

Provider Training Session: Updates & Revalidation/ Reenrollment

Behavioral Health Organization Providers



Department of
Medicaid

Agenda

Updates & Revalidation/ Reenrollment

This course is designed to deliver a detailed process for completing an update to a provider file within the PNM system

This course will also show how to complete the revalidation/reenrollment process.

A revalidation/reenrollment occurs every 3 years for credentialed providers and 5 years for non-credentialed providers

In this session, we will review and discuss slides, then open the Provider Network Management (PNM) system to review how the processes are completed

01

Completing an Update in PNM

02

Display in PNM System – Updates

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Accessing & Initiating Self-Service Functionalities

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Submitting Revalidation/Reenrollment

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Display in PNM System – Revalidation/Reenrollment

Completing an Update in PNM

Updates & Revalidation - Homepage

Menu

Ohio

Provider Network Management

Medicaid Home

Learning

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trainingprov

Log out

My Providers

Select Provider

Pending Agent Requests

Account Administration

New Provider ?

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
519470	Training Mental Health Provider	Complete	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro				04/25/17	04/25/17	04/25/22


Menu: The menu can be accessed by clicking on the three-bars in the top left-hand corner of the screen. This will provide you with access to the Provider Directory, Learning Resources, Provider Financials, My Profile, Contact Us, and other key information for the Provider

Select Provider: This button allows you to search for and move Providers to your OHID account based on identifying information, such as Tax ID, NPI, and Medicaid ID


Pending Agent Requests: This button allows you to approve any Agents that wish to have access to Provider records to Submit Claims, Run Reports, and other functions



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

Initiating Update to Provider File

Menu

Ohio

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[My Providers](#) [Select Provider](#) [Pending Agent Requests](#) [Account Administration](#) [New Provider ?](#)

- It may be necessary to update your provider file with new or changed information
- Updates are necessary to ensure that all your details with the State Medicaid Program are accurate
- A lack of up-to-date information may cause issues during data review periods
- To begin the update process, access the 'Manage Application' section by clicking either on the Reg ID or Provider Name hyperlink

Initiating Update to Provider File

- Select the '+' icon to expand the section titled 'Enrollment Actions'
- Click the hyperlink for 'Begin ODM Enrollment Profile Update'
- A pop-up appears informing you that you have 10 days to submit your update

Manage Application

Enrollment Actions



Enrollment Action Selections:

Programs



Program Selections:

Self Service



Self Service Selections:

Enrollment Actions



Enrollment Action Selections:

[Begin ODM Enrollment Profile Update](#)

[Edit Key Provider Identifiers](#)

[Request Disenrollment](#)

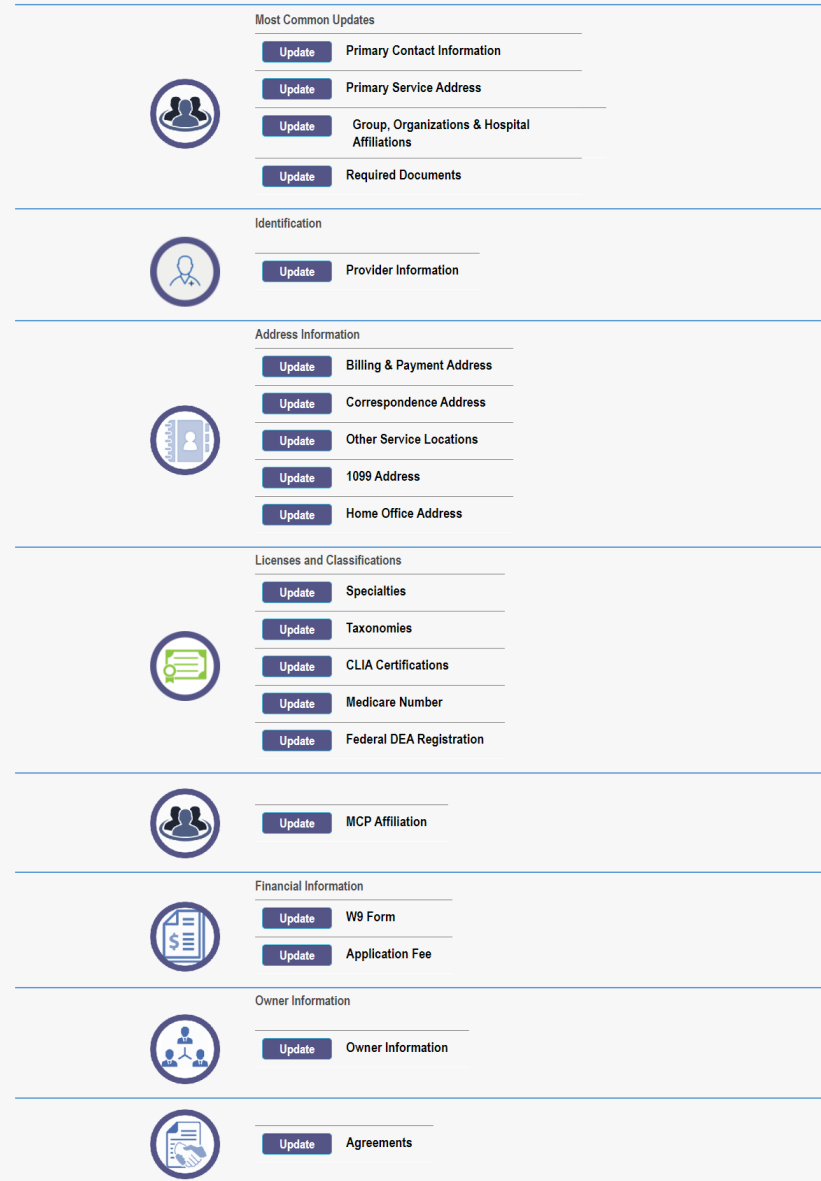
You will have 10 days to submit your update. After 10 days, your information will be removed, and you will have to restart your update.

Ok

Initiating Update to Provider File

Provider Update - Lets keep your information current !

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



The screenshot displays a web interface for updating provider information. It is organized into several sections, each with a representative icon and a list of updateable items:

- Most Common Updates** (Icon: Group of people):
 - Update Primary Contact Information
 - Update Primary Service Address
 - Update Group, Organizations & Hospital Affiliations
 - Update Required Documents
- Identification** (Icon: Person):
 - Update Provider Information
- Address Information** (Icon: Address card):
 - Update Billing & Payment Address
 - Update Correspondence Address
 - Update Other Service Locations
 - Update 1099 Address
 - Update Home Office Address
- Licenses and Classifications** (Icon: Document with checkmark):
 - Update Specialties
 - Update Taxonomies
 - Update CLIA Certifications
 - Update Medicare Number
 - Update Federal DEA Registration
- MCP Affiliation** (Icon: Group of people):
 - Update MCP Affiliation
- Financial Information** (Icon: Document with dollar sign):
 - Update W9 Form
 - Update Application Fee
- Owner Information** (Icon: Group of people):
 - Update Owner Information
- Agreements** (Icon: Document with checkmark):
 - Update Agreements

- The Provider Update page will display, showing the different sections of the application that can be updated
- The sections to update include:
 - Most Common Updates
 - Identification
 - Credentialing Information
(for Credentialed providers)
 - Address Information
 - Licenses and Classifications
 - MCP Affiliation
 - Financial Information
 - Agreements

Initiating Update to Provider File

- One or multiple updates can be completed in one sitting, however only one update can be completed at a time
- Determine which set of data you wish to update and click 'Update'

Provider Update - Lets keep your information current !

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



Most Common Updates

Update

Primary Contact Information

Update

Primary Service Address

Update

Group, Organizations & Hospital Affiliations

Update

Required Documents



Owner Information

Update

Owner Information

Initiating Update to Provider File

Owner Information
This is a required section.

Return to Summary

Generate PDF

Save

Cancel

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

+ Instructions

+ Definitions & Requirements

+ Owner, Managing Employee and Controlling Interest Information

+ Real Estate Owners

+ Additional Disclosure

+ Questions

Type	Name	Title	Percentage		
Organization	Training Clinic LLC		50.00		
Organization	Clinic Systems LLC		50.00		

Add New

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

- If you click ‘Update’ for the wrong section by mistake, go back to the Provider Update page by clicking ‘Return to Summary’
- Click the ‘pencil and paper’ icon to edit the existing owner information or ‘Add New’ to add additional owner information
- In this example, we have edited the ownership percentage of the existing owner and added a new owner
- After all updates have been completed on the page, click ‘Save’

Initiating Update to Provider File



Before

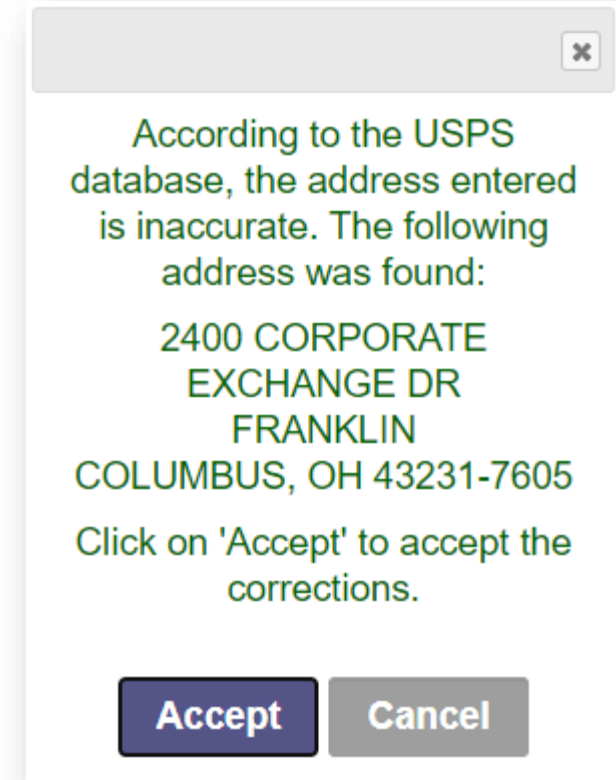


After



- To confirm an update has been saved, a 'red dot' will appear in the navigation bar for page that has been updated
- Initiate additional updates by clicking 'Return to Summary'

- To maintain accurate addresses, PNM uses a USPS system search validation for addresses entered
- If your update includes a change of address, the pop-up window may display
- Complete the following steps to advance the process:
 - Confirm the validation and accuracy of the address information
 - Click 'Accept' on the USPS confirmation prompt



Performing Multiple Updates

Provider Update - Lets keep your information current !

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



Most Common Updates

Update

Primary Contact Information

Update

Primary Service Address

Update

Group, Organizations & Hospital
Affiliations

Update

Required Documents



Owner Information

Update

Owner Information



- On the Provider Update screen, the section updated will display a green checkmark
- Click 'Update' for any additional sections that need updated data and enter the new information on that page
- Repeat the process for any other sections that need to be updated

Affiliations Updates

Individual Providers Associated with Your Group

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

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

Always verify that NPI you enter for Individuals are correct.

Display Active Only

☐ Yes

☒ No

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

Add New

- Organizations must confirm individual provider affiliations. (This is when an individual provider lists the affiliation on their file)
- To confirm, an update must be initiated for Group, Organization & Hospital Affiliations
- Review the individual providers that are highlighted and have a status of 'Pending Approval'
- Click the 'pencil and paper' icon to edit the provider

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Updates

Affiliations Updates

Edit Group Member

First Name*

Training

Last Name*

Trainer

NPI*

Rendering Location*

2400 CORPORATE EXCHANGE DR, STE 200, COLUMBUS

Start Date*

10/15/2021

[What is this?](#)

End Date

12/31/2299

Medicaid ID

Affiliation Status

Pending Approval

Save

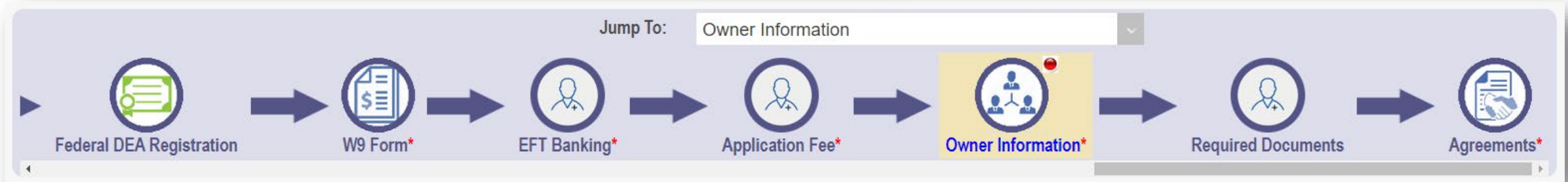
Cancel

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

- Select a Rendering Location for the provider and click ‘Save’
- Continue this process for all providers with a ‘Pending Approval’ affiliation status
- Once all ‘Pending Approval’ providers have been updated, they will no longer display in yellow

Submitting an Update

Submitting Update to Provider File



- When all updates are complete, click 'Submit for Review'
- A pop-up window displays indicating that the file has been modified and which sections have been changed
- Click 'OK' to proceed and submit



You have modified the following sections in your application. Click "Ok" to complete your submission. Click "Cancel" to review your application prior to submission.

Group, Organizations & Hospital Affiliations
Owner Information

OK

Cancel

Submitting Update to Provider File

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 updated file has been successfully submitted
- Click 'Return to Homepage' to view your dashboard

My Providers

Select Provider

Pending Agent Requests

Account Administration

New Provider ?

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
519470	Training Mental Health Provider	Complete	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro				04/25/17	04/25/17	04/25/22

Continuing an Unfinished Update

- Click on the Reg ID or Provider Name Hyperlink
- Select the '+' icon to expand the section titled 'Enrollment Actions'
- Click the hyperlink for 'Continue ODM Enrollment Profile Update'
- 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	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"/>
519379	Training Clinic	Complete	50 - CLINIC	1568718724	0000276	Primary Care Clinic	04/25/22	04/25/22	04/25/27

Manage Application

Enrollment Actions



Enrollment Action Selections:

Programs



Program Selections:

Self Service



Self Service Selections:

Enrollment Actions



Enrollment Action Selections:

[Continue ODM Enrollment Profile Update](#)

[Cancel Update Registration](#)


[Edit Key Provider Identifiers](#)


Submitting Update to Provider File


<u>Scenario</u>	<u>Requires Screening</u>	<u>Requires Review</u>
Change in Provider Name	Yes	Yes
Change in Ownership	Yes	Yes
Practice Location (Moderate/High Risk)	Yes	Yes
Add Initial Services (Multi-Agency)	Yes	Yes
Adding Specialties	No	Yes
Updating Affiliations	No	No
Other Address Screens	No	No
Primary Contact Information	No	No
Updates to Required Documents (W9 Form)	No	No
Professional Licenses (In State)	No (automatic call with e-license)	No
Professional Licenses (Out of State)	Yes	Yes
Taxonomies	No	No
Medicare Number	No	No
Board Certifications	No	No
MCP Affiliation (Interest)	No	No
DEA/CDS	No	No
Work History	No	No
Education and Training	No	No
Credentialing Contact	No	No
Malpractice Claims History	No	No
CLIA Certifications	No	No
Provider Agreement	No	No
DME Information	No	No



Accessing & Initiating Self-Service Functions

Accessing Self-Service Functions

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 [trainingprov](#)  [Log out](#)

[My Providers](#) [Select Provider](#) [Pending Agent Requests](#) [Account Administration](#) [New Provider ?](#)

- The self-service panel of functions is accessed through the Provider Management homepage
- To begin the process, click either on the Reg ID or Provider Name hyperlink

Accessing Self-Service Functions

- Select the '+' icon to expand the section titled 'Self Service'
- The panel will display with several options, or hyperlinks, for you to access to begin the process

Manage Application


Enrollment Actions

+ Enrollment Action Selections:

Programs

+ Program Selections:

Self Service

 + Self Service Selections:

Self Service

- Self Service Selections:

[View Provider File](#)

[Provider Correspondence](#)

[Remittance Advice](#)

[Recipient Eligibility](#)

[Claims](#)

[Prior Authorization](#)

[Cost Reports and Rate Setting](#)

[Hospice](#)

[Payment Innovation Reports](#)

Self Service

- Self Service Selections:

[View Provider File](#)

[Provider Correspondence](#)

[Remittance Advice](#)

[Recipient Eligibility](#)

[Claims](#)

[Prior Authorization](#)

[Cost Reports and Rate Setting](#)

[Hospice](#)

[Payment Innovation Reports](#)

- **View Provider File:** Opens a 'read-only' version of the provider file
- **Provider Correspondence:** Allows you to access any correspondence that has been sent from PNM or MITS relating to the provider file
- **Remittance Advice:** Redirects you to MITS to begin a Remittance Advice search
- **Recipient Eligibility:** Redirects you to MITS to begin an Eligibility search
- **Claims:** Redirects you to MITS to begin a claim submission or inquiry
- **Prior Authorization:** Redirects you to MITS to begin a prior authorization submission or inquiry
- **Cost Reports and Rate Setting:** Redirects you to MITS to access the information
- **Hospice:** Redirects you to MITS for Hospice details
- **Payment Innovation Reports:** Redirects you to the Haven portal

Provider Correspondence

- Click the hyperlink for 'Provider Correspondence'
- Select a Correspondence Type from the drop-down
 - Ex. For Correspondence related to the provider enrollment application, select 'Enrollment Notifications'
- Enter a date range for the search
- Click 'Search'
- The results will appear at the bottom of the page

Self Service

Self Service Selections:

[View Provider File](#)
[Provider Correspondence](#)
[Remittance Advice](#)
[Recipient Eligibility](#)
[Claims](#)
[Prior Authorization](#)
[Cost Reports and Rate Setting](#)
[Hospice](#)
[Payment Innovation Reports](#)


*** SEARCH CORRESPONDENCE**


*Correspondence TYPE

Date Available From: ⓘ

Date Available To: ⓘ

Enrollment Notifications ▼

01/01/2022 

04/11/2022 

Search

Clear

Provider Correspondence

- Click on the Correspondence you wish to view
- A pop-up window opens containing the text of the correspondence
- 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		
				1 2 3

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,

Self-Service Redirect to MITS



- For the functions that redirect you to MITS, the MITS panel will open, and the options will display at the top of the screen
- Complete the processes for Claims, Prior Authorization, Recipient Eligibility, Hospice and Cost Reports as you do today in the MITS portal

Payment Innovation Reports

Self Service

Self Service Selections:

[View Provider File](#)
[Provider Correspondence](#)
[Remittance Advice](#)
[Recipient Eligibility](#)
[Claims](#)
[Prior Authorization](#)
[Cost Reports and Rate Setting](#)
[Hospice](#)
[Payment Innovation Reports](#)



The screenshot shows the Ohio.gov website interface. At the top is the Ohio.gov logo. Below it, a welcome message reads 'Welcome (THTCTY1) TRINITY HOSPITAL TWIN CITY'. A navigation bar contains links for 'Payment Innovation Reports', 'Episode Claim Search', and 'CPC Performance'. The main heading is 'Payment Innovation', followed by the instruction 'Please select one of the panel options'. Below this, there are three links: 'Payment Innovation Reports' (highlighted with an orange arrow), 'Episode Claims', and 'CPC Performance'. At the bottom right, it says 'Powered by Gainwell Technologies'.

- Selecting 'Payment Innovation Reports' from the Self-Service menu directs you to the Haven portal where you can access the Payment Innovation Reports by clicking on the hyperlink listed

Revalidation/ Reenrollment

Revalidation/Reenrollment - Homepage

My Providers Select Provider Pending Agent Requests Account Administration												New Provider ?
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/> <input type="button" value="Y"/>	<input type="text"/> <input type="button" value="Y"/>	All <input type="button" value="v"/>	<input type="text"/> <input type="button" value="Y"/>	<input type="text"/> <input type="button" value="Y"/>	<input type="text"/> <input type="button" value="Y"/>	All <input type="button" value="v"/>	<input type="text"/> <input type="button" value="Y"/>	<input type="text"/> <input type="button" value="Y"/>	<input type="text"/> <input type="button" value="Y"/>	<input type="text"/> <input type="button" value="Y"/>	<input type="text"/> <input type="button" value="Y"/>	<input type="text"/> <input type="button" value="Y"/>
519470	Training Mental Health Provider	Complete	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro				04/25/17	04/25/17	04/25/22

- Make note of the Revalidation Due Date on the far-right column
- If within 120 days of Revalidation Due Date, the option to begin a revalidation/reenrollment will be present
- Revalidation/Reenrollment is required to be completed by all providers:
 - For credentialed providers, every three (3) years
 - For non-credentialed providers, every five (5) years
- To begin the Revalidation/Reenrollment process, access the 'Manage Application' section by clicking either on the Reg ID or Provider Name hyperlink

Initiating Revalidation/Reenrollment

- Select the '+' icon to expand the section titled 'Enrollment Actions'
- Click the hyperlink for 'Begin Revalidation'
- The file will open to the first page: Provider Information

Manage Application

Enrollment Actions



Enrollment Action Selections:

Programs



Program Selections:

Self Service



Self Service Selections:

Enrollment Actions



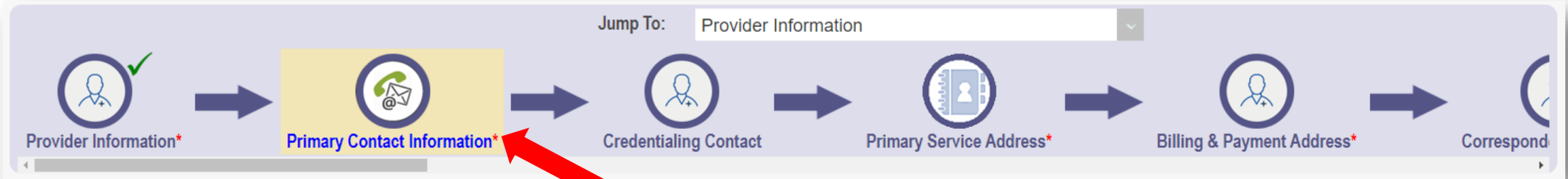
Enrollment Action Selections:

[Begin Revalidation](#)

[Edit Key Provider Identifiers](#)

[Request Disenrollment](#)

Revalidation - Navigation



- A navigational bar appears at the top of the application allowing you to view which page you are actively working (highlighted)
- 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*)

Provider Information

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- Click 'Next' to save the information and proceed to the next page

Provider Information

This is a required section.



Name of Business Entity*

Training Mental Health Provider

DBA

Practice Type*

REHABILITATION

Ownership Type*

DOMESTIC PROFIT LIMITED LIABILITY COMPANY

Tax ID*

564564564

NPI

1164846499

NPI Start Date

02/06/2014

Provider Type*

84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER

Revalidation Date

Not Set Yet

Enrollment Status

ACTIVE

Enrollment Status Reason

ACTIVE

Save

Cancel

Next

Primary Contact Information

Primary Contact Information

This is a required section.

Save

Cancel

Previous

Next

History

Name* Tom Trainer

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) 555-4321

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* trainer@trainingclinic.com

Email Address 2

Office Manager

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- Click 'Next' to save the information and proceed to the next page

Primary Service Address

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- Click 'Next' to save the information and proceed to the next page



Primary Service Address

This is a required section.

Save

Cancel

Previous

Next

History

Organization Name*

Training Mental Health Provider

Primary Service Address*

2400 CORPORATE EXCHANGE DR

Address 2

City*

COLUMBUS

State*

OH

County

Franklin County

Zip*

43231

Ext Zip*

7605

Border State

No

Phone Number 1*

(614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

trainer@trainingmentalhealth.com

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 housed in a public-facing Provider Directory through 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

☐ 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

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.

Save

Cancel

Previous

Next

History

Same as Practice Location ☐

Address Type ☐ Individual ☒ Organization

Organization Name* Training Mental Health Provider

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) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name



Email Address 1* trainer@trainingmentalhealth.com

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- Click 'Next' to save the information and proceed to the next page

Correspondence Address

Correspondence Address

This is a required section.



Save

Cancel

Previous

Next

History

Same as Practice Location

Address Type

☐ Individual ☒ Organization

Organization Name*

Training Mental Health Provider

Address 1*

2400 CORPORATE EXCHANGE DR

Address 2

City*

COLUMBUS

State*

OH

County

Franklin County

Zip*

43231

Ext Zip*

7605

Phone Number 1*

(614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

trainer@trainingmentalhealth.com

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- Click 'Next' to save the information and proceed to the next page

Other Service Locations

- This section asks you to include details for any other service locations that bill/will bill under the same Medicaid ID
- To skip this section, click ‘Next’ to move to the next page
- If you wish to update existing information, click the ‘pencil and paper’ icon to edit
- If you wish to add new information, click ‘Add New’

Other Service Locations

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

Save

Cancel

Previous

Next

*Please enter Other Service locations that bill/will bill under the same Medicaid ID

Additional Practice Name	Additional Practice Address	Additional Practice Phone Number	
Location II	1000 N HIGH ST COLUMBUS, OH 43201- 2410	(614) 555-4321	

Add New

History

Other Service Locations

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

Save

Cancel

Previous

Next

*Please enter Other Service locations that bill/will bill under the same Medicaid ID

No additional practice locations found.

Add New

Other Service Locations cont'd

- Located below the Other Service Location information, you can enter additional details about your practice location (*this information is not required*)
- Can enter details about:
 - Provider Information
 - Hours of Operation
 - Office Information
 - Patient Information
- This information will be housed in a public-facing Provider Directory through PNM (*and MCP Directory, if you are enrolled with MCP*)
- **Note:** If you do not wish to have the location be a part of the Directory, you can **opt out** by clicking box at the top
- Click 'Next' to save and proceed to the next page

☐ 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

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

1099 Address

1099 Address

This is a required section.

Save

Cancel

Previous

Next

History

Same as Practice Location ☐

Address Type ☐ Individual ☒ Organization

Organization Name* Training Mental Health Provider

Address 1* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County Franklin County

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Email Address 1* trainer@trainingmentalhealth.com

IRS Tax Type ☐ SSN ☒ FEIN

IRS Tax ID 564564564

Tax Exempt ☐ Yes ☒ No

W9 Form ☐ Yes ☒ No

Form 147 ☐ Yes ☒ No



- Review the information on the page to determine accuracy
- Change or update any information that is not current
- Click 'Next' to save the information and proceed to the next page

Home Office Address

Home Office Address

This is a required section.

Save

Cancel

Previous

Next

History

Same as Practice Location

☐

Address Type

☐ Individual ☒ Organization

Organization Name*

Training Mental Health Provider

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) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1*

trainer@trainingmentalhealth.com



- Review the information on the page to determine accuracy
- Change or update any information that is not current
- Click 'Next' to save the information and proceed to the next page

Specialties

This is a required section.

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

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status		
842 Community Mental Health Professional Medicare Cro	Yes	05/06/2022	12/31/2299	ACTIVE		

[Add New](#)[History](#)

- Review the information on the page to determine accuracy
- If you wish to update an existing specialty, click the 'pencil and paper' icon to edit
- To remove a specialty, click the 'x' associated with the applicable specialty line
- If you wish to add a new specialty, click 'Add New'
- Click 'Next' to save the information and proceed to the next page

Taxonomies



This is a required section.

Save

Cancel

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

Add New

History

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- To edit a taxonomy, click on the 'pencil and paper' icon and update the information
- To remove a taxonomy, click the 'x' associated with the taxonomy
- Click 'Next' to save the information and proceed to the next page

Professional Licenses

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	2400 Corporate Exchange Drive Columbus, OH 43231 Franklin County			

Add New

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- To edit a license, click on the ‘pencil and paper’ icon and update the information
- To remove a license, click the ‘x’ associated with the license
- Click ‘Next’ to save the information and proceed to the next page
- A copy of each license must be uploaded to the page


Medicare Number

Medicare Number


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

SaveCancelPreviousNext

Medicare Number

Medicare Number	NPI	Medicare Enrollment Status	Medicare Enrollment Date
4534534534354		Completed	

Add NewHistory



Medicaid

No Other State Medicaid Number found



Add New

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- To edit a Medicare or Medicaid number, click on the 'pencil and paper' icon and update the information
- If you wish to add a new Medicare or Medicaid Number, click 'Add New'
- Click 'Next' to save the information and proceed to the next page

Behavioral Health Information

- Review the Behavioral Health information on the page to change or update:
 - Behavioral Health Certification Date
 - Certification Type
 - Interim
 - Full Certification
 - Certification Type
 - Yes or No
 - Fill in the blank
- Click 'Next' to save and proceed to the next page

Behavioral Health Information
This is a required section.



Behavioral Health Information

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

Behavioral Health Certification Date

Certification Type

Do you offer emergency appointments (within 24 hours of call)? ☒ No ☐ Yes

Do you treat younger children (age 0-5)? ☒ No ☐ Yes

Do you treat older children (age 6-12)? ☐ No ☒ Yes

Do you treat adolescents (age 13-20)? ☐ No ☒ Yes

Do you treat adults (age 21-65)? ☐ No ☒ Yes

Do you treat geriatric patients (age 65 and older)? ☐ No ☒ Yes

Do you provide family therapy? ☐ No ☒ Yes

Do you provide group therapy? ☐ No ☒ Yes

Do you provide crisis evaluation/intervention services? ☒ No ☐ Yes

Are you available to see clients at least 4 full days a week? ☐ No ☒ Yes

What is the average waiting time to obtain an appointment?

Do you provide residential treatment for Substance Use Disorder? ☒ No ☐ Yes

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

Do you provide residential treatment for serious Mental Health conditions? ☒ No ☐ Yes

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

Save

Cancel

Previous

Next

Group, Organizations & Hospital Affiliations

Group, Organizations & Hospital Affiliations

This is a required section.

Save

Cancel

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Individual Providers Associated with Your Group



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

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

Always verify that NPI you enter for Individuals are correct.

Display Active Only ☐ Yes ☒ No

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status	Revalidation Due Date	Medicaid ID	Rendering Location	Directory OptOut		
Dale Ada	1669862637	CLINICAL COUNSELING	LICENSED PROFESSIONAL COUNSELOR	5/16/2022	12/31/2299	Confirmed	2023-06-30	0195728	2400 CORPORATE EXCHANGE DR			

Add New

History

Affiliation Status Definitions

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

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

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

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

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

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

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

Member Not Found - The individual provider cannot be found.

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

- Change or update any information that is not current
- To edit an affiliation, click on the 'pencil and paper' icon and update the information
- To add any new group or hospital provider affiliations, click 'Add New'
- Click 'Next' to save the information and proceed to the next page

Professional Liability Insurance

Professional Liability Insurance

This is a required section.

Save

Cancel

Previous

Next

History

Carrying malpractice insurance?	Policy Number	Effective Date	Expiration Date	Policy Holder	Coverage Account Per Occurrence	Coverage Account Per Aggregate	Explanation regarding malpractice insurance
Yes	34534543543	01/01/2020	01/01/2025	Test Policy Holder	3,000,000	5,000,000	

Add New

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- To edit Professional Liability Insurance information, click the ‘pencil and paper’ icon
- To add Professional Liability Insurance information, click ‘Add New’
- Click ‘Next’ to save the information and proceed to the next page

W9 Form

This is a required section.

Save

Cancel

Previous

Next

Information from the Identification page displayed below.

Corrections to this information must be made in Organization/Individual Identification and Primary Contact sections of the Identification page.

Legal Business Name: Training Mental Health Provider

EIN: 564564564

Select the most appropriate category below:

- ☐ Individual/sole proprietor of single-member LLC
- ☐ C Corporation
- ☐ S Corporation
- ☐ Partnership
- ☐ Trust/Estate
- ☐ Limited Liability C Corporation
- ☐ Limited Liability S Corporation
- ☒ Limited Liability Partnership
- ☐ Other

Indicate the form you are uploading

- ☒ W9
- ☐ Form 147

** Please visit <https://www.irs.gov/forms-pubs/about-form-w-9> to obtain a copy of the W9 with instructions.

Required Document

W-9

W9.pdf

[Download](#)



[Remove](#)

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- Upload the document by clicking 'Browse,' locate the document on your computer, 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

- Review the information on the page to determine accuracy
- Change or update any information that is not current
- To edit Banking Information or EFT Contact details, click on the 'pencil and paper' icon and update the information
- Click 'Next' to save the information and proceed to the next page

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


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

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

EFT Contact

Provider Contact Name	Phone Number	Ext	E-mail Address	
Tom Trainer	(614) 555-4321		trainer@traininghospital.com	

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.

56

Revalidation/Reenrollment

Application Fee

- An application fee will be required to be paid during revalidation
- Select the 'Payment Type'
- If you are requesting a waiver of the application fee payment, indicate that via the Payment Type, provide a Waiver Reason and upload a document
- Click 'Next' to save the information and proceed to the next page

Application Fee

This is a required section.

Save

Cancel

Previous

Next

Application Fee

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

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

Fee Amount

\$595.00

Fee Status

Waived

Payment Type

☐ Credit Card

☐ Request Waiver of Application Fee

Authorize Payment

Select Payment

Please note your Registration ID on the check.

Amount*

\$595.00

Waiver Reason

Comments

Fee Payment History

Fee Amount	Fee Status	Status Date	Waiver Reason	Transaction ID
\$	Waived	4/25/2022 3:37:00 PM	PaidinThePast5Years	

Optional Document

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

Proof of Payment.pdf


Download

Remove

Browse

Application Fee

Application Fee
This is a required section.



Application Fee

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

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

Fee Amount

\$595.00

Fee Status

Waived

Payment Type

☐ Credit Card

☐ Request Waiver of Application Fee

Authorize Payment

Select Payment

Please note your Registration ID on the check.

Amount*

\$595.00


Waiver Reason

Comments

Fee Payment History

Fee Amount	Fee Status	Status Date	Waiver Reason	Transaction ID
\$	Waived	4/25/2022 3:37:00 PM	PaidInThePast5Years	

- If Credit Card is selected, click 'Select Payment' to complete the credit card information
- Click 'Submit'
- Click the 'Authorize Payment' button
- Click 'Next' to save the information and proceed to the next page





 BETA

Enter New Account

Name on Card

Card Number

MM/YY



Address Line 1

Address Line 2

City

State

Zip

Country

Phone Number

Email Address

☐ Remember For Future Use

Cancel


Submit

Owner Information

Owner Information
This is a required section.

SaveCancelPreviousNext



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




+ Instructions

+ Definitions & Requirements

- Owner, Managing Employee and Controlling Interest Information

Type	Name	Title	Percentage		
Organization	Training Health LLP		100.00		

Add New

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

+ Real Estate Owners

+ Additional Disclosure

+ Questions

- To expand a section, click the ‘+’ icon. To reduce the section, click the ‘-’ icon
- Review the information on the page to determine accuracy
- Change or update any information that is not current
- To edit an, click on the ‘pencil and paper’ icon and update the information
- To remove an owner, click the ‘X’ associated with the owner

Owner Information

- Questions

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

- ☐ Yes
☒ No

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

- ☐ Yes
☒ No

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

- ☐ Yes
☒ No

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

- ☐ Yes
☒ No

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

- ☐ Yes
☒ No

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

- ☐ Yes
☒ No

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

- ☐ Yes
☒ No

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

- ☐ Yes
☒ No

- Expand the 'Questions' section by clicking the '+' icon
- Review the information on the page to determine accuracy
- Change or update any information that is not current
- **Note:** If 'Yes' is answered, additional information will need to be added/uploaded by clicking 'Add New'
- Click 'Next' to save the information and proceed to the next page

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

- ☒ Yes
☐ No

Please provide the following information about the Subcontractors.

No subcontractors found.

Add New

Required Documents

- The 'Required Documents' page will display with required or optional documents that can be uploaded
- To upload updated documents, 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


Required Documents

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

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

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

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



Uploaded Documents

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

Required Document

ODI (Ohio Department of Insurance) Attestation	
ODI Attestation.pdf	Download Remove
<input type="text"/>	Browse



Required Document

Site Visit/Accreditation	
Site Visit Accreditation.pdf	Download Remove
<input type="text"/>	Browse

Agreements

This is a required section.

SaveCancelPreviousNext



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

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: Test Training

User ID: jamieprov

Save

- Complete the following:
 - Read Ohio Medicaid Provider Agreements
 - Attest to the information submitted on the application
 - Provide 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.

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 400 and Sections 2921.42 and 2921.43 of the Ohio Revised Code, Medicaid requires that providers sign this document and pay a fee.

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 Medicaid Time Limited Provider Agreements

Credentialed Providers

In accordance with Ohio Administrative Code 5160-1-42, providers who are subject to centralized credentialing are required to revalidate/recredential every 36 months. Failure to recredential within 36 months will result in the termination of this provider agreement.

Non-Credentialed Providers

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.

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.

☐ I agree to Terms and Conditions

- This section lists each Ohio Medicaid Provider Agreement
- Use the scroll bars on the right side in each section to navigate, acknowledge the statements, and agree to the terms

Agreements

- Select the checkboxes if you agree to the terms and conditions
- Read the Provision Check and select the checkbox if you meet the provision
 - If you do not meet the provision, leave it blank



I agree to Terms and Conditions



I agree to Terms and Conditions

Agreement Date: 3/14/2022

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

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.

- Read the attestation statement to ensure you understand what you are agreeing to
- Click the checkbox to attest to the information

Provider Agreement Signature

Provider Agreement Signature

Name of Person Attesting*: Tom Trainer ▼

Provider Name: Training Mental Health Provide

User ID: trainingprov

Save

- Provide a digital signature for the application by selecting the following:
 - Name of Person Attesting
 - **Provider Name*
 - **User ID*

**These lines auto-fill*
- Click 'Save' once agreements, attestation, and signature are complete

Submitting Revalidation/ Reenrollment

Submitting Revalidation/Reenrollment

- After you click ‘Save’ and all pages are complete, you will receive a message in a pop-up window
 - Click ‘OK’
- Review any 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



Provider Information*	✓
Primary Contact Information*	✓
Primary Service Address*	✓
Billing & Payment Address*	✓
Correspondence Address*	✓
Other Service Locations	✓
1099 Address*	✓
Home Office Address*	✓
Specialties*	✓

Submitting the Revalidation/Reenrollment

- If you would like a copy for your records, click ‘Generate PDF’ to download a copy of the updated file 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 revalidation/reenrollment, click ‘Submit for Review’

Generate PDF

Submit for Review

Save

Cancel

Previous

Next

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

Ohio

Department of Medicaid

Registration Application Details

Provider Information

Name of Business Entity	Training Mental Health Provider
DBA	
Practice Type	REHABILITATION
Ownership Type	DOMESTIC PROFIT LIMITED LIABILITY COMPANY
First Name	
Tax ID	563453453
NPI	1396220638
NPI Start Date	10/02/2018
Provider Type	OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER
Revalidation Date	
Enrollment Status	Not Set Yet
Enrollment Status Reason	Not Set Yet

Example of pdf

Summary - Updates

- Click either the Reg ID or Provider Name hyperlink to access the 'Manage Application' menu
- Select the '+' icon to expand the section titled 'Enrollment Actions'
- Click the hyperlink for 'Begin ODM Enrollment Profile Update'

My Providers Select Provider Pending Agent Requests Account Administration New Provider ?												
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
519470	Training Mental Health Provider	Complete	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro					05/16/22	

Manage Application

Enrollment Actions

+

Enrollment Action Selections:

Programs

+

Program Selections:

Self Service

+

Self Service Selections:

Enrollment Actions

-

Enrollment Action Selections:

[Begin ODM Enrollment Profile Update](#)

[Add ODA Services](#)

[Edit Key Provider Identifiers](#)

[Request Disenrollment](#)

Summary - Updates

- Click 'Update' for the section you wish to change information
- Complete the new/updated information and click 'Save'
- The navigation bar will display a 'red dot' to indicate the update saved
- To make additional updates, click 'Return to Summary' and repeat the update steps
- Once all updates are made, click 'Submit for Review' to send updates for review

Provider Update - Lets keep your information current !

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



Most Common Updates

[Update](#)[Primary Contact Information](#)[Update](#)[Primary Service Address](#)[Update](#)[Group, Organizations & Hospital Affiliations](#)[Update](#)[Required Documents](#)

Owner Information

[Update](#)[Owner Information](#)[Return to Summary](#)[Generate PDF](#)[Submit for Review](#)[Save](#)[Cancel](#)


Summary – Revalidation/Reenrollment

- Click either the Reg ID or Provider Name hyperlink to access the 'Manage Application' menu
- Select the '+' icon to expand the section titled 'Enrollment Actions'
- Click the hyperlink for 'Begin Revalidation'

My Providers Select Provider Pending Agent Requests Account Administration New Provider ?												
Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	All	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
519470	Training Mental Health Provider	Complete	84 - OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	1164846499		Community Mental Health Professional Medicare Cro				04/25/17	04/25/17	04/25/22

Manage Application

Enrollment Actions

 + Enrollment Action Selections:


Programs

+ Program Selections:

Self Service

+ Self Service Selections:

Enrollment Actions

 - Enrollment Action Selections:
[Begin Revalidation](#)
[Edit Key Provider Identifiers](#)
[Request Disenrollment](#)

Summary – Revalidation/Reenrollment

- Proceed through each page of the file, reviewing the information present
- If changes need to be made, edit the existing information or add new details
- Once all pages have been reviewed, confirm each page has received a green checkmark
- Click 'Submit for Review' to send the revalidation/reenrollment to be looked at



Generate PDF

Submit for Review

Save Cancel Previous Next

Revalidation/Reenrollment occurs:

- *Every three (3) years for credentialed Providers*
- *Every five (5) years for non-credentialed providers*

Thank you!

We welcome your feedback!

Evaluation

Evaluate Course



Please complete the
course evaluation in the
Absorb LMS

Training materials & guides can
be found in the Absorb LMS

For additional questions,
please reach out to us at
ohiotrainingteam@maximus.com