORSHIP
- 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

Have you been a resident of the state of Ohio for the last 5 years?

YES = You only need a BCI background check.

NO = You need both BCI and FBI background checks completed.

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

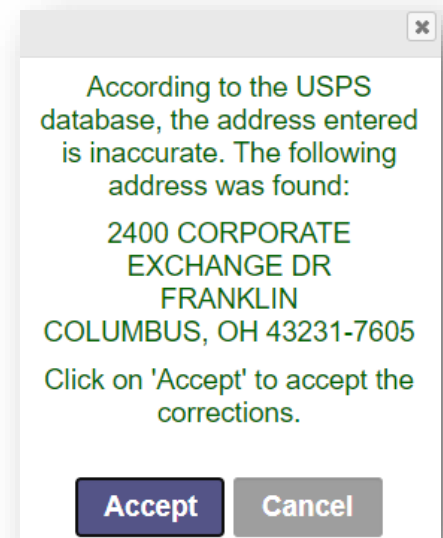
USPS Address Search Pop-Up

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.

Tips

- Throughout the application process you will be asked for addresses and phone numbers, both personal and business. Most Independent Providers do not have a separate business office address or telephone number.
- All information is required to be entered if there is an asterisk* but it IS acceptable to use the same address and phone number for both personal and business throughout the application.



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 web form titled "Provider Directory Opt-Out" with several sections. Red circles with numbers 2 through 5 highlight specific areas:

- 2:** "Provider Information" section, which includes three dropdown menus for "Cultural Competencies", "Languages Spoken", and "Specialized Training".
- 3:** "Hours of Operation" section, which includes a table of days (Monday through Sunday) with two dropdown menus for each day, and a column of checkboxes for "Open 24 Hours" for each day.
- 4:** "Office Information" section, which includes several dropdown menus for "Website", "24-hour telephone coverage", "Public transportation access", "Electronic billing", "TDD/TTY", "Cultural Competencies", "Languages Spoken", "Specialized Training", and "ADA Compliance*", and a dropdown for "ASL Offered*", and checkboxes for "Translation Services" (Language Line and Translation).
- 5:** "Patient Information" section, which includes several dropdown menus for "Accept new patients", "Accept new patients from referral only", "Youngest patients accepted", "Oldest patients accepted", "Gender of patient Accepted", "Accept newborn*", and "Accept pregnant women".

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.

This section is NOT REQUIRED. Select next to skip this section.

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 navigation bar with icons for Service Locations, 1099 Address*, Home Office Address*, Specialties* (highlighted), Taxonomies*, Professional Licenses*, and CLIA Certifications. Below the navigation bar, the 'Specialties' section is titled 'Specialties' with a note 'This is a required section.' It includes a 'Generate PDF' button and a row of buttons: Save, Cancel, Previous, and Next. A message states 'Primary Specialties are not editable by provider after application submission.' Below this, it says 'No records found'. A red circle with the number '1' highlights the 'Add New' button.

The screenshot shows the 'Add New' form for a specialty. It includes a 'Generate PDF' button and a row of buttons: Save, Cancel, Previous, and Next. A message states 'Primary Specialties are not editable by provider after application submission.' Below this, it says 'No records found'. A red circle with the number '1' highlights the 'Add New' button. The form includes a checkbox labeled 'Designate a Primary Specialty' which is checked. Below the checkbox, a red note says 'Designate a Primary Specialty and save first before secondary specialties can be entered.' The form fields are: Specialty* (a dropdown menu), Start Date* (10/21/2021), and End Date (12/31/2299). A red arrow points to the Specialty* dropdown menu.

Personal Care Aides - For specialty select "250 ODM Waiver Non-Agency Personal Care Aide"

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

Note: Personal Care Aides should see "3747P1801X - TECHNICIAN-PERSONAL CARE ATTENDANT"

Note: Additional taxonomy is not required, select 'Next' to move to the CPR& First Aid Page

CPR & First Aid Page

- This is the first location where you need to upload documents.
- Personal Care Aides only need to add a First Aid certificate.
- Certificate can be earned online but the date of certification, trainer signature, and valid until date (valid until dates are typically 2 years or less) are required.

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 are buttons for 'Generate PDF', 'Save', 'Cancel', 'Previous', and 'Next'. The 'W9 Form' section is active, with a red note stating 'This is a required section.' Below this, there is a text input for 'Individual Name' containing 'Training' and an 'SSN' field. A prompt asks to 'Select the most appropriate category below:' with a list of radio button options. The first option, 'Individual/sole proprietor of single-member LLC', is selected and highlighted with a yellow background. A red circle with the number '1' is placed next to this 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

This screenshot shows the 'Indicate the form you are uploading' section. It has two radio button options: 'W9' (selected) and 'Form 147'. A red circle with the number '2' is 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 named 'W-9' with 'W9.pdf' in green text, and buttons for 'Download' and 'Remove'. A 'Browse' button is at the bottom. A red circle with the number '3' is next to the 'Browse' button.

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

EFT Banking Information Page

This page 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.

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'

Banking Information

4

Financial Institution Name* Training Bank

Financial Institution Routing Number* 041215537

Confirm Financial Institution Routing Number* 041215537

Account Number* 25435345443


Confirm Account Number* 25435345443

Account Type* Checking Savings

5 Save Cancel

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

Banking Information

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

EFT Contact

No EFT contact found.

6 Add New

Confirm

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

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

I confirm the information provided is true and accurate.

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

Required

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

Optional

- Middle Name
- Phone Extension
- Fax Number

The screenshot shows a form titled "EFT Contact Information" with a red circle containing the number 7 in the top right corner. The form contains the following fields: "Provider Contact First Name*", "Middle Name", "Last Name*", "Phone Number*" (with a dropdown for area code and two input boxes for digits), "Extension", "Email Address*", and "Fax Number*" (with a dropdown for area code and two input boxes for digits). At the bottom, there are two buttons: "Save" and "Cancel". A red circle containing the number 8 is positioned over the "Save" button.

Step 8: Click 'Save'

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

The screenshot shows a "Confirm" section. It contains the text: "By selecting the confirmation box below, the submitting individual is attesting and acknowledging on behalf of the Medicaid Provider listed above that:" followed by two bullet points: "• He or she is authorized to complete and submit this Enrollment Form." and "• The information provided is accurate and true." Below the bullet points is a checkbox with the text "I confirm the information provided is true and accurate." A red circle containing the number 9 is positioned over the checkbox.

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

The screenshot shows a section titled "EFT Banking Information" with the text "This is a required section." below it. At the bottom right, there are four buttons: "Save", "Cancel", "Previous", and "Next". A red circle containing the number 10 is positioned over the "Next" button.

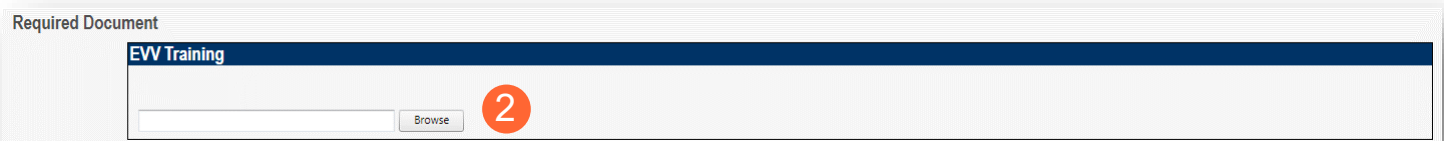
Required Documents Page

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

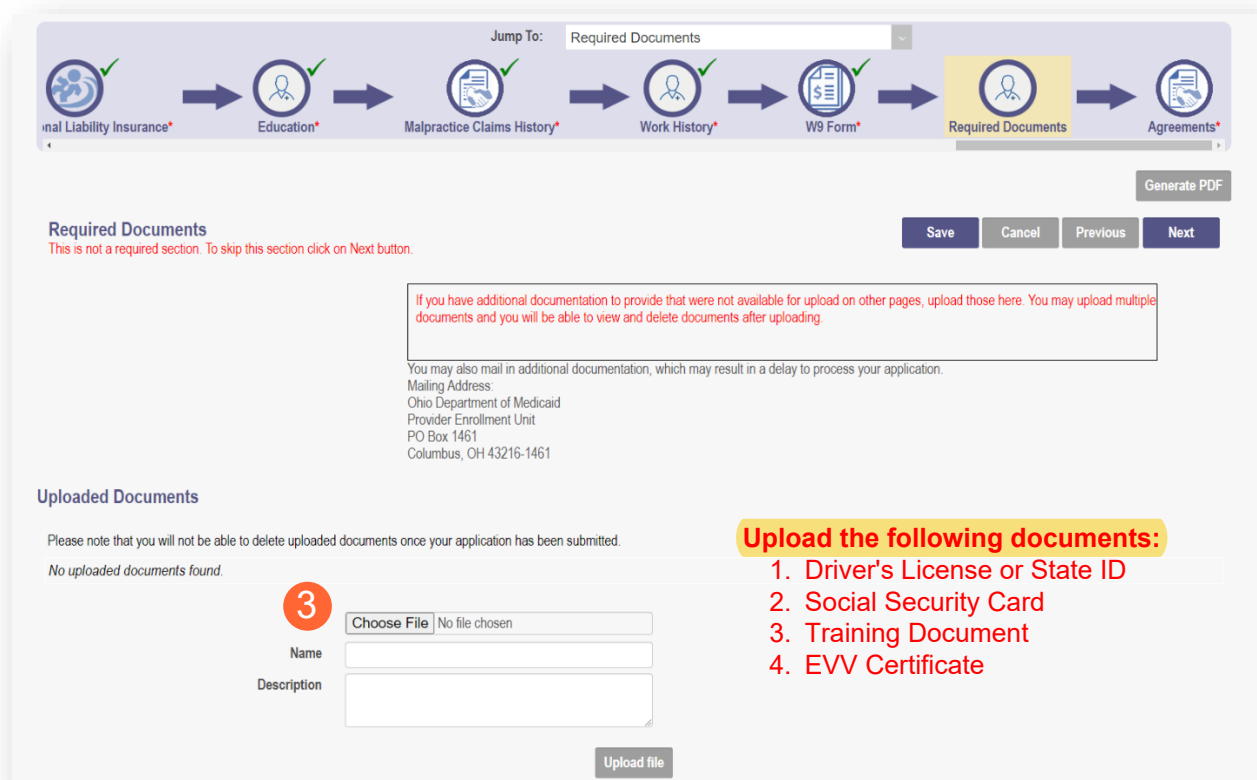
Step 2: If you are required to upload documents, blue upload boxes will be displayed under the Required Documents section. **The required documents are listed in step 3 below.**

- 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

Tip: Be sure to scroll through each section of the agreement page.

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*: Training

Provider Name: Training

User ID: provaccount

8 Save

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

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

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

9 OK

Submitting Application

Step 1: When you are satisfied that all information has been entered accurately on the application, click ‘Submit for Review’ found in the upper right-hand corner of the application.

Jump To: Agreements

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

Generate PDF
 1 Submit for Review
 Save Cancel Previous Next

Agreements
 This is a required section.

Ohio Medicaid Provider Agreement
 Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step.
 All Providers must read the statements below and agree to the terms

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

False Statement Agreement

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

Step 3: Click ‘Return to Home Page’ to go to your dashboard

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

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

3 Return to Home Page