
How to enroll a rendering practitioner in Ohio Medicaid

Go to: <https://portal.ohmits.com/Public/Providers/Enrollment/tabId/44/Default.aspx>

FIGURE 1 ENROLL AS A PROVIDER

- Click on “new application” button and proceed to next screen

The screenshot shows a web browser window with the following elements:

- Browser Tabs:** .aspx, Ohio Department of Medicaid ..., Enrollment
- Header:** Ohio Department of Medicaid logo, navigation links (About ODM | Our Services | Resources | News & Events), and a search box.
- Secondary Navigation:** Home, Consumers, **Providers**, Trading Partners, Public Information, Publications. Sub-links under Providers include enrollment, enrollment tracking search, long-term care, and account setup.
- Page Info:** Friday 03/04/2016 10:35:59 AM
- Main Content Area:**
 - Instructions Panel:** A blue-bordered box with a title bar containing "Instructions" and a question mark icon. The text reads: "Welcome to the online Provider Enrollment/Revalidation process." It includes three radio button options:
 - I need to enroll as a provider to bill Ohio Medicaid
 - I need to revalidate my current Medicaid provider number
 - I need to enroll for the sole purpose of Ordering, Referring, or Prescribing (ORP Provider)Below these are several paragraphs of instructions, including a "Checklist" link, a question mark icon in the title bar, and a "new application" button.
 - Footer:** Home | Privacy Statement | Contact Us, AMA & ADA Copyright, Copyright 2012 HP Enterprise Services. All rights reserved.

Figure 2:

- Select “Individual Practitioner” from the “enrollment Type” drop down Menu
- Select “Initial Enrollment” form the “Action Request” drop down Menu

NOTE: Record your Application Tracking Number of “ATN”! If you do not complete the application before submission, the data will be purged from the system within 72 hours.

The screenshot shows a web browser window with the URL 'aolt.aspx' and the page title 'Ohio Department of Medicaid ... Enrollment'. The page features the Ohio Department of Medicaid logo and navigation links: 'About ODM | Our Services | Resources | News & Events'. A search bar is located in the top right corner. Below the logo, there is a navigation menu with 'Home', 'Consumers', 'Providers', 'Trading Partners', 'Public Information', and 'Publications'. The 'Providers' link is highlighted. A secondary menu includes 'enrollment', 'enrollment tracking search', 'long-term care', and 'account setup'. The main content area is titled 'Ohio Department of Medicaid' and contains a 'Request Type' form. The form has the following fields:

- *Enrollment Type**: A dropdown menu with the following options: INDIVIDUAL PRACTITIONER, ORDERING/REFERRING/PRESCRIBING, GROUP PRACTICE, ORGANIZATION, LONG TERM CARE NURSING FACILITY OR INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED, and HOSPITAL.
- *Action Request**: A dropdown menu with the following options: ORDERING/REFERRING/PRESCRIBING, GROUP PRACTICE, ORGANIZATION, LONG TERM CARE NURSING FACILITY OR INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED, and HOSPITAL.
- *Provider Type**: A dropdown menu with the following options: ORDERING/REFERRING/PRESCRIBING, GROUP PRACTICE, ORGANIZATION, LONG TERM CARE NURSING FACILITY OR INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED, and HOSPITAL.
- *Are you a provider new to Ohio Medicaid?**: Radio buttons for 'Yes' and 'No'.

At the bottom of the form, there are 'previous', 'next', and 'exit' buttons. The footer of the page includes 'Home | Privacy Statement | Contact Us', 'AMA & ADA Copyright', and 'Copyright 2012 HP Enterprise Services. All rights reserved.'

Figure 3:

- For example, nursing applicants will select from the “Provider Type” drop down menu “38 – Nurse – RN or LPN”.
- Select the “Yes” radial button for the question “Are you a provider new to Ohio Medicaid”
- Click Next

The screenshot shows a web-based form titled "Request Type" from the Ohio Department of Medicaid. The form is part of an enrollment process, as indicated by the navigation tabs at the top: "enrollment" (highlighted in red), "enrollment tracking search", "long-term care", and "account setup". The form contains the following fields and options:

- *Enrollment Type:** A dropdown menu with "INDIVIDUAL PRACTITIONER" selected.
- *Action Request:** A dropdown menu with "INITIAL ENROLLMENT" selected.
- *Provider Type:** A dropdown menu with "38 - NURSE -- RN OR LPN" selected.
- *Are you a provider new to Ohio Medicaid?:** A question with two radio buttons: "Yes" (which is selected) and "No".

At the bottom of the form, there are three buttons: "previous", "next", and "exit".

Figure 4: Complete the Identifying Information page.

- Enter relevant applicant information. Questions marked with an asterisk are REQUIRED.
- Ownership type: The individual completing this field must decide which option best describes their tax reporting designation. "Individual practitioners" who are employees of a Medicaid enrolled agency and who do not intend to bill Medicaid independently may enter "Unknown".
- Click the next button to proceed to next page.

The screenshot shows the 'Identifying Information' form on the Ohio Department of Medicaid website. The form is titled 'Identifying Information' and contains the following fields:

- *Individual Last Name: WEAVER
- *First, MI: ILENE
- Medicare Type: [Dropdown]
- Medicare Provider Number: [Text]
- Previous Medicaid Provider Number: [Text]
- Certification Number: [Text]
- *Ownership Type: UNKNOWN
- Title/Degree (As appears on license): [Text]
- *SSN: 012345678
- *Gender: FEMALE
- *Date of Birth: 01/01/1956
- Place of Birth:
 - *Country: UNITED STATES
 - *City: COLUMBUS
 - *State (enter NA if not applicable): OHIO
- NPI Associated with SSN: 1234567892
- NPI Verified?: Yes No
- License Number: RN12345
- License Type: OHIO NURSING BOARD
- License Issue Date: 01/01/1975
- License Expiration Date: 10/01/2016

Navigation buttons at the bottom include 'previous', 'next', and 'exit'.

Figure 5: 1099 Tax ID Panel

- Applicant should enter their name. If the applicant is enrolling in Ohio Medicaid as an employee of a Medicaid enrolled agency and does not intend to bill Medicaid independently, enter the full address of their employer.
- The Applicant is required to enter their own social security number. This is a Federal and State requirement.
- This information is kept confidential within MITS and is not part of any publicly available provider lists.

Instructions > Request Type > Identifying Information

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The screenshot shows the 'Tax ID - 1099 Information' panel. The form is titled 'Tax ID - 1099 Information' and contains the following fields:

- *IRS Tax Type: SSN
- *IRS Tax ID: 012345678
- *Name: ILENE WEAVER
- *Address 1: 123 E MAIN ST
- Address 2: [Text]
- *City: COLUMBUS
- *Zip: 43215 9537
- *IRS Effective Date: 01/01/1900
- IRS End Date: 12/31/2299
- Tax ID Exempt?: NO
- W9 Form?: YES
- Form 147?: NO
- *State: OH
- Phone: (614)012-3456

Navigation buttons at the bottom include 'previous', 'next', and 'exit'.

Figure 6: DEA Panel – Does not apply. Click NEXT.

Instructions > Request Type > Identifying Information > Tax ID - 1099 Information

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The screenshot shows a table header with columns 'DEA Number', 'Effective Date', and 'End Date'. Below the header, there is a message: '*** No rows found ***'. Underneath this message, it says 'Select row above to update -or- click Add button below.' There are 'delete' and 'add' buttons. At the bottom of the panel, there are 'previous', 'next', and 'exit' buttons.

Figure 7: NO DEA IS REQUIRED – CLICK NEXT.

Instructions > Request Type > Identifying Information > Tax ID - 1099 Information

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The screenshot shows the same table header as Figure 6. Below the header, it says 'Type data below for new record.' There are 'delete' and 'add' buttons. Below these buttons are three input fields: '*DEA Number', '*Effective Date', and '*End Date'. At the bottom of the panel, there are 'previous', 'next', and 'exit' buttons.

Figure 8: OOPS! I ADDED A LINE ON DEA PAGE

Instructions > Request Type > Identifying Information > Tax ID - 1099 Information

The following messages were generated:

- DEA Number is required.
- Effective Date is required.
- End Date is required.

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The screenshot shows the same table header and input fields as Figure 7. However, there are red exclamation mark icons next to the labels '*DEA Number', '*Effective Date', and '*End Date', indicating that these fields are required but empty. At the bottom of the panel, there are 'previous', 'next', and 'exit' buttons.

Figure 9: NOW IT WON'T LET ME CONTINUE WITHOUT PUTTING IN DEA INFORMATION

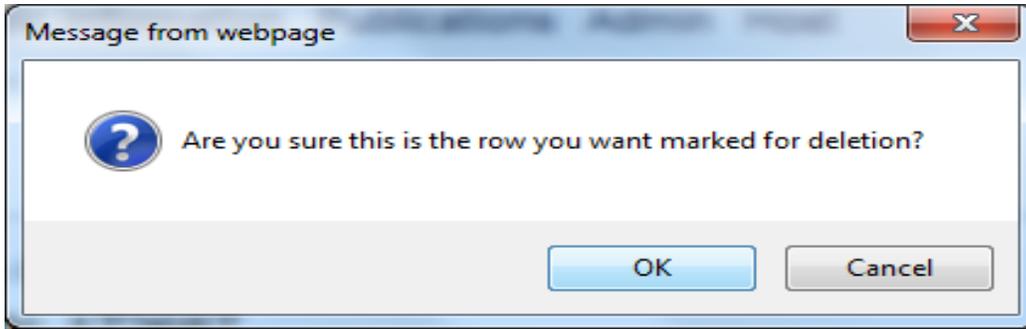


Figure 10: SELECT THE EMPTY LINE AND CLICK "DELETE" BUTTON TO REMOVE

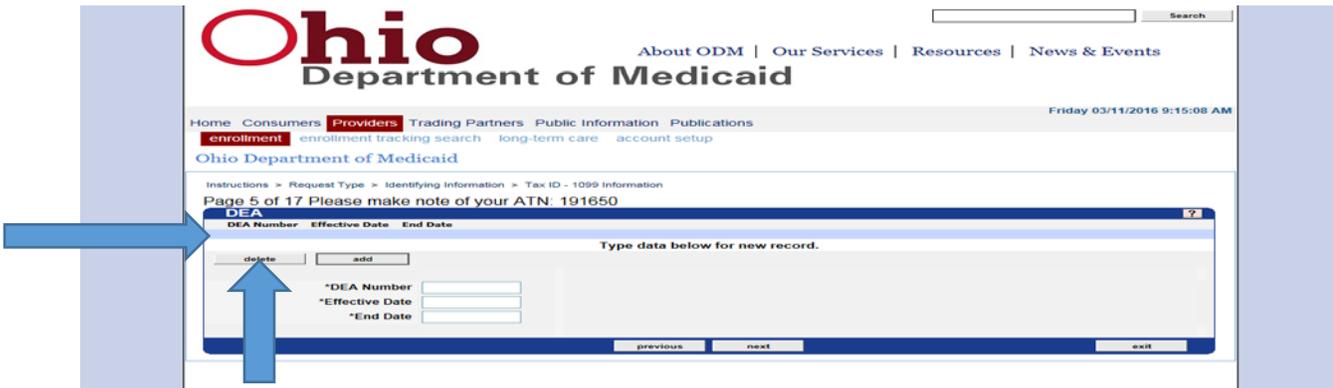


Figure 11: Address Information Panel –

APPLICANT MUST ENTER EMAIL ADDRESS & CONTACT NAME IN EVERY FIELD OR THIS ERROR WILL APPEAR

The following messages were generated:
 Contact Name is required.
 E-Mail Address is required.
 Contact Name is required.
 E-Mail Address is required.
 Contact Name is required.
 E-Mail Address is required.

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Address Information ?

Address Type	Address 1	City	State	Zip	E-Mail Address	Phone 1
HOME/CORP OFFICE	123 E MAIN ST	COLUMBU	OH	43215	CONTACT@EMAILADDRESS.COM	(614)012-3456
MAIL TO/CORRESPONDENCE	6633 MINERAL SPRINGS RD	PEEBLES	OH	45660		(937)587-3067
PAY TO	6633 MINERAL SPRINGS RD	PEEBLES	OH	45660		(937)587-3067
PRACTICE LOCATION	6633 MINERAL SPRINGS RD	PEEBLES	OH	45660		(937)587-3067

Type data below for new record.

delete add

Address Type: MAIL TO/CORRESPONDENCE

*Address 1: 6633 MINERAL SPRINGS RD

Address 2: []

*City: PEEBLES

*County: ADAMS

*State: OH

*Zip: 45660 9537

*E-Mail Address: []

*Contact Name: []

*Phone 1: (937)587-3067 [] CELL PHONE

Phone 2: [] [] CELL PHONE

Fax 1: []

Fax 2: []

TDD: []

previous next exit

Figure 12 ALL LINES HAVE EMAIL ADDRESS AND CONTACT NAME - CLICK NEXT TO CONTINUE

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Address Information ?

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	(614)012-3456
MAIL TO/CORRESPONDENCE	123 E MAIN ST	COLUMBUS	OH	43215	CONTACT@EMAILADDRESS.COM	(614)012-3456
PAY TO	123 E MAIN ST	COLUMBUS	OH	43215	CONTACT@EMAILADDRESS.COM	(614)012-3456
PRACTICE LOCATION	123 E MAIN ST	COLUMBUS	OH	43215	CONTACT@EMAILADDRESS.COM	(614)012-3456

Type data below for new record.

delete add

Address Type: HOME/CORP OFFICE

*Address 1: 123 E MAIN ST

Address 2: []

*City: COLUMBUS

*County: FRANKLIN

*State: OH

*Zip: 43215 []

*E-Mail Address: CONTACT@EMAILADDRESS.COM

*Contact Name: CONTACT NAME

*Phone 1: (614)012-3456 [] OFFICE

Phone 2: [] [] CELL PHONE

Fax 1: []

Fax 2: []

TDD: []

previous next exit

Figure 13a: CHECK PRIMARY SPECIALTY BOX

NOTE: For Behavioral Health LPNs select "SPECIALTY" "385-BEHAVIORAL HEALTH LPN".

The screenshot shows the Ohio Department of Medicaid enrollment system. The page title is "Page 7 of 17 Please make note of your ATN: 201036". The main heading is "Type and Specialty". Below this, there is a table with columns "Specialty Desc", "Primary?", and "Primary Taxonomy Code". The table contains one row with "No" in the "Primary?" column. Below the table, there is a section for "Provider Type" set to "NURSE -- RN OR LPN" and "Specialty" set to "385-BEHAVIORAL HEALTH LPN". The "Primary Specialty?" checkbox is checked. There are also fields for "Primary Taxonomy Code", "Ancillary Taxonomy Code", and "Ancillary Taxonomy Code", each with a "[Search]" button. At the bottom of the form, there are "previous", "next", and "exit" buttons.

Figure 13b: CHECK PRIMARY SPECIALTY BOX

NOTE: For Behavioral Health RN'S select "SPECIALTY" "384-BEHAVIORAL HEALTH RN".

The screenshot shows the Ohio Department of Medicaid enrollment system. The page title is "Page 7 of 17 Please make note of your ATN: 201036". The main heading is "Type and Specialty". Below this, there is a table with columns "Specialty Desc", "Primary?", and "Primary Taxonomy Code". The table contains one row with "No" in the "Primary?" column. Below the table, there is a section for "Provider Type" set to "NURSE -- RN OR LPN" and "Specialty" set to "384-BEHAVIORAL HEALTH RN". The "Primary Specialty?" checkbox is checked. There are also fields for "Primary Taxonomy Code", "Ancillary Taxonomy Code", and "Ancillary Taxonomy Code", each with a "[Search]" button. At the bottom of the form, there are "previous", "next", and "exit" buttons.

Figure 14: - "LEGAL ENTITY" SHOULD BE THE NAME OF THE INDIVIDUAL PRACTITIONER.

- HOWEVER INDIVIDUAL PRACTITIONERS MAY USE THE MAILING ADDRESS OF THEIR EMPLOYING AGENCY.
- EMAIL ADDRESS IS REQUIRED IF "EMAIL" IS THE PREFERRED CONTACT METHOD.
- THE APPLICANT MUST ACCEPT THE TERMS & CONDITIONS.

Certification ?

*Legal Entity Name

Legal Entity Name must match the Legal Entity Name as it appears on IRS documentation such as the W-9, IRS 147 or IRS CP578

*Individual Last Name

First, MI

Click this printable [Enrollment Checklist](#) link to ensure a complete provider enrollment request.

Legal Provider Primary Practice Address:

*Address 1

Address 2

*City

*State

*Zip

E-Mail Address

*Preferred Contact Method

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

Executive Order 2007-01S Agreement

In accordance with Executive Order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (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 Executive Order 2007-01S 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.

I do not accept the terms and conditions

I accept the terms and conditions

A copy of the Executive Order can be found on our website at
<http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx>

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 do not accept the terms and conditions

I accept the terms and conditions

Figure 15: INITIALLY ONLY 3 TERMS ARE VISIBLE. DRAG THE SCROLL BAR DOWN TO THE BOTTOM TO INDICATE THAT THEY'VE READ ALL 11 TERMS

Ohio Medicaid 5-Year Time Limited Provider Agreement

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, state 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, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.
2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.
3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

I do not accept the terms and conditions

I accept the terms and conditions

Agreement Date 02/29/2016

Figure 16: ACCEPT/ATTEST TO TRUE & COMPLETE APPLICATION.

COMPLETE FULL NAME AS THE LEGAL NAME OF THE INDIVIDUAL PRACTITIONER. This is an electronic signature.

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 advance 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 02/29/2016

previous next exit

Figure 17: SELECT DOCUMENT SUBMISSION TYPE.

Electronic "Upload" is suggested, but documents can also be mailed.

ACTUAL DOCUMENT SUBMISSION DESCRIBED ON FIGURE 20.

Page 17 of 18 - Please make note of your ATN: 172687

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

Figure 18: SUBMISSION CAN TAKE 1-2 MINUTES TO COMPLETE

Home Consumers Providers Trading Partners Public Information Publications Admin Host

enrollment enrollment tracking search long-term care account setup

Ohio Department of Medicaid

Instructions > Request Type > Identifying Information > Tax ID - 1099 Information > DEA > Address Information > Type and Specialty > Language > Group Affiliations > Criminal Offense I > Criminal Offense II > Violations of State or Federal Law > Previously Participated > Medicare Sanctions > Addendum C > Certification

Page 17 of 18 - Please make note of your ATN: 172687

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

Figure 19: APPLICATION SUBMITTED SUCCESSFULLY!

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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 20: UPLOAD REQUIRED DOCUMENTATION

FOR EXAMPLE, INDIVIDUAL PRACTITIONERS SHOULD UPLOAD A COPY OF IRS FORM W-9 BEARING THEIR SOCIAL SECURITY NUMBER, SIGNATURE AND DATE.

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.