



Department of Medicaid

John R. Kasich, Governor
Barbara R. Sears, Director

How to enroll as a provider in the Ohio Medicaid program Guidance for Physical Therapists (PT), Occupational Therapists (OT), Speech Language Pathologists (SLP), and Audiologists working under a Medicaid School Program (MSP) May 2017

House Bill 89 (HB89), authorized PT/OT/SLP and Audiology practitioners to make referrals for certain services under the Medicaid School Program (MSP). In order to make a referral for a service, such practitioners are required to enroll with the Ohio Department of Medicaid (ODM) and have an active provider agreement. This guide includes step-by-step instructions for completing the provider enrollment application and offers specific guidance for the practitioners impacted by HB89.

For dates of service July 1, 2017 and after, the National Provider Identifier (NPI) of the practitioner who referred a therapy service under MSP will be required on claims submitted to ODM for reimbursement. Practitioners impacted by HB89 are encouraged to start the provider enrollment application as soon as possible to ensure claim payment is not disrupted. To ensure no delays in processing, provide all required information at the time of application. When an incomplete application is submitted to ODM, it will be returned to the applicant to provide the missing information.

To complete the enrollment application, you must provide the following documentation and identifying information:

- Your Social Security Number (SSN)
- Your National Provider Identifier (NPI)
- Your professional license number with the issue date and expiration date
- Your Medicare Provider ID (If applicable)
- You will be required to upload or mail IRS form W-9 completed with your information. This form may be downloaded from the IRS Website: <https://www.irs.gov/uac/about-form-w9>

Figure 1: ENROLL AS A PROVIDER

Access the Provider Enrollment Portal:

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

- Select “I need to enroll as a provider to bill Ohio Medicaid”
 - PT/OT/ST and Audiology practitioners are not eligible to enroll with Ohio Medicaid as “ORP Providers” because they cannot order or prescribe services. The “ORP Provider” designation is only for physicians and other prescribers who have the full professional scope to order, refer, **and** prescribe services for Medicaid covered individuals.
- Click on “new application” button and proceed to next screen

The screenshot shows a web browser window with the URL <https://portal.ohmits.com/Public/Providers/Enrollment/tabId/44/Default.aspx>. The page header includes the Ohio Department of Medicaid logo and navigation links: About ODM | Our Services | Resources | News & Events. The date and time are Friday 03/04/2016 10:35:59 AM. The main navigation bar includes Home, Consumers, Providers (highlighted), Trading Partners, Public Information, and Publications. Below this, there are links for enrollment, enrollment tracking search, long-term care, and account setup. The main content area is titled "Instructions" and contains the following text:

Welcome to the online Provider Enrollment/Revalidation process.

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)

Please complete each of the steps in the enrollment process. When you have completed all the steps, please click on the "submit" button to submit the application for processing.

Please click the [Checklist](#) link prior to starting the enrollment application in order to select the checklist for your provider type.

For instructions on completing the enrollment application please click on the question mark (?) in the title bar.

Please click the "new application" button to start a new Provider Enrollment application or click the "continue application" button to continue with an existing application.

If you are a provider currently rendering Medicaid services to consumers and wish to make changes to your name, address, email, etc., please login to the secured portal and select the Demographic Maintenance Tab.

Please click the [Forms Central](#) link to access a comprehensive listing of forms and publications. To view documents regarding the administration and compliance of programs and services, please click the [eManuals](#) link.

Your application will be saved until 12:00 EST Midnight in 3 days. At 12:00 EST Midnight in 3 days, your application will be deleted from the system if your application has not been submitted.

[FAQ for Provider Enrollment](#)

IMPORTANT - An Application Tracking Number (ATN) will be assigned to you. This number is necessary for accessing the status of submitted applications and for continuing an application that was not finished. Please write the number down and keep it for your records **PRIOR TO EXITING**.

new application continue application

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Figure 2: "REQUEST TYPE" Panel

- Select "Individual Practitioner" from the "enrollment Type" drop down Menu
- Select "Initial Enrollment" from the "Action Request" drop down Menu

Instructions

Request Type ?

*Enrollment Type: INDIVIDUAL PRACTITIONER
ORDERING/REFERRING/PRESCRIBING
GROUP PRACTICE
ORGANIZATION
LONG TERM CARE NURSING FACILITY OR INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED
HOSPITAL

*Action Request: ORDERING/REFERRING/PRESCRIBING

*Provider Type: HOSPITAL

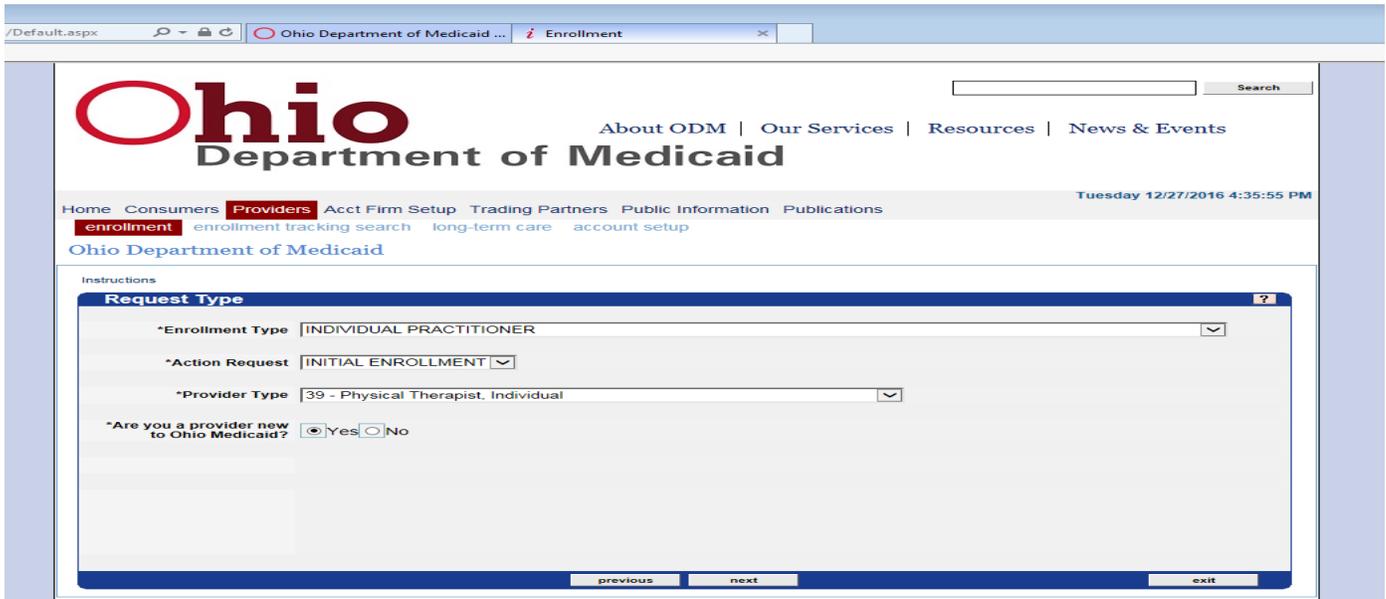
*Are you a provider new to Ohio Medicaid? Yes No

previous next exit

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Figure 3: “REQUEST TYPE” Panel

- Select appropriate provider type from the drop-down menu:
 - Physical Therapist: 39 – Physical Therapist, Individual
 - Speech Language Pathologist: 40 – Speech and Language Pathologist Individual
 - Occupational Therapist: 41 – Occupational Therapist, Individual
 - Audiologist: 43 – Audiologist Individual
- Select the “Yes” radial button for the question “Are you a provider new to Ohio Medicaid?”
- Click “Next”



IMPORTANT NOTE: Record your Application Tracking Number (ATN)! If you do not complete and submit the application within 72 hours, the application will be purged from the system and you will need to start a new application.

Figure 4: “IDENTIFYING INFORMATION” Panel.

- Enter relevant applicant information. Questions marked with an asterisk are REQUIRED.
- When answering the “Medicare Participation Exemption” question, you should consider whether you will ever render and bill Medicare or Medicaid for services delivered to dually eligible individuals (those enrolled in both Medicare and Medicaid) outside of the MSP setting (Ex: working in a different setting when school is not in session). If so, you should **leave this box unchecked**, indicating you are not exempt from Medicare participation.
 - Leaving this box unchecked will prompt you to provide your Medicare ID as issued by CMS’ Provider Enrollment Chain and Ownership System (PECOS). ODM will use this information to verify Medicare enrollment and participation
 - **Check this box** if you render services under MSP and do not work in any other settings where you would render and directly bill Medicare or Medicaid.
- Ownership type: The individual completing this field must decide which option best describes their tax reporting designation. In most cases “Individual practitioners” should enter “Sole Proprietorship.”
 - **Please note:** This designation is made by ODM and is used solely for the purposes of the provider enrollment application. ODM does not report this information to any of the following: Internal Revenue Service, the Ohio Department of Taxation, the Ohio Secretary of State, any city tax office in the state of Ohio or any other business licensing entity. Selecting the “sole proprietor” designation on this application does not, in and of itself, incur a responsibility to this applicant to declare himself or herself to be a sole proprietor in terms of business ownership, nor does it require the applicant to pay additional business expenses or to purchase additional business or health care liability insurance.
- Click the next button to proceed to next page.

Figure 4:

The screenshot shows a web browser window with the URL 'aalt.aspx' and the page title 'Ohio Department of Medicaid ... Enrollment'. The page header includes navigation links: Home, Consumers, Providers, Acct Firm Setup, Trading Partners, Public Information, and Publications. The 'enrollment' link is highlighted. The page content is titled 'Ohio Department of Medicaid' and includes a sub-header 'Instructions > Request Type'. The main form is titled 'Identifying Information' and contains the following fields:

*Individual Last Name	WEAVER
*First, MI	ILENE
Medicare Participation Exemption	<input checked="" type="checkbox"/> By checking this block, I am certifying that I do not provide services to Medicare beneficiaries and that I meet all Medicare participation requirements. I understand that claims submitted for services rendered to Medicare beneficiaries will be denied.
Medicare Type	[Dropdown]
Medicare Provider Number	[Text]
Previous Medicaid Provider Number	[Text]
Certification Number	[Text]
*Ownership Type	SOLE PROPRIETORSHIP [Dropdown]
*Title/Degree (As appears on license)	PHYSICAL THER [Text]
*SSN	012345678
*Gender	FEMALE [Dropdown]
*Date of Birth	01/01/1956
Place of Birth	
*Country	UNITED STATES [Dropdown]
*City	COLUMBUS
*State (enter NA if not applicable)	OHIO
*NPI	1234567892
*NPI Verified?	<input checked="" type="radio"/> Yes <input type="radio"/> No
*License Number	PT012345
*License Type	OCC THERAPY, PHYS THERAPY, AND ATHLETIC TRAINERS BOARD [Dropdown]
*License Issue Date	01/01/2016
*License Expiration Date	12/31/2018

At the bottom of the form are buttons for 'previous', 'next', and 'exit'. Below the form, there are links for 'Home | Privacy Statement | Contact Us', 'AMA & ADA Copyright', and a copyright notice: 'Copyright 2012 HP Enterprise Services. All rights reserved.'

Figure 5: “TAX ID – 1099 INFORMATION” Panel

- Please enter all required fields.
- IRS Effective Date: enter your date of birth.
- Zip code: enter your five digit zip code
- Under State and Federal law, all applicants are required to provide their individual social security number, complete the 1099 information and submit a completed W-9 form. All information is kept confidential within MITS and is not part of any publicly available provider lists.
- Ohio Medicaid requires the completion of the 1099 Tax ID Information for all applicants. If you never bill to Medicaid directly, you will not receive a 1099. Medicaid is required to send a 1099 only if the individual practitioner submits claims and is paid more than \$600 in a given tax year.

Instructions > Request Type > Identifying Information

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

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

Figure 6: “DEA” Panel

- This does not apply to PT/OT/SLP or Audiologists
- Click “next”

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

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

DEA

*** No rows found ***

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

delete add

previous next exit

Figure 7: “DEA” Panel, continued

- This does not apply to PT/OT/SLP or Audiologists
- Click “next”

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

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

The screenshot shows a web browser window titled "DEA" with a question mark icon in the top right corner. The page header includes "DEA Number", "Effective Date", and "End Date". Below the header, there is a section titled "Type data below for new record." with "delete" and "add" buttons. On the left side, there are three input fields: "*DEA Number", "*Effective Date", and "*End Date". At the bottom of the window, there are "previous", "next", and "exit" buttons.

Figure 8: “DEA” Panel error message

- OOPS! I added a line on the DEA page by mistake, how do I remove it?

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.

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

This screenshot is similar to Figure 7 but shows error messages. The "DEA" window title is present. The "Type data below for new record." section has "delete" and "add" buttons. The input fields for "*DEA Number", "*Effective Date", and "*End Date" now have red error icons to their left. At the bottom, "previous", "next", and "exit" buttons are visible.

Figure 9: Now it won't let me continue without putting in DEA information

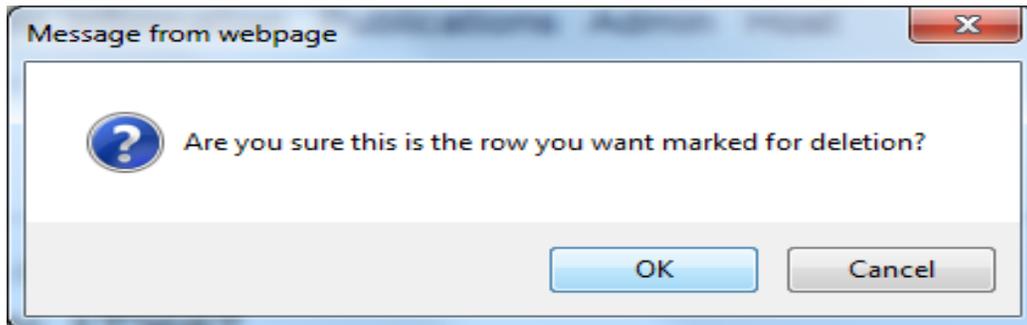


Figure 10: Select the empty line and click “delete button to remove”

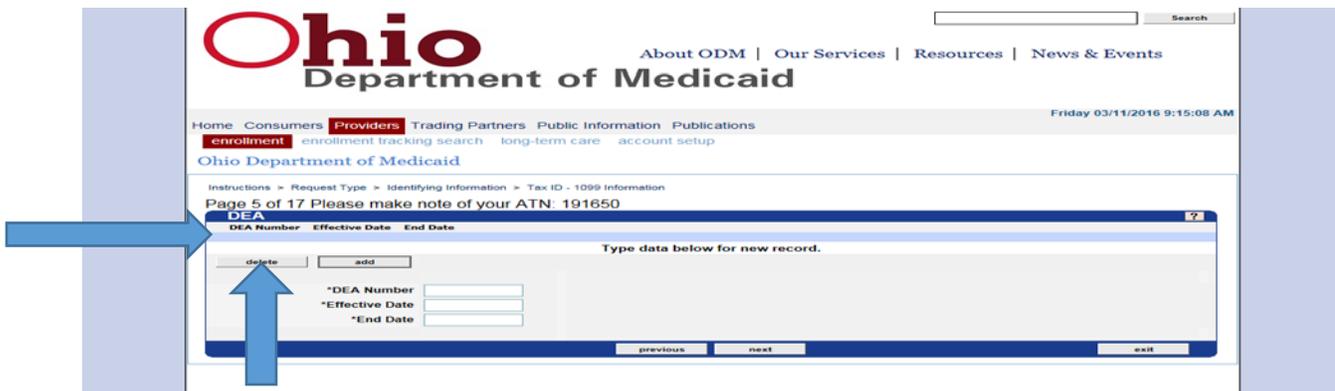


Figure 11: “Address Information” Panel

- Applicant must enter an e-mail address and contact name for each Address Type given – if any of these elements are missing, the below error message 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.

Page 6 of 17 - Please make note of your ATN: 172687

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: "Address Information" panel, continued

- Click "next" to continue

Page 6 of 18 - Please make note of your ATN: 172687

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.

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: [] []

Figure 13: "TYPE AND SPECIALTY" Panel

- Select a specialty from the drop-down menu and check the "primary specialty" box.
- **NOTE:** Select a primary specialty that corresponds with your provider type:
 - Physical Therapist: 391 – Physical Therapy.
 - Occupational Therapist: 410 – Occupational Therapy
 - Speech Therapist: 400 – Speech and Language Pathology
 - Audiologist: 430 - Audiology

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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

Page 7 of 17 Please make note of your ATN: 244666

Type and Specialty

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.

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]

Figure 14: "LANGUAGE PANEL"

- SELECT LANGUAGE



Figure 15: "GROUP AFFILIATIONS" Panel

NOTE: Do not complete this panel. Physical Therapists, Occupational Therapists, Speech Language Pathologists, and Audiologists who are employed by a school and provide services under the MSP are **not required to affiliate** with the MSP provider (the school district).



Figure 16: "CRIMINAL OFFENSE AND EXCLUSION" Panels

- The next series of six panels ask questions pertaining to criminal offences and exclusion history in regard to Medicare participation.

default.aspx Ohio Department of Medicaid ... Enrollment

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Department of Medicaid

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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

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

Figure 17: "CERTIFICATION" Panel

- Applicant must accept the terms and conditions
- Email address is required if "Email" was selected as preferred contact method
- "Legal Entity Name" should be the individual practitioner's name

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 18: “Terms and Conditions” panel

- Initially only 3 terms are visible.
- Applicant must drag the scroll bar down to the bottom and indicate they have read all 16 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 19: “Terms and Conditions” panel, continued

- Applicant must accept/attest that the application is true and complete
- **IMPORTANT – ELECTRONIC SIGNATURE MUST BE THAT OF THE APPLICANT**

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 20: Provision Check box for retroactive billing.

- **Important retroactive billing note:** You may request the effective date of your Medicaid provider enrollment to be retroactive up to twelve months prior to the application date or to the date of your NPI enumeration (whichever comes first). This can only be selected at the time of application and **cannot be changed** once the application has been submitted.
 - Example #1: You submitted your Ohio Medicaid provider enrollment application on June 1, 2017 but obtained your licensure and NPI more than a year prior, on March 15, 2016. By checking the provision box, your provider enrollment will be backdated with an effective date of June 1, 2016.
 - Example #2: You submitted your Ohio Medicaid provider enrollment application on June 1, 2017 and obtained your licensure and NPI on March 15, 2017. By checking the provision box, your provider enrollment will be backdated with an effective date of March 15, 2017.

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

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.

ProvisionCheck 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 21: “Document Submission Type and Notes” Panel.

- Select the method of how you would like to submit required documents

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.

Figure 22: “Document Submission Type and Notes” panel

- Document upload may take 1-2 minutes to complete

Home Consumers **Providers** Trading Partners Public Information Publications Admin Host UAT A (R27.0) Monday 02/29/2016 3:38:29 PM

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.

Figure 23: APPLICATION SUBMITTED SUCCESSFULLY!

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

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 24: UPLOAD REQUIRED DOCUMENTATION

- All practitioners who enroll with Ohio Medicaid are required by state and federal law to provide a completed W-9. The W-9 must contain the **social security number** of the **individual applying**, along with the applicant's signature and date.
- The W-9 form may be uploaded through the secure portal, mailed to ODM, or e-mailed to the address below.
- If any information related to your application needs to be updated and you are not able to do so through the self-service feature, please contact:
MEDICAID_PROVIDER_UPDATE@medicaid.ohio.gov

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.