

GO TO [WWW.MEDICAID.OHIO.GOV](http://WWW.MEDICAID.OHIO.GOV) **PUT YOUR CAPS LOCK ON!!!**

Click on the **PROVIDERS** tab, then **Enrollment and Support**, then **Provider Enrollment**. (see screen below)



- **Enroll as a New Provider**
- FAQs for new provider enrollment
- Annual Background Check information
- Revalidate as a Current Provider
- FAQs for provider revalidation
- **Check Provider Enrollment Status**
- Update Demographic Information
- Group Member linkage instructions
- Electronic Visit Verification (EVV)
- Step-by-step instructions for Therapist enrollment

Figure 1: "WELCOME" Panel

Select [I need to enroll as a provider to bill Ohio Medicaid](#)

Select [New Application](#)

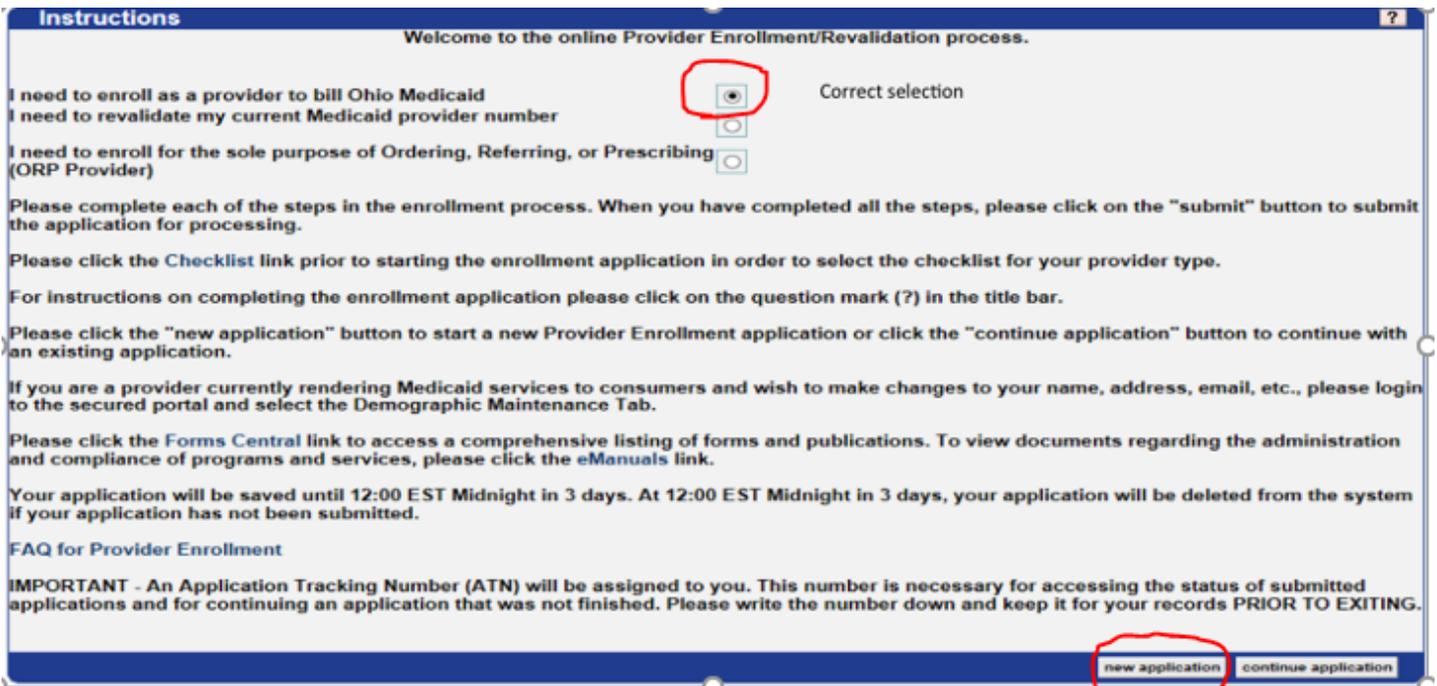


FIGURE 2: “REQUEST TYPE” Panel

Enrollment Type: Select **Individual Practitioner** from drop-down Menu

Action Request: Select **Initial Enrollment** from the drop-down Menu

Provider Type: Select A) **39 - PT**

B) **40 - SLP**

C) **41 - OT**

D) **43 - Audiologist**

Are you a provider new to Ohio Medicaid? Select **YES, NEXT**

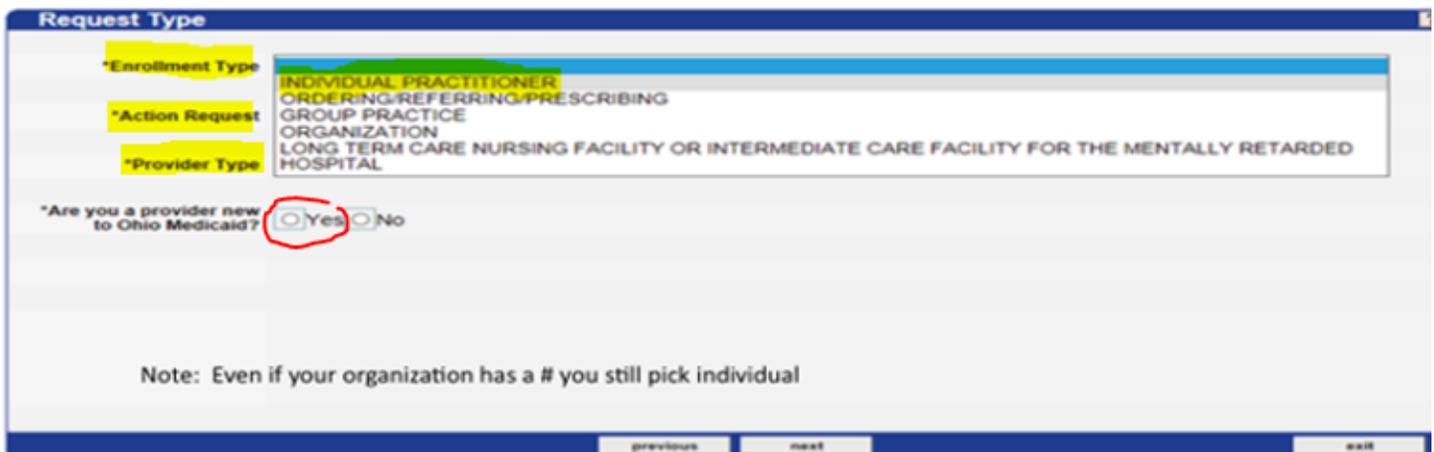


FIGURE 2A (just added in Sept 2017): “MANAGED CARE INTEREST FOR PARTICIPATION” Panel

Are you interested in...: Select **NO, then NEXT**

Instructions > Request type

**Managed Care Interest for Participation** ?

Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans?

Yes  **No**

From the list below, indicate your interest in possible participation with one or more Ohio Medicaid Managed Care Plans

**Managed Care Plans**

**Available Managed Care Plans**

- AETNA BETTER HEALTH OF OHIO
- BUCKEYE COMMUNITY HEALTH PLAN
- CARESOURCE
- MOLINA HEALTHCARE OF OHIO
- PARAMOUNT ADVANTAGE
- UNITEDHEALTHCARE COMM. PLAN OF OHIO

**Selected Managed Care Plans**

Please note: This indication does not ensure a contract with the Ohio Medicaid Managed Care Plans. Providers must still go through the plans' contracting and/or credentialing process, if applicable

previous next exit

Figure 3: “IDENTIFYING INFORMATION” Panel

Enter **Individual Last Name**

Enter **First, MI**

**Check box** for “Medicare Participation Exemption” (unless you independently provide and bill services for Medicare)

**SKIP TO “Ownership Type”**

**Ownership Type:** Select **Sole Proprietorship**

Enter **Title/Degree** (as much of it until you run out of space), **SSN, Gender, Date of Birth**

Enter Place of Birth information: **Country, City, State** (enter NA if not applicable), and **NPI Number**

**NPI Verified:** Enter **Yes**

Enter **Ohio License Number, License Type, License Original Issue Date, and License Expiration Date** (If you don't have this information readily available, you can pull it up on the License Search sites. OT/PT will go to [https://elicense.ohio.gov/oh\\_verifylicense?firstName=emily&lastName=lazar&licenseNumber=&searchType=individual](https://elicense.ohio.gov/oh_verifylicense?firstName=emily&lastName=lazar&licenseNumber=&searchType=individual),

and SLP and Audiologists go to <https://license.ohio.gov/lookup/default.asp>, **NEXT**

After you click NEXT, your **APPLICATION TRACKING NUMBER (ATN)** will show up in a pop-up. **VERY IMPORTANT TO WRITE DOWN THIS NUMBER!!!**

Figure 4: "TAX ID-1099 INFORMATION" Panel

- IRS Tax Type: Select **SSN** from drop-down
- IRS Tax ID: **Enter your SSN**
- Fill out **Name, Address 1, City, Zip**
- IRS Effective Date: **Enter your date of birth**
- IRS End Date: **Enter 12/31/2299** if not auto-populated
- Tax ID Exempt: **NO**
- W9 Form: **YES**
- Form 147: **NO**
- State: **OH, NEXT**

*If you are not able to enter any information after IRS Tax ID, you can skip this section by clicking NEXT.*

Page 4 of 17 - Please make note of your **ATN: 172687**

Figure 5: “DEA” Panel & Figure 7: “DEA Panel

**This does not apply to PT/OT/SLPs or Audiologists** - Click **NEXT**

Page 5 of 17 - Please make note of your ATN: 172687

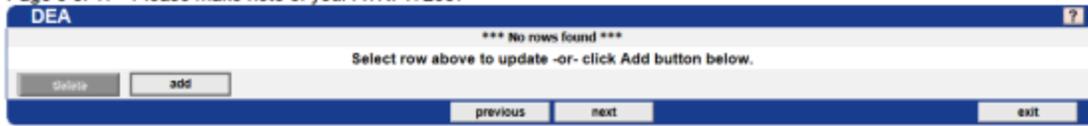


Figure 6: “Address Information” Panel

Enter **DISTRICT** Address, Phone, and your Work Email **4 times**

Under Address Type: Add Address for each one - A) **Home/Corp Office**

B) **Mail to/Correspondence**

C) **Pay To**

D) **Practice Location**

Contact Name: **Enter Your name, Phone**

MUST have email address and contact name in every field. (If you have any blank lines, you will need to Delete them before clicking “NEXT”) **NEXT**

The screenshot shows the "Address Information" panel. It contains a table with the following data:

Address Type	Address 1	City	State	Zip	E-Mail Address	Phone 1
HOME/CORP OFFICE	123 E MAIN ST	COLUMBUS	OH	43215	CONTACT@EMAILADDRESS.COM	(814)012-3456
MAIL TO/CORRESPONDENCE	123 E MAIN ST	COLUMBUS	OH	43215	CONTACT@EMAILADDRESS.COM	(814)012-3456
PAY TO	123 E MAIN ST	COLUMBUS	OH	43215	CONTACT@EMAILADDRESS.COM	(814)012-3456
PRACTICE LOCATION	123 E MAIN ST	COLUMBUS	OH	43215	CONTACT@EMAILADDRESS.COM	(814)012-3456

Below the table is the instruction: "Type data below for new record." There are "delete" and "add" buttons. The form fields are:

- Address Type: HOME/CORP OFFICE (dropdown)
- \*Address 1: 123 E MAIN ST
- Address 2: (empty)
- \*City: COLUMBUS
- \*County: FRANKLIN (dropdown)
- \*State: OH (dropdown)
- \*Zip: 43215
- \*E-Mail Address: CONTACT@EMAILADDRESS.COM
- \*Contact Name: CONTACT NAME
- \*Phone 1: (614)012-3456, OFFICE (dropdown)
- Phone 2: (empty), CELL PHONE (dropdown)
- Fax 1: (empty)
- Fax 2: (empty)
- TDD: (empty)

Figure 7: “TYPE AND SPECIALTY” Panel

Select a **Specialty** from the drop-down menu  
**Check box** for “Primary Specialty”  
Click **NEXT**

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Specialty Desc	Primary?	Primary Taxonomy Code
391-Physical Therapy	No	

You may choose additional specialties from the list that you are licensed and/or authorized to provide.

delete    add

Provider Type: PHYSICAL THERAPIST, INDIVIDUAL

\*Specialty: 391-Physical Therapy

Primary Specialty?

Primary Taxonomy Code: [ ] [ Search ]

Ancillary Taxonomy Code: [ ] [ Search ]

Ancillary Taxonomy Code: [ ] [ Search ]

Ancillary Taxonomy Code: [ ] [ Search ]

previous    next    exit

Figure 8: “LANGUAGE” Panel

Select **Add**  
Select a **Language** (English)  
Enter Effective Date (use **01/01/2017**)  
Click **NEXT**

Page 8 of 17 - Please make note of your ATN: 244666

Language

\*\*\* No rows found \*\*\*

Select row above to update -or- click Add button below.

delete    add

previous    next    exit

Figure 9: “GROUP AFFILIATIONS” Panel

Click **Next** (no longer need to affiliate with each school)

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Group ID	Group Type	Group Name	Effective Date	End Date
012345				

Type data below for new record.

Are you affiliated with a group practice or practices? If so, complete the fields below for each group affiliated.

delete    add

\*Group ID: 012345

\*Effective Date: 01/01/2017

Group Name

\*End Date: 01/01/2025

previous    next    exit

Figure 10: “CRIMINAL OFFENSE AND EXCLUSION” Panels

Click **NO**, then **NEXT** (for the next 3 to 6 screens depending on discipline)

Page 10 of 17 - Please make note of your ATN: 244666

### Criminal Offense I

Answer	Name	Role	Offense	Disposition	Date of Offense	SSN/FEIN
--------	------	------	---------	-------------	-----------------	----------

delete      add

Type data below for new record.

\*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?

Yes  No

Name

Offense

Type

SSN/FEIN

Role

Disposition

Date of Offense

previous      next      exit

Next Screen: Have you ever been issued a Provider Number?

Select **NO** for New Applications/Continued Applications

Figure 11: "CERTIFICATION" Panel

Legal Entity Name: **Enter Therapist Name**  
**Individual Last Name**

**First, MI**  
**Enter Address** (if not already populated)  
**Enter Email Address** (use personal email address)  
Preferred Contact Method: Select **Email**

**Read and accept all terms**  
*You will need to scroll down on Term 3 and others before you will be able to Select I accept.*

The screenshot shows a 'Certification' form with the following sections:

- Legal Entity Name:** A text box containing 'ENTER YOUR NAME HERE'. Below it is a note: 'Legal Entity Name must match the legal Entity Name as it appears on RS documentation such as the W-9, RS 147 or IRS CP578'.
- Individual Last Name:** A text box containing 'LAST NAME'. Below it are two smaller text boxes for 'First, MI' containing 'FIRST NAME' and an empty space.
- Enrollment Checklist:** A link to ensure a complete provider enrollment request.
- Legal Provider Primary Practice Address:** Fields for 'Address 1' (123 E MAIN ST), 'Address 2', 'City' (COLUMBUS), 'State' (OH), and 'Zip' (43215). Below these is an 'E-Mail Address' field (CONTACT@EMAILADDRESS.COM) and a 'Preferred Contact Method' dropdown menu set to 'E-mail'.
- All Providers must read the statements below and agree to the terms**
- Executive Order 2007-01S Agreement:** A paragraph of text followed by two radio button options: 'I do not accept the terms and conditions' and 'I accept the terms and conditions'. A red circle highlights the 'I accept' option. To the right is a scroll bar with a red circle around it.
- False Statement Agreement:** A paragraph of text followed by two radio button options: 'I do not accept the terms and conditions' and 'I accept the terms and conditions'. A red circle highlights the 'I accept' option. To the right is a scroll bar with a red circle around it.

Applicant must drag the scroll bar down to the bottom and indicate they have read all 16 items

Figure 12: "TERMS AND CONDITIONS" Panel, continued

**Check box** for "I have read the contents..."  
**Type Full Name** Here

Ohio Medicaid 5-Year Time Limited Provider Agreement

9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.

10. Provide to ODM, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Ohio Department of Medicaid, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".

11. Comply with the licensure directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d). This provider agreement may be canceled by either party upon 30 days written notice prior to termination date. 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.

I do not accept the terms and conditions

I accept the terms and conditions

Agreement Date 02/29/2016

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.

\*Type Full Name Here TYPE YOUR NAME HERE 02/29/2016

previous next exit

Figure 13: "PROVISION CHECK BOX (for retroactive billing)

Provision/Check: **Check box**  
**Type Full Name Here**

the Ohio Medicaid program. Full cooperation includes, but is not limited to, making yourself and your records available upon request.

15. This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.

16. 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 do not accept the terms and conditions

I accept the terms and conditions

Agreement Date 09/06/2016

If you meet this provision, please check the box

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.

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.

\*Type Full Name Here ILENE WEAVER 09/06/2016

previous next exit

Figure 14: "DOCUMENT SUBMISSION TYPE AND NOTES" Panel "Information" Panel

Document Submission Type: **Upload** (W-9 will be uploaded on next screen after you "Submit")  
 Click **Submit**

**Document Submission Type and Notes**

As part of submitting your application, you will be required to submit supporting documents. Please identify the method: mailing or uploading, for submitting your documents.

\*Document Submission Type U - Upload

Please enter any other additional information that you believe should be considered in reviewing your application. Do not enter questions here. Notes are limited to 5000 characters. If you desire to ask additional questions, please click on the Contact Us link and follow the directions.

Click the submit button below to submit your enrollment application for review.

previous submit exit

- Select **SUBMIT**

Figure 15: “SUBMITTED” Panel - APPLICATION SUBMITTED SUCCESSFULLY! If you have not recorded your ATN yet, be sure to record it now. Otherwise, it can only be obtained by calling Provider Support.

**Confirmation of Receipt**

Your revalidation application for WEAVER has been submitted.

Tracking Number: 172687

**IMPORTANT** - This Application Tracking Number (ATN) is necessary for accessing the status of submitted applications and for editing an application that was returned for additional information. Please write this number down and keep it for your records PRIOR TO EXITING.

Status: Application has been submitted and is in process.

\*\*\* Please retain the tracking number for your records. The tracking number will be used as the key for tracking the status of the application. \*\*\*

Please remember to submit the following required documents.

Figure 16: “WHAT’S NEXT” Panel

Click on **Upload required documents**

**WHAT'S NEXT?**

- **Upload required documents.**
- Additional required documents can be mailed or uploaded.
  - A cover page is required for documents that are sent by mail. *Print Cover Page.*
  - Print a copy of the application for your records *Print Application*

For attachments submitted via mail, not electronically attached, please send to the appropriate address below.

Figure 17: “UPLOAD” Panel

Click on the **IRS FORM W-9** (W-9 should include Your Name, Check box for Individual/Sole Proprietor, Your Personal Address, Social Security Number, Signature, and Date.)

Click on **Browse/Choose File**. Then **find and select your saved W-9 form**  
Click **Upload Attachment**

The screenshot shows the 'Attachment Upload' page on the Ohio Department of Medicaid website. At the top, there is a navigation bar with links for 'About ODM', 'Our Services', 'Resources', and 'News & Events'. Below this is a secondary navigation bar with links for 'Home', 'Consumers', 'Providers', 'Acct Firm Setup', 'Trading Partners', 'Public Information', and 'Publications'. The main content area is titled 'Attachment Upload' and contains a table with the following data:

Type of Document	Reference
W-9 FORM (S)	264060
COMBINED - USE THIS SELECTION IF YOU SUBMIT MULTIPLE 'TYPES OF DOCUMENT' IN ONE FILE	264060
OTHER - USE THIS SELECTION IF YOU ATTACH A DOCUMENT NOT LISTED	264060

Below the table, there are instructions: 'Please note the following important parameters when uploading files:'

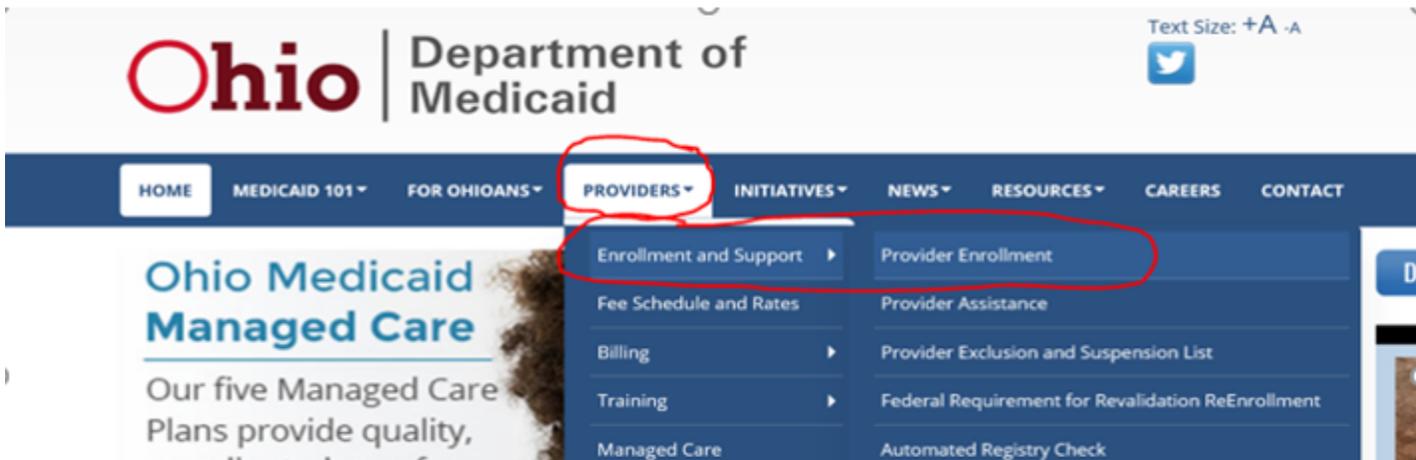
- File size cannot be greater than 50MB (51200KB).
- Only file types of gif, tiff, bmp, jpg, ppt, pptx, doc, docx, xls, xlsx, pdf, txt, and midi can be uploaded.
- For Provider Enrollment attachments: Select row from the list above and then use the below panel to select the file for upload.
- To check status of uploaded attachments for Provider Enrollment, go to the Provider Menu and select Enrollment Tracking Search.

At the bottom of the form, there is a section for uploading a file. It includes a text input field for the file name, which currently contains 'C:\Users\CCESC\Desktop\W-9-BADWAY.pdf', and a 'Browse' button. There is also a small 'upload attachment' button to the left of the input field.

- Print your application for your records

This completes the application process. It is recommended that after you complete the process you check to ensure the application does show as submitted.

Go back to the Main Menu by clicking on **Providers>Enrollment and Support>Provider Enrollment**



Click on **Check Provider Enrollment Status**

- [Enroll as a New Provider](#)
- [FAQs for new provider enrollment](#)
- [Annual Background Check information](#)
- [Revalidate as a Current Provider](#)
- [FAQs for provider revalidation](#)
- [Check Provider Enrollment Status](#)
- [Update Demographic Information](#)

**PUT YOUR CAPS LOCK ON! ENTER ALL DATA IN CAPS**

- Enter your **ATN #**
- Enter Last **Name**
- Click **Search**
- **View the status**

**Enrollment Tracking Search**

\*ATN

\*Business OR Last Name

If you need to find forms to submit with an enrollment please [click here](#)

search

clear

**Search Results**

ATN	Name	Document	Date Received	Status
244666	WEAVER ILENE	ONLINE ENROLLMENT APPLICATION	04/13/2017	SUBMIT
244666	WEAVER ILENE	COMBINED - USE THIS SELECTION IF YOU SUBMIT MULTIPLE "TYPES OF DOCUMENT" IN ONE FILE		OPTIONAL
244666	WEAVER ILENE	OTHER - USE THIS SELECTION IF YOU ATTACH A DOCUMENT NOT LISTED		OPTIONAL
244666	WEAVER ILENE	IRS FORM W-9		NOT RECEIVED

- Print a copy of the application for your records. [Print Application](#)
- Required documents can be mailed or uploaded:
  - Enrollment forms are available on this site.
  - A cover page is required for documents that are sent by mail. [Print Cover Page](#).
  - [Upload required documents](#).

- Look to make sure the online application status says “Submit”.
- Look to make sure the IRS Form W-9 says “Received”. If not Received, click on “upload required documents”. (After clicking, make sure the IRS Form W-9 is highlighted, then go to “Choose File”)

Thursday 04/13/2017 1:34:16 PM

Home Consumers **Providers** Acct Firm Setup Trading Partners Public Information Publications  
 enrollment **enrollment tracking search** long-term care account setup

Ohio Department of Medicaid

**Enrollment Tracking Search** ? ▲

\*ATN

\*Business OR Last Name

If you need to find forms to submit with an enrollment please [click here](#)

**Search Results**

ATN	Name	Document <sup>A</sup>	Date Received	Status
244666	WEAVER ILENE	ONLINE ENROLLMENT APPLICATION	04/13/2017	NOT SUBMITTED

- If it was not submitted, go back to [Enroll as a New Provider](#), Click “Continue Application”.

If you have any issues with the enrollment process or have questions it is recommended that you contact the Ohio Department of Medicaid. 800-922-3042 as soon as the recording starts press 2, then 2 again, then 0. They may ask for an NPI # and Medicaid #. Let them know you don't have the Medicaid # yet.

Remember to check your email on a regular basis (especially if it is your personal email) to see if you receive anything from Medicaid. Remember it can take up to 120 business days to get a response. It is also recommended that you sign in from time to time to check your status.

Once you receive your Medicaid number please contact the appropriate person in your Pupil Services Department, ESC or company with this information. They will provide the information to HBS via spreadsheet so we can update your information in our system.

Support phone line for ODM 800-922-3042 press 2, press 2, press 0

**When submitting the W-9, please be sure to fill out the following information or it won't be accepted, and you won't be assigned a Medicaid number...**

- Fill out Your Name**
- Check box for Ind/Sole Prop**
- Fill out Your Address**
- Fill out your Social Security Number**
- Sign and Date**