

Creating a New Application in PNM

Creating a New Application - Homepage

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>					
519101	Sharon Aikens	Complete	96 - Behavioral Health Para-Professionals	1972798320	0000223	QUALIFIED MH SPECIALIST				09/13/22	09/13/22	09/13/27

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

Account Administration: This button allows you to manage/setup Agents and transfer the Provider Administrator role to another Account Administrator

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

Creating a New 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.”

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



 Click here for more application types...

- Determine which application type to begin and click **‘Select’** within its corresponding box
 - **Standard Application**
 - Ordering, Referring, Prescribing
 - Change of Operator
 - MCP Single Case

Creating a New Application

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Select

MCP Single Case

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

Select



Less...

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

- Medicaid Waiver (ODM)
- Medicaid Waiver (ODA)
- Medicaid Waiver (DODD)
- Non-Medicaid (DODD)

Creating a New Application

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

Application Type [Change](#)



Individual



Group



Organization



Facility/Institution



Pharmacy

- After choosing the Application Type, Click Individual

Creating a New Application

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Application Type [Change](#)

Waiver Type



- Waiver providers will have a few less options when it comes to choosing a Provider Type
- Either Individual or Independent and Agency appear

Creating a New 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	Standard application	Change
Category*	Individual	Change
Provider Type*	20 - Physician/Osteopath Individual	▼
First Name*	Iris	
Middle Name		
Last Name*	Davis	
Tax ID Type*	<input type="radio"/> EIN <input checked="" type="radio"/> SSN	
Tax ID*	158865429	
Are you requesting retro coverage?	<input type="checkbox"/> What is this 	
NPI*	1588654297	
DD Contract Number (If Applicable)		
Requested Effective Date*	3/22/2022 	
Gender*	<input checked="" type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Unknown	
Date of Birth*	12/16/1976	
Zip Code*	43212	
Zip Code Extension*	4706	
	<input type="button" value="Save"/>	<input type="button" value="Cancel"/>

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.

- Complete the required information on the page, indicated by an *asterisk:
 - Provider Type
 - First and Last Name
 - Tax ID Type
 - Tax ID
 - National Provider Identifier (NPI)
 - Check retro coverage
 - Requested Effective Date (NPI effective date)
 - Gender of the Provider
 - Date of Birth
 - Zip Code
 - Zip Code Extension
- Once all required fields are filled in, click 'Save'

Creating a New Application - Taxonomy

“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	Standard application	Change
Category*	Individual	Change
Provider Type*	20 - Physician/Osteopath Individual	▼
First Name*	Iris	
Middle Name		
Last Name*	Davis	
Tax ID Type*	<input type="radio"/> EIN <input checked="" type="radio"/> SSN	
Tax ID*	158865429	
Are you requesting retro coverage?	<input type="checkbox"/> What is this ?	
NPI*	1588654297	
DD Contract Number (If Applicable)		
Requested Effective Date*	3/22/2022	
Gender*	<input checked="" type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Unknown	
Date of Birth*	12/16/1976	
Zip Code*	43212	
Zip Code Extension*	4706	
Taxonomy*		▼
	Internal Medicine (207R00000X)	

- After clicking ‘Save’, PNM will read the NPI Number, and a **new drop-down menu** will appear at the bottom with **Taxonomy choices**
- Select the appropriate Taxonomy and then click ‘Save’ again on the application page

Creating a New Application

Application Type: Standard application [Change](#)

Category*: Organization [Change](#)

Provider Type*: 44 - Hospice

Name of Business Entity*: Above and Beyond Caregivers
Business Name as it appears on your IRS Assignment letter

Tax ID Type*: EIN SSN

Tax ID*: 152839847

Are you requesting retro coverage? What is this

NPI*: 1528398476

DD Contract Number (If Applicable):

Requested Effective Date*: 4/18/2022

Zip Code*: 43219

Zip Code Extension*: 1793

Save Cancel

- Complete the required information on the page indicated by an ***asterisk***:
 - Provider Type
 - Name of Business Entity
 - Tax ID Type
 - Tax ID
 - National Provider Identifier (NPI)
 - Requested Effective Date (will default to today's date)
 - Zip Code
 - Zip Code Extension
- Once all required fields are filled in, click '**Save**'

PNM validates NPI is a Type 2 NPI number with the National Plan and Provider Enumeration System (NPPES) Registry database

If it is not a Type 2 NPI number, you will receive an error message

The NPI entered is not in the NPPES list.

The NPI entered must be a Type 2 NPI.

Creating a New Application - Taxonomy

“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	Standard application	Change
Category*	Organization	Change
Provider Type*	44 - Hospice	▼
Name of Business Entity*	Above and Beyond Caregivers	
	<small>Business Name as it appears on your IRS Assignment letter</small>	
Tax ID Type*	<input checked="" type="radio"/> EIN <input type="radio"/> SSN	
Tax ID*	152839847	
Are you requesting retro coverage?	<input type="checkbox"/> What is this	
NPI*	1528398476	
DD Contract Number (If Applicable)		
Requested Effective Date*	4/18/2022	
Zip Code*	43219	
Zip Code Extension*	1793	
Taxonomy*	Home Health (251E00000X)	
	<input type="button" value="Save"/>	<input type="button" value="Cancel"/>

- After clicking ‘Save’, PNM will read the NPI Number, and a **new drop-down menu** will appear at the bottom with **Taxonomy choices**
- Select the appropriate Taxonomy and then click ‘Save’ again on the application page

Creating a New Application - Navigation



- A navigational bar appears at the top of the application and highlights the page you are actively working
- Once an application page has been completed and saved with the required information, a **green checkmark** will appear next to the image in the navigational bar
- Pages can also be accessed through the '**Jump To**' drop-down

A red asterisk (*) indicates the application page is required to be completed



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 of the application

Generate PDF: Creates a file with all the application information to be saved to your records (*use once application is complete*)

Continuing an Unfinished Application

- After you log into PNM, click on the **Reg ID** or **Provider** hyperlink
- Select the '+' icon to expand 'Enrollment Actions Selections'
- Click the hyperlink for 'Continue Registration'
- PNM will open the application to the last unsaved page
- Continue entering provider details for the new enrollment application

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty
517978	Iris Davis	Not Submitted	20 - Physician/Oste Individual	1588654297		

Manage Application

Enrollment Actions **+ Enrollment Action Selections:**

Programs + Program Selections:

Self Service + Self Service Selections:

Enrollment Actions - Enrollment Action Selections:

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

Application Pages

Provider Information

- Complete the required Provider Information:
 - Practice Type (Individual) using the drop-down menu
 - Ownership Type (Sole Proprietor) using the drop-down menu
 - First and Last Name
 - Date of Birth
 - Ohio Residency
- Click **Next** to save the information and proceed to the next page of the application

Provider Information

This is a required section.

An asterisk * indicates a required field



Name of Business Entity* Scott Berry

DBA

Practice Type*

Ownership Type*

First Name*

Middle Initial

Last Name*

Title

Tax ID*

NPI

NPI Start Date

Gender*

Date of Birth*

Provider Type*

Revalidation Date

Enrollment Status

Enrollment Status Reason

Birth Country

Birth State

Birth City

CAQH #

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

Yes No

Save Cancel **Next**

Provider Information

Provider Information

This is a required section.

An asterisk * indicates a required field



Name of Business Entity*	CHILD THERAPY INSTITUTE
DBA	
Practice Type*	OTHER
Ownership Type*	UNKNOWN
Tax ID*	167960738
NPI	1679607386
NPI Start Date	03/15/2007
Provider Type*	01 - Hospital
Revalidation Date	Not Set Yet
Enrollment Status	INACTIVE
Enrollment Status Reason	INACTIVE

Save

Cancel

Next

- Complete the required Provider Information:
 - Practice Type (Individual) using the drop-down menu
 - Ownership Type (Sole Proprietor) using the drop-down menu
- Click **Next** to save the information and proceed to the next page of the application

Primary Contact Information

Primary Contact Information

This is a required section.

** Enter the Address
* Enter the City
* Select a State
* Enter Zip (First 5 digits)
* Enter Phone Number 1
* Enter E-mail Address
An asterisk * indicates a required field*

A checkmark box named 'Override Address Validation' is available to continue with the New Enrollment Application and successfully submit this page if the Address entered will not be found in the USPS database

Save Cancel Previous Next

History

Override Address Validation

Name* Scott T Berry

The primary contact is the main person responsible for the information submitted.

Title

Address 1* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County Franklin County

Zip* 43231

Ext Zip 7605

Phone Number 1* (614) 555-5555

Phone Ext 1

Yes No Indicate this is a cell phone if you wish to receive text message. Standard text messaging and data rates may apply

Phone Number 2

Phone Ext 2

Yes No Indicate this is a cell phone if you wish to receive text message. Standard text messaging and data rates may apply

Fax Number 1

Fax Number 2

Email Address 1* email@email.com

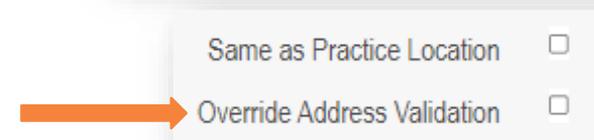
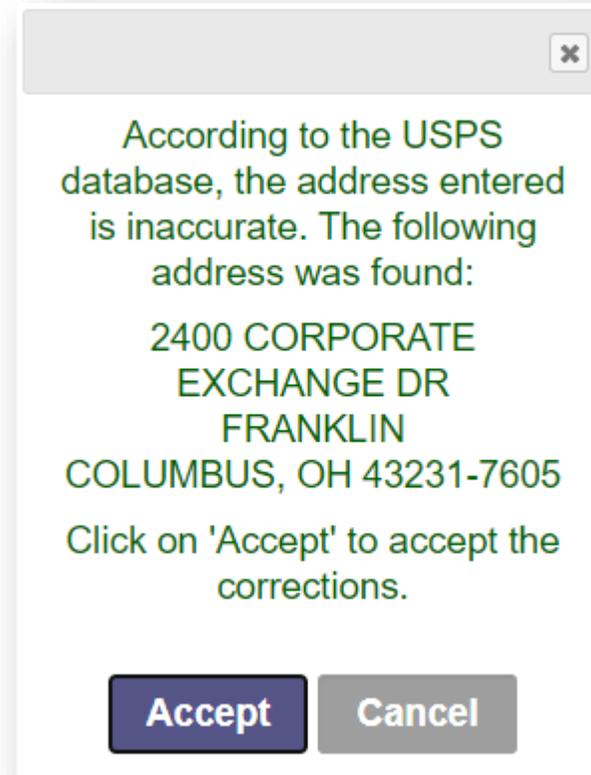
Email Address 2 email@email.com

Office Manager



- Complete the required Primary Contact Information:
 - Name
 - Address
 - City
 - State
 - Zip
 - Phone Number
 - Email Address
- Click **Next** to save the information and proceed to the next page of the application

- To verify the accuracy of the addresses entered in a provider file, PNM uses the United States Postal Service (USPS) database to validate the addresses entered or updated on each address page
- The USPS pop-up window to the right will display each time an address page has information entered or updated on it
- Complete the following steps to move through the USPS address verification pop-up process:
 - Confirm the validation and accuracy of the address information
 - Click **Accept** on the USPS confirmation prompt
 - If the address cannot be validated, then click **Cancel** on the pop-up and check the 'Override Address Validation' box located below the 'Same as Practice Location' checkbox
 - The click **Save** again to save the address page updated address information



- To skip this section, click **Next** to move to the next page
- If you wish to complete this information, click **Add New**
- Fill in the required information for the Credentialing Contact
- Click **Next** to save and proceed to the next page

Credentialing Contact

Save Cancel Previous Next

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

History

Add Contact

No records found

Add New

An asterisk * indicates a required field

*Contact Name

*Practice Name

*Contact Phone No

Contact Phone Extension

Contact Fax No

*Contact Email

Comments

Primary Service Address

- Complete the required information at the top of the Primary Service Address page:

- Provider Name (You)
- 885 E. Buchtel Ave
- Akron
- Ohio
- 44305
- 330-535-8116
- Email Address (Yours)

- Click **Next** to save and proceed to the next page

Primary Service Address

This is a required section.

Override Address Validation

A checkmark box named 'Override Address Validation' is available to continue with the New Enrollment Application and successfully submit this page if the Address entered will not be found in the USPS database

Organization Name* CHILD THERAPY INSTITUTE

Primary Service Address* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County* Franklin County

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-5555

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1* emailtest@test.com

Save Cancel Previous Next

History



Primary Service Address cont'd

- Located below the Primary Service Address information, you can enter additional details about your practice location (*this information is not required*)
- Enter details regarding:
 - Provider Information
 - Hours of Operation
 - Office Information
 - Patient Information
- This information will be accessible to a public-facing Provider Directory once it is entered in PNM. *If you are enrolled in a Managed Care Plan (MCP), the information will also be accessible in the MCP Directory*
- **Note:** If you do not wish to be a part of the Directory, you can **opt out** by clicking the box at the top of the section
- Click **Next** to save and proceed to the next page

A checkmark box is available To 'Opt-Out' of the (public facing) Provider Directory

Provider Directory Opt-Out

Provider Information *Only required for Individual registrations

Cultural Competencies

Languages Spoken

Specialized Training

Hours of Operation *Hours providers available for appointments

Monday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Tuesday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Wednesday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Thursday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Friday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Saturday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Sunday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours

Office Information

Website

24-hour telephone coverage

Public transportation access

Electronic billing

TDD/TDY

Cultural Competencies

Languages Spoken

Specialized Training

ADA Compliance*

ASL Offered*

Translation Services Language Line Translation

Patient Information

Accept new patients

Accept new patients from referral only

Youngest patients accepted

Oldest patients accepted

Gender of patient Accepted

Accept newborn*

Accept pregnant women

Billing & Payment Address

Billing & Payment Address

This is a required section.

To Save Time: A checkmark box is available to auto-fill the address of the Practice Location if it is the same as the one needed for this page

A checkmark box named 'Override Address Validation' is available to continue with the New Enrollment Application and successfully submit this page if the Address entered will not be found in the USPS database

Save Cancel Previous Next

History

Same as Practice Location

Override Address Validation

Address Type Individual Organization

Title

First Name*

Middle Name

Last Name*

Address 1*

Address 2

City*

State*

County*

Zip*

Ext Zip*

Phone Number 1*

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*



- Since the Billing & Payment address is the same as the Practice Location Address, click the box at the top of the page to auto-fill the information
- Click **Next** to save the information and proceed to the next page of the application

Other Service Locations

- This section asks you to include details for any Other Service Locations that bill or will be billed under the same Medicaid ID

A checkmark box named 'Override Address Validation' is available to continue with the New Enrollment Application and successfully submit this page if the Address entered will not be found in the USPS database

- To skip this section, click **Next** to move to the next page
- If you wish to complete this information, click **Add New**
- Fill in the required information for the Other Service Location
- Click **Next** to save the information and proceed to the next page of the application

Other Service Locations cont'd

- Located below the Other Service Locations Address information, you can enter additional details about your practice location (*this information is not required*)
- Enter details regarding:
 - Provider Information
 - Hours of Operation
 - Office Information
 - Patient Information
- This information will be accessible to a public-facing Provider Directory once it is entered in PNM. *If you are enrolled in a Managed Care Plan (MCP), the information will also be accessible in the MCP Directory*
- **Note:** If you do not wish to be a part of the Directory, you can **opt out** by clicking the box at the top of the section
- Click **Next** to save and proceed to the next page

 A checkmark box is available To 'Opt-Out' of the (public facing) Provider Directory

Provider Directory Opt-Out

[Provider Information](#) *Only required for Individual registrations

Cultural Competencies

Languages Spoken

Specialized Training

[Hours of Operation](#) *Hours providers available for appointments

Monday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Tuesday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Wednesday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Thursday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Friday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Saturday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours
Sunday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Open 24 Hours

[Office Information](#)

Website

24-hour telephone coverage

Public transportation access

Electronic billing

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Cultural Competencies

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[Patient Information](#)

Accept new patients

Accept new patients from referral only

Youngest patients accepted

Oldest patients accepted

Gender of patient Accepted

Accept newborn*

Accept pregnant women

- Click **Add New** to add a Specialty
- Select the Primary Specialty from the Specialty the drop-down menu *(Available specialties for the provider type will be listed in the drop-down menu)*
- The 'Start Date' can be updated, and the 'End Date' will default with an infinite date *(12/31/2299)*
- Additional Specialties can be added after clicking **Save** on the Primary Specialty designation and then repeating the process

Specialties
This is a required section.

Save Cancel Previous Next

Primary Specialties are not editable by provider after application submission.

No records found

Add New

Designate a Primary Specialty .

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

Specialty* 209 - INTERNAL MEDICINE

Start Date* 201 - GENERAL PRACTICE

End Date 202 - GENERAL SURGERY

216 - Geriatric

223 - GYNECOLOGICAL ONCOLOGY

219 - GYNECOLOGY

267 - HEMATOLOGY

218 - HEMATOLOGY/ONCOLOGY

268 - HEPATOLOGY

269 - IMMUNOLOGY

356 - INFECTIOUS DISEASE

209 - INTERNAL MEDICINE

273 - MAXILLOFACIAL SURGERY

282 - NEONATAL-PERINATAL MEDICINE

283 - NEPHROLOGY

211 - NEUROLOGICAL SURGERY

210 - NEUROLOGY

290 - OBSTETRICS

212 - Obstetrics & Gynecology

220 - Oncology

292 - OPHTHALMOLOGY

Specialties

This is a required section.

Save

Cancel

Previous

Next

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status	
209 INTERNAL MEDICINE	Yes	03/23/2022	12/31/2299	INACTIVE	 

Add New

History

- To edit a Specialty, click on the 'pencil and paper' icon and update the information
- To remove an added Specialty, click the 'x' associated with the applicable Specialty line
- Click **Next** to save the information and proceed to the next page of the application

Professional Licenses
This is a required section.

Save Cancel Previous Next

History

Add New

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



- A copy of each license must be uploaded to the page
 - If an Ohio license and Ohio e-license information can be successfully pulled in PNM, a license upload is not needed
- Click 'Add New' to add an entry for Professional License information

- Enter the required information for the professional license (*marked with an asterisk*)
- If entering Endorsement information, click the green '+' icon at the bottom of the page to add a new Focus, Endorsement Specialty and Certifying Organization

Data cannot be populated, manual entry required.

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

State*	Ohio	▼
License Board Name*	Medical Board	▼
If Other, enter Board Name:		
License Number*	66453289	
Effective Date*	3/23/2022	
Expiration Date*	3/23/2027	
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		





Professional Licenses – Upload License

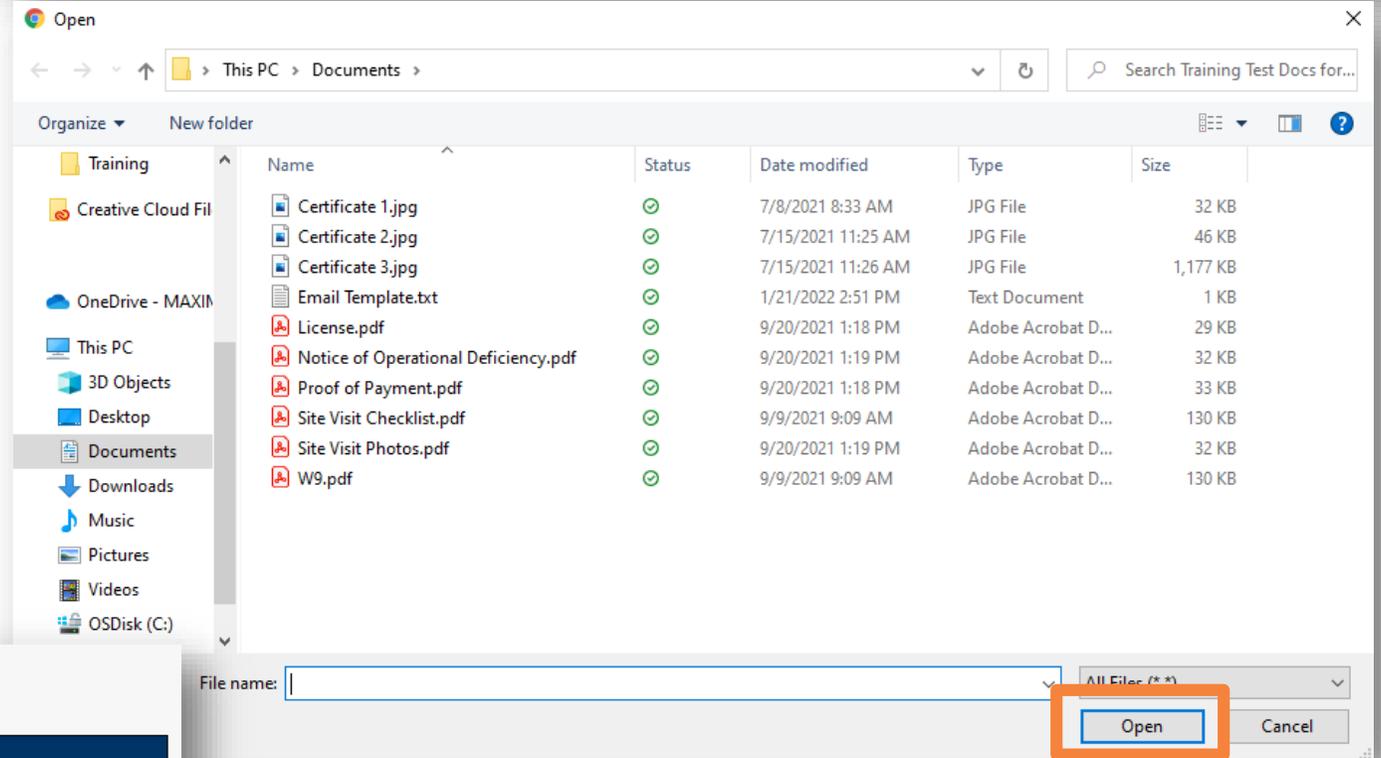
- To upload a Professional License document, click **Browse**
- Locate the license document on your computer, select it, and click **Open**
- Confirm the document has been uploaded by locating the file name in green text
- Click **Next** to save the information and proceed to the next page of the application

Uploaded Documents

Required Document

Professional License

Browse



Uploaded Documents

Required Document

Professional License

License.pdf

Download

Remove

Browse

Medicare Number
This is a required section.

Medicare Number
No records found

Medicaid
No Other State Medicaid Number found

Save Cancel Previous Next

Add New

Add New

- This screen can be skipped by pressing Next
- This page allows you to indicate a Medicare Number you hold, a Medicaid Number that you hold outside of Ohio, or both
- To add an entry for either section, click **Add New**

Group, Organizations & Hospital Affiliations

Group, Facility & Hospital Affiliations (Individual) Save Cancel Previous Next

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

If you are a provider working as a hospitalist or strictly inpatient only, Please click add new under hospital affiliations, and designate that you practice exclusively within the inpatient setting

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.								

Hospital Affiliations

Facility Name	NPI	Medicaid ID	Start Date	End Date	Affiliation Status	Address		
No hospital affiliations found.								

Group Affiliation

Medicaid ID

NPI

Save Cancel

- This screen can be skipped by pressing Next
- This page asks you to indicate any Group or Hospital Affiliations
- A *Group Affiliation* begins as a 'Pending Group Affiliation' until it is confirmed by the Affiliated Group
- To add a Group, click **Add New** within the 'Pending Group Affiliations' section
- Enter the Medicaid ID and NPI for the Group Affiliation
- Once details are entered, click **Save**

Federal DEA Registration

Federal DEA Registration
This is a required section.



DEA Question

Do you have a current DEA registration? Yes No

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

DEA Number	<input type="text"/>
DEA State	<input type="text" value="v"/>
Issue Date	<input type="text"/>
Expiration Date	<input type="text"/>
DEA Status	Active <input type="text" value="v"/>

[History](#)

[Add New](#)

[Save](#) [Cancel](#) [Previous](#) [Next](#)

- This screen can be skipped by pressing Next
- This section allows you to enter Federal Drug Enforcement Agency (DEA) Registration information
- Answer the DEA Question by selecting the appropriate 'Yes' or 'No' radio button
- If 'Yes' is selected, a new box appears to enter the DEA information
- Once the information is complete, click **Next** to save the information and proceed to the next page of the application

Professional Liability Insurance

Professional Liability Insurance
This is a required section.

Save Cancel Previous Next

History

No records found

Add New

Do you carry malpractice insurance? Yes No

If No, please provide explanation below.

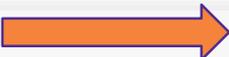
Please provide an explanation regarding malpractice insurance

- To enter details of your Professional Liability Insurance, click **Add New**
- Click a 'Yes' or 'No' radio button to the question, *Do you carry malpractice insurance?*
- If 'No' is selected, provide an explanation in the text box
- Click **Next** to save the information and proceed to the next page of the application

Professional Liability Insurance cont'd



Do you carry malpractice insurance?



Yes No

Self Insured?	Yes
Policy Number*	A478578394
Effective Date*	3/25/2022
Original Effective Date*	3/25/2010
Expiration Date*	3/25/2027
Type of Coverage*	Individual
Do you have unlimited coverage?	Yes
Policy includes tail coverage*	Yes
Carrier or Self-Insured Name*	Insurance Carrier
<input type="checkbox"/> Check here if insurance is through Federal Tort Claims Act (FTCA)	
Carrier address 1	2400 Corporate Exchange Drive
Carrier address 2	
City*	Columbus
State*	OH
County	
Zip*	43212
Policy Holder*	Iris Davis
Coverage Amount Per Occurrence*	3,000,000
Coverage Amount Per Aggregate*	5,000,000

- If 'Yes' is selected, complete the required information including dates, coverage details, address, policy holder, and coverage amounts

- Click **Next** to save the information and proceed to the next page of the application

Malpractice Claims History

This is a required section.

Save

Cancel

Previous

Next

History

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

No Yes

- This required section allows you to enter Malpractice Claims History
- Click **Add New** to answer the question using the 'Yes' or 'No' radio buttons
- When 'No' is selected, click **Next** to save and advance to the next page

- This screen can be skipped by pressing Next
- This section asks you to indicate enrollment of Electronic Fund Transfer (EFT), which is required to receive payments directly from the State Medicaid Program
- Use the 'Yes' or 'No' radio buttons to answer the question at the top of the page
 - If 'No' is answered, no additional details need to be entered
- Read the instructions on the page before entering any information
- To enter *Banking Information*, click the **Add New** button below the Banking Information heading

EFT Banking Information

This is a required section.

Save Cancel Previous Next

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

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.

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.

Required Documents

- The 'Required Documents' page *may or may not* display as a required page with the application
- To upload a required document, click **Browse** under the document type you want to upload, locate the document on your computer, select and click **Open** to upload
- Confirm the document has been uploaded by locating the file name in green text
- Click **Next** to save the information and proceed to the next page of the application

Required Documents Save Cancel Previous Next

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

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

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

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



Required Document

W-9

W9.pdf

[Download](#)

[Remove](#)

Optional Document

Documentation of Training/Certification

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.

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

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

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.

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.

Provider Agreement Attestation

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



- The final page of the application is the Agreements page
- This section is required before the application can be submitted
- This section includes **Ohio Medicaid Provider Agreements, Individual Provider Questions, Provider Agreement Attestation, and a digital signature**

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.

This provider agreement is a contract between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, Ohio statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, color, age, gender, sexual orientation, marital status, and bill the Department for no more than the lesser of the provider's billed charges or the reasonable and customary charges for the service.
2. Ascertain and recoup any third-party payment for services rendered to the patient, and bill the patient for the lesser of the provider's billed charges or the reasonable and customary charges for the service from the patient, any member of the patient's family, or any other person.
3. Accept the allowable reimbursement for services rendered to the patient, any member of the patient's family, or any other person, and bill the patient for the lesser of the provider's billed charges or the reasonable and customary charges for the service from the patient, any member of the patient's family, or any other person.
4. Fully cooperate with the Department, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation includes, but is not limited to, making yourself and your records available upon request.
5. This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.
6. I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement and certify that the information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in accordance with 42 CFR, Part 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code.



I agree to Terms and Conditions

Agreement Date:

- Read through all statements in The Ohio Medicaid Provider Agreement section
- Use the scroll bars on the right side to navigate each section
- Once the Ohio Medicaid Provider Agreement section is completed, check the box to agree to the Terms and Conditions

Provision Check

Certain provider agreements may be retroactive (up to 12 months) to encompass dates on which the provider furnished covered services to a Medicaid consumer and the service has not been billed to Medicaid.

A failure to check this box shall be taken by ODM to mean that you waive your rights to a retroactive period of months prior to the date ODM approves your application. This agreement is limited to 5 years from the effective date.

If you meet this provision, please check this box

- This section includes the Ohio Medicaid Provider Agreement Provision
- If you requested retro coverage, you must check this box
- If you do not, leave the box blank

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.



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.

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?

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

- This section includes three Individual Provider Questions
- Each question has a 'Yes' or 'No' radio button answer
- 'Yes' answers require a comment
- Each question needs answered before moving to the next section

Provider Agreement Attestation

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.

Provider Agreement Signature

Name of Person Attesting*:

Provider Name:

User ID:



Save

- This section includes the Provider Agreement Attestation and Provider Agreement Signature
- Check the box next to the Provider Agreement Attestation statement
- Enter the required digital signature information:
 - Name of Person Attesting
 - **Provider Name*
 - **User ID*
 - **These lines auto-fill*
- Click **Save** once the digital signature is completed

Submitting Application

Submitting the Application

- Once all pages of the application are complete, click 'Save'
- You will receive a pop-up window as a reminder to *review the application* before it is submitted
 - Click **OK**
- Review any application pages by clicking on the icon or selecting the page from the 'Jump To' drop-down menu
- Pages that have been completed or viewed should have a green checkmark

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.

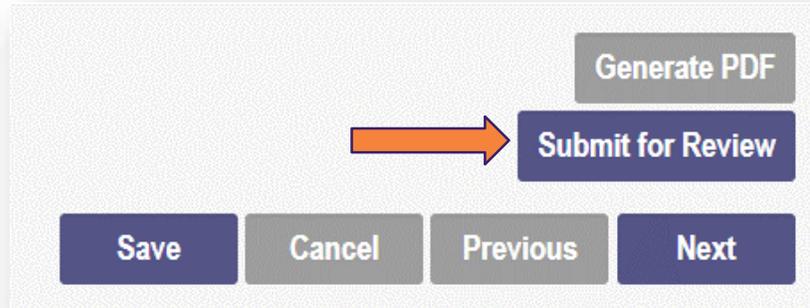
OK



Home Office Address*	✓
Specialties*	✓
Taxonomies*	✓
Professional Licenses*	✓
Board Certification	✓
CLIA Certifications	✓
Medicare Number	✓
Group, Facility & Hospital Affiliations (Individual)*	✓
MCP Affiliation	✓
State CDS Number	✓

Submitting the Application

- If you would like a copy of the application for your records, click **Generate PDF** to download a PDF copy of the application to your computer
- The PDF copy will download to the folder that you have specified for downloads in your browser
- When you are ready to submit your application, click **Submit for Review**



Ohio | Department of Medicaid

Registration Application Details

Office Information
Provider Information

Provider Directory Opt-Out

Provider Information

Name of Business Entity	Iris Davis
DBA	
Practice Type	INDIVIDUAL PRACTICE
Ownership Type	SOLE PROPRIETORSHIP
First Name	Iris
Middle Initial	
Last Name	Davis
Title	
Tax ID	158865429
NPI	1588654297
NPI Start Date	10/24/2005
Gender	FeMale
Date of Birth	12/16/1976
Provider Type	Physician/Osteopath Individual
Revalidation Date	
Enrollment Status	Not Set Yet
Enrollment Status Reason	Not Set Yet

Example of pdf

Submitting the Application

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.

 [Return to Home Page](#)

- A Submission Confirmation message displays to verify your application has been successfully submitted
- Click **Return to Homepage** to view your dashboard
- On your dashboard, the completed application Status will display as ‘Submitted’

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>
517978	Iris Davis	Submitted	20 - Physician/Oste Individual	1588654297		INTERNAL MEDICINE			

Return to Provider

Return to Provider

- During the review process for New Enrollment, an Enrollment Specialist or Credentialing Specialist may return the application to the provider/provider administrator seeking additional information
- The Primary Contact on the application will receive an email indicating a notice on the account has been issued by the Ohio Department of Medicaid.

- The notice may require you to act

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.

- The details of the notice are accessed in PNM
 - Click on the link under Reg ID or Provider to manage the application

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>					
517968	James Aust	Return to Provider	30 - Dentist Individual	1770659625	9999889	General Dentistry				03/18/22	03/14/22	03/14/27

Return to Provider

- Select the '+' icon to expand the section titled 'Self Service'
- Click the hyperlink for 'Provider Correspondence'
- Select a Correspondence Type from the drop-down
 - For Correspondence related to Return to Provider, select 'Enrollment Notifications'
- Enter a date range for the search
- Click **Search**
- The results will appear at the bottom of the page

The screenshot shows the 'Manage Application' interface. It has three main sections: 'Enrollment Actions', 'Programs', and 'Self Service'. Each section has a '+' icon to its right, followed by a grey bar containing the section name and 'Selections:'. An orange arrow points to the '+' icon next to 'Self Service'. Below this, the 'Self Service' section is expanded, showing a '-' icon and a grey bar with 'Self Service Selections:'. An orange arrow points to a blue hyperlink labeled 'Provider Correspondence' within this expanded section.

The screenshot shows the 'SEARCH CORRESPONDENCE' form. It has a blue header with the title. Below the header, there are three input fields: a dropdown menu for '*Correspondence TYPE' with 'Enrollment Notifications' selected, a date field for 'Date Available From:' with '01/01/2022', and a date field for 'Date Available To:' with '04/11/2022'. At the bottom right, there are two buttons: 'Search' and 'Clear'.

Return to Provider

- Click on the Correspondence you wish to view
- A pop-up window opens containing the text of the correspondence
 - The reasons for the return are listed in the body of the email
- Click the 'x' in the top-right corner to close the message pop up

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		

Provider Communication

Body **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,

Return to Provider

Manage Application

Enrollment Actions



Enrollment Action Selections:

Programs



Program Selections:

Self Service



Self Service Selections:

Enrollment Actions



Enrollment Action Selections:

[Continue Registration](#)

[Cancel New Registration](#)

[Edit Key Provider Identifiers](#)

Programs



Program Selections:

Self Service



Self Service Selections:

- Select the '+' icon to expand the section titled 'Enrollment Actions'
- Click the hyperlink for 'Continue Registration'
- PNM will open directly to the page(s) that need additional information

Return to Provider

Proper paperwork not attached (P032)
- License document uploaded is a blank page

Jump To: Professional Licenses

Hospital Address* Specialties* Taxonomies* Professional Licenses* CLIA Certifications Medicare Number* Group, Organ

Generate PDF

Professional Licenses
This is a required section.

Save Cancel Previous Next

History

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

License Number	License Board	License State	Effective Date	Expiration Date	Address	Endorsement	
HS2345234	Ohio Department of Health	OH	1/1/2010	1/1/2025			

Add New

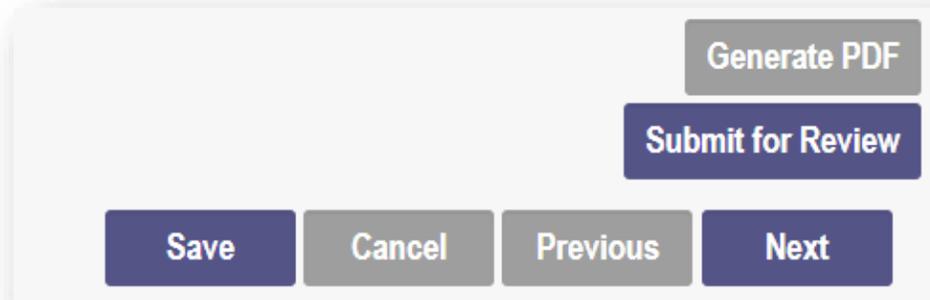
- That page(s) that need additional information or a correction will be marked with a yellow exclamation point
- The reason that page was returned will be listed in red text at the top of the page
- Make the proper updates or corrections to the page and click **Next** to update the information

Return to Provider

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.

OK



- If any additional pages need additional information, complete those pages
- When updates/corrections are made to the page(s) a pop-up window displays stating that the application is complete
 - Click **OK**
- The page(s) with the yellow exclamation point will now display a green checkmark
- Click **Submit for Review** to return the application, with the additional information, to be reviewed

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.

[Return to Home Page](#)

- A submission confirmation message displays to verify your application, with the additional information, has been successfully submitted
- Click **Return to Homepage** to view your dashboard
- The completed application will have an updated status of 'Submitted'

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>					
517968	James Aust	Submitted	30 - Dentist Individual	1770659625	9999889	General Dentistry				03/18/22	03/14/22	03/14/27

Contact Information

- If you need assistance or run into issues when using PNM, please reach out to the following:



ODM Integrated Help Desk

1-800-686-1516

PNM Assistance/Error Messages: *Option 2 followed by Option 3*

Ohio Medicaid Enrollment/Credentialing Questions: *Option 2 followed by Option 2*



Email

ODM Integrated Help Desk: ihd@medicaid.ohio.gov

PNM Assistance/Error Messages: pnmsupport@medicaid.ohio.gov

Ohio Medicaid Enrollment (updates to effective date):

Medicaid_Provider_Update@medicaid.ohio.gov

Ohio Medicaid Credentialing Questions : credentialing@medicaid.ohio.gov

Help Locating Training Materials/LMS: ohiotrainingteam@maximus.com