Ohio | Medicaid Information Technology System

Ohio Medicaid Web Portal
Enrolling Provider Checklists
by Request Type

Ohio Department of Job and Family Services

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General Instructions

1. Review the table of contents to locate the page containing the checklist that pertains to your provider enrollment type.

2. Review the checklist to ensure that you are prepared for the Web Portal enrollment process.

3. To print the individual checklist select File from the menu at the top of the window and click the Print option. The Print popup opens.

4. On the Print popup, in the Print Range area, click the Current page option.

5. Click the OK button to print the selected checklist.

6. Use the checklist to determine you have all required documentation. Do not include the checklist in your application.

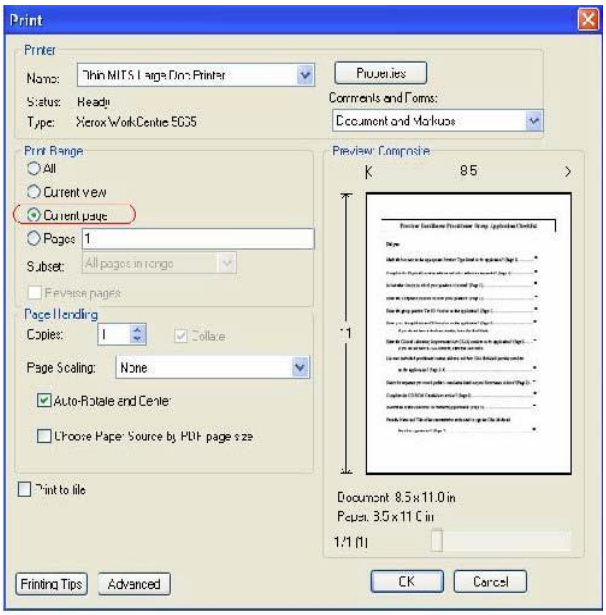

Figure 1. Printing a Checklist on the Print Popup

7. At the end of the online application process, the "Confirmation of Receipt" panel displays:

- Print a copy of the application package for your records by clicking "Print Application".
- Print a cover page to use when mailing documentation by clicking "Print Cover Page".
- Electronically submit the required documents found on the checklists by clicking "Upload required documents".

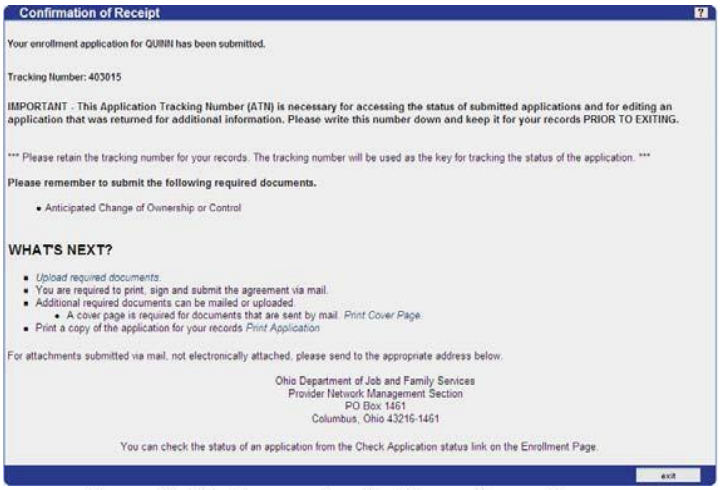

Figure 2. Printing an Application or Cover Page or Uploading Required Documents

If you need assistance completing the application, please call the Provider Enrollment Unit Customer Service Line at 1-800-686-1516. This line is available Monday through Friday from 8:00 am to 4:30 pm.

Nursing Facilities and ICF-MR Facilities, if you need assistance completing the application, please call the Bureau of Provider Services, Network Management Section at 1-614-466-2365, available Monday through Friday from 8:00 am to 4:30 pm.

Provider Enrollment Application Checklist:
Individual Practitioner

Current Ohio Medicaid Individual Practitioners			
Anesthesiologist Assistant	Nurse, RN, LPN	Occupational Therapist	Physician/Osteopath
Chiropractor	Non-Agency Personal Care Aide	Optician	Podiatrist
Clinical Nurse Specialist	Nurse Anesthetist	Optometrist	Psychologist
Dentist	Nurse Midwife	Physical Therapist	Waiver Service Provider
Non Agency HCA (Limited)			

You will need to submit the following documents with your application:

For the following provider types: Anesthesiologist Assistant, Chiropractor, Optician, Optometrist, Physician/Osteopath, and Podiatrist:	**Done**
Signed Provider Agreement	
IRS form W-9 completed with your name, address, Social Security Number, signature, and date	
A copy of the letter/email received from NPPES showing your NPI number	
A copy of your board license indicating the license number and issue date	
A copy of your board license renewal indicating the next license renewal date	
A copy of your DEA certificate (if applicable)	
A copy of the Medicare certification letter (if applicable)	
A copy of your CLIA certificate (if applicable)	

For the following provider types: Physical Therapist, Occupational Therapist, Psychologist:	**Done**
Signed Provider Agreement	
IRS form W-9 completed with your name, address, Social Security Number, signature, and date	
A copy of the letter/email received from NPPES showing your NPI number	
A copy of your board license indicating the license number and issue date	
A copy of your board license renewal indicating the next license renewal date	
A copy of the Medicare certification letter	

For the following provider types: Clinical Nurse Specialist, Nurse Anesthetist, Nurse Midwife, Nurse Practitioner	**Done**
Signed Provider Agreement	
IRS form W-9 completed with your name, address, Social Security Number, signature, and date	
A copy of the letter/email received from NPPES showing your NPI number	
A copy of your board license indicating the license number and issue date	
A copy of your board license renewal indicating the next license renewal date	
A copy of your Certificate of Authority	
A copy of certification as a Nurse Midwife from either American College of Nurse Midwives, The American Midwifery Certification Board, or American College of Nurse Midwives Certification Council (Nurse Midwives Only)	
A copy of certification showing one of the following specialties: Pediatric, Palliative Care, Acute Care, Psychiatric, Gerontological, Adult Health, or Oncology (Nurse Specialists Only)	
A copy of certification showing one of the following specialties: Pediatric, Palliative Care, Acute Care, Psychiatric, Gerontological, Acute Care, Neonatal, OB/GYN, Family, or Adult Practitioner (Nurse Practitioners Only)	

For the following provider types: Non-Agency Personal Care Aide, Non-Agency Home Care Attendant, Waiver Service	**Done**
Signed Provider Agreement	
IRS form W-9 completed with your name, address, Social Security Number, signature, and date	
Copy of Social Security card and government-issued photo ID	
The results of a Criminal Background Check (see next section for details)	
A copy of your certification as a State Tested Nurse's Aide (STNA) (if applicable)	
Copy of First Aid card (for Personal Care Aides and Home Care Attendants)	
Confirmation from Consumer – **JFS 06724** (for Personal Care Aide and Home Care Attendant)	
Documentation of Training if not STNA **JFS 06722** (for Personal Care Aide and Home Care Attendant)	
Home Care Attendant Addendum M **JFS 02391** (for Home Care Attendant)	
Home Care Attendant Skilled Task Authorization – **JFS 02390** (for Home Care Attendant)	
Home Care Attendant Medication Authorization – **JFS 02389** (for Home Care Attendant)	
Proof of vehicle inspection and copy of vehicle liability insurance (Supplemental Transportation)	
Copy of liability insurance (Home Modification)	
A copy of the letter/email received from NPPES showing your NPI number (if applicable)	

Background Checks Required for Ohio Home Care Providers:
Non-agency Ohio Home Care waiver providers for ODJFS (personal care aides, home care attendants, nurses and other waiver service providers) are required to have a criminal background check conducted by the Bureau of Criminal Identification and Investigation (BCI&I). If you have lived in Ohio for at least five years, you are required to have only an Ohio criminal background check. If you have lived in Ohio for fewer than five years, or if you were convicted of a crime in another state, you must request both an Ohio background check and a FBI background check.

The results of your background check must be submitted **DIRECTLY** to ODJFS from BCI&I to the address below. Background checks submitted to us by the Webcheck vendor, local law enforcement agencies, the applicant, or any entity other than BCI&I cannot be accepted. You must provide the address below to the Webcheck vendor when you have your background check completed:

ODJFS
Attn: BCI&I
PO Box 183017
Columbus, Ohio 43218-3017

To obtain a background check, you must go to a location that performs electronic WebCheck background checks for submission to BCI&I. A listing of WebCheck agencies can be found on the Ohio Attorney General's website at the following link: **WebCheck Community Listing**. You may also contact BCI&I by telephone at (877)224-0043.

These forms can be submitted electronically or mailed to the Provider Enrollment Unit:

If the documents are submitted **electronically**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Select the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process.
- Follow the instructions on the screen.

If the documents are submitted by **mail**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Include a Cover Page with: your name; Document Type: Provider; and Application Tracking Number (ATN).

- Mail to the Provider Enrollment Unit at:

  Ohio Department of Job and Family Services
  Provider Network Management Section
  PO Box 1461
  Columbus, Ohio 43216-1461

Print a copy of the application package for your records by clicking “Print Application” on the online “Confirmation Receipt” panel displayed at the end of the enrollment process.

If you need assistance completing the application, please call the **Provider Enrollment Unit Customer Service Line at 1-800-686-1516**. This line is available Monday through Friday from 8:00 am to 4:30 pm.

Provider Enrollment Application Checklist:
Practitioner Group

Current Ohio Medicaid Practitioner Groups			
Dental Group	Professional Medical Group		

You will need to submit the following documents with your application:

Document	Done
Signed Provider Agreement	
IRS form W-9 completed with the group name, address, Tax ID, authorized representative signature, and date	
A copy of the letter/email received from NPPES showing your NPI number	
A copy of the Medicare certification letter (if applicable)	
A copy of your CLIA certificate (if applicable)	

These forms can be submitted electronically or mailed to the Provider Enrollment Unit:

If the documents are submitted **electronically**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Select the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process.
- Follow the instructions on the screen.

If the documents are submitted by **mail**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Include a Cover Page with: your name; Document Type: Provider; and Application Tracking Number (ATN).
- Mail to the Provider Enrollment Unit at:

  Ohio Department of Job and Family Services
  Provider Network Management Section
  PO Box 1461
  Columbus, Ohio 43216-1461

Print a copy of the application package for your records by clicking “Print Application” on the online “Confirmation Receipt” panel displayed at the end of the enrollment process.

If you need assistance completing the application, please call the **Provider Enrollment Unit Customer Service Line at 1-800-686-1516**. This line is available Monday through Friday from 8:00 am to 4:30 pm.

Provider Enrollment Application Checklist:
Hospital

You will need to submit the following documents with your application:

Document	Done
Signed Provider Agreement	
IRS form W-9 completed with the group name, address, Tax ID, authorized representative signature, and date	
A copy of the letter/email received from NPPES showing your NPI number	
A copy of any licenses, certificates, or accreditations as reported in the application	
A copy of the Medicare certification letter (if applicable)	
A copy of your CLIA certificate (if applicable)	
ODH Bed Registration for all Instate (Situational)	
ODMH License for Instate Provider Type 02 (Situational)	
Home State Psychiatric License for Out-of-State Provider Type 02 (Situational)	
Verification of Bed Size document for Out-of-State Provider Type 02 (Situational)	
ODH Nursery Level document for Instate Provider Type 01 (Situational)	

These forms can be submitted electronically or mailed to the Provider Enrollment Unit:

If the documents are submitted **electronically**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Select the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process.
- Follow the instructions on the screen.

If the documents are submitted by **mail**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Include a Cover Page with: your name; Document Type: Provider; and Application Tracking Number (ATN).
- Mail to the Provider Enrollment Unit at:

  Ohio Department of Job and Family Services
  Provider Network Management Section
  PO Box 1461
  Columbus, Ohio 43216-1461

Print a copy of the application package for your records by clicking “Print Application” on the online “Confirmation Receipt” panel displayed at the end of the enrollment process.

If you need assistance completing the application, please call the **Provider Enrollment Unit Customer Service Line at 1-800-686-1516**. This line is available Monday through Friday from 8:00 am to 4:30 pm.

Provider Enrollment Application Checklist:
Organization

Current Ohio Medicaid Organizations		
Ambulance	Home Health Agency	ODMH Certified Community Mental Health Agency
Ambulatory Surgery Center	Hospice	Pharmacy
Ambulette	Independent Diagnostic Testing Facility	Portable C-Ray Laboratory
Assisted Living Waiver Provider	Independent Laboratory	Primary Care Clinic
Durable Medical Equipment	Mental Health Clinic	Professional Dental School Clinic
End Stage Renal Disease Dialysis Clinic	Mental Hospital	Professional Optometry School Clinic
Family Planning Clinic	Medicaid School Program	Rural Health Clinic
Federal Qualified Health Center	Outpatient Health Facility	Targeted Case Management
General Hospital	Outpatient Rehabilitation Clinic	Waiver Service Provider
Hearing and Speech Clinic	ODADAS Certified Licensed Treatment Program	

You will need to submit the following documents with your application:

Document	Done
Signed Provider Agreement	
IRS form W-9 completed with the group name, address, Tax ID, authorized representative signature, and date	
A copy of the letter/email received from NPPES showing your NPI number (if applicable)	
A copy of any licenses, certificates, or accreditations as reported in the application	
A copy of the Medicare certification letter (if applicable)	
A copy of your CLIA certificate (if applicable)	
Proof of vehicle inspection and copy of vehicle liability insurance (Supplemental Transportation)	
Copy of liability insurance (Home Modification)	

These forms can be submitted electronically or mailed to the Provider Enrollment Unit:

If the documents are submitted **electronically**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Select the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process.
- Follow the instructions on the screen.

If the documents are submitted by **mail**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal
- Include a Cover Page with: your name; Document Type: Provider; and Application Tracking Number (ATN).
- Mail to the Provider Enrollment Unit at:

  Ohio Department of Job and Family Services
  Provider Network Management Section
  PO Box 1461
  Columbus, Ohio 43216-1461

Print a copy of the application package for your records by clicking “Print Application” on the online “Confirmation Receipt” panel displayed at the end of the enrollment process.

If you need assistance completing the application, please call the **Provider Enrollment Unit Customer Service Line at 1-800-686-1516**. This line is available Monday through Friday from 8:00 am to 4:30 pm.

Provider Enrollment Application Checklist:

Managed Care Provider

You will need to complete the following in your application:

Document	Done
On the application, provide ALL names, addresses, and legal numbers as required	
On the application, complete ALL date fields	
Authorized representative signed and dated the Application	
Look for notes or directions on the Application that reference attaching required documents	
Double check the Application to make sure all applicable information has been included	
Complete, sign, date, and attach your Form W–9	
Complete, sign, date, and attach your EFT Application with a VOIDED CHECK that includes the account and transit routing/ABA number of the provider's account	

You will need to submit the following documents with your application:

Document	Done
Ohio Medicaid Provider Number Application for Managed Care Plans (either provider type 77 Managed Care Plan or provider type 78 Enhanced Care Management Plan)	
Designation of an 835 or 834-820 Trading Partner	
W-9 Request for Taxpayer Identification Number and Certification	
OBM Authorization Agreement for State Medicaid Payments	

These forms can be submitted electronically or mailed to the Provider Enrollment Unit:

If the documents are submitted **electronically**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Select the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process.
- Follow the instructions on the screen.

If the documents are submitted by **mail**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal
- Include a Cover Page with: your name; Document Type: Provider; and Application Tracking Number (ATN).
- Mail to the Provider Enrollment Unit at:

Ohio Department of Job and Family Services
Provider Network Management Section
PO Box 1461
Columbus, Ohio 43216-1461

Print a copy of the application package for your records by clicking “Print Application” on the online “Confirmation Receipt” panel displayed at the end of the enrollment process.

If you need assistance completing the application, please call the **Provider Enrollment Unit Customer Service Line at 1-800-686-1516**. This line is available Monday through Friday from 8:00 am to 4:30 pm.

Provider Enrollment Application Checklist:
Nursing Facility (NF)

You will need to submit the following documents with your application:

Document	Done
CMS 671 (Long Term Care Facility Application for Medicare and Medicaid)	
Authorization Agreement for State Medicaid Payments (OBM 5678) completed, signed and dated. Be sure to include the requisite banking information as delineated on the form. This form may be submitted to the address given for the Ohio Shared Services on the form once the applicant receives their new Medicaid number.	
Vendor Information Form (Form OBM 5657).	
A completed, signed, and dated, “Request for Taxpayer Identification Number and Certification” (Form W-9).	
A copy of the National Provider Identifier (NPI) assignment notification from the National Plan and Provider Enumeration System (NPPES). The NPI information is required for all NFs.	
A copy of the certificate of need approved by the Ohio Department of Health.	
A copy of the facility license issued by the Ohio Department of Health.	

These forms can be submitted electronically or mailed to the Provider Enrollment Unit:

If the documents are submitted **electronically**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Select the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process.
- Follow the instructions on the screen.

If the documents are submitted by **mail**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal
- Include a Cover Page with: your name; Document Type: Provider; and Application Tracking Number (ATN).
- Mail to the LTC Provider Enrollment Unit at:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Provider Services
Network Management Section
P.O. Box 182709
Columbus, Ohio 43218-2709
ATTN: LTC Enrollment Coordinator

Print a copy of the application package for your records by clicking “Print Application” on the online “Confirmation Receipt” panel displayed at the end of the enrollment process.

If you need assistance completing the application, please call the **LTC Provider Enrollment Unit at 1-614-466-2365**. This line is available Monday through Friday from 8:00 am to 4:30 pm.

Provider Enrollment Application Checklist:
Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

You will need to submit the following documents with your application:

Document	Done
Authorization Agreement for State Medicaid Payments (OBM 5678) completed, signed and dated. Be sure to include the requisite banking information as delineated on the form. This form may be submitted to the address given for the Ohio Shared Services on the form once the applicant receives their new Medicaid number.	
Vendor Information Form (Form OBM 5657).	
A completed, signed, and dated, “Request for Taxpayer Identification Number and Certification” (Form W-9).	
A copy of the National Provider Identifier (NPI) assignment notification from the National Plan and Provider Enumeration System (NPPES). The NPI information is required for all NFs. The NPI information is required for ICFs-MR only if enumeration has been requested and received from NPPES.	
A copy of the Ohio Department of Developmental Disabilities development approval.	
A copy of the facility license issued by the Ohio Department of Developmental Disabilities.	

These forms can be submitted electronically or mailed to the Provider Enrollment Unit:

If the documents are submitted **electronically**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Select the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process.
- Follow the instructions on the screen.

If the documents are submitted by **mail**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal
- Include a Cover Page with: your name; Document Type: Provider; and Application Tracking Number (ATN).
- Mail to the LTC Provider Enrollment Unit at:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Provider Services
Network Management Section
P.O. Box 182709
Columbus, Ohio 43218-2709
ATTN: LTC Enrollment Coordinator

Print a copy of the application package for your records by clicking “Print Application” on the online “Confirmation Receipt” panel displayed at the end of the enrollment process.

If you need assistance completing the application, please call the **LTC Provider Enrollment Unit at 1-614-466-2365**. This line is available Monday through Friday from 8:00 am to 4:30 pm.

Provider Enrollment Change of Operator (CHOP) Checklist:
Nursing Facilities (NFs)
Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

THIS CHECKLIST PRESUMES THAT THE PROPER ADVANCE NOTIFICATION OF A CHANGE-OF-OPERATOR REQUIRED BY OHIO REVISED CODE 5111.67 (http://codes.ohio.gov/orc/5111) WAS PROVIDED TO ODJFS. IF THIS IS NOT THE CASE, PLEASE CONTACT THE CHOP COORDINATOR AT 1-614-466-2365. There are three parts to this checklist. Be sure to check both pages.

1. As the **Entering Operator**, you will need to submit the following documents with the CHOP application. These items apply to both NFs and ICFs-MR unless otherwise stated.

Document	Done
A completed, signed, and dated "Statement of Acceptance and Intent"	
A completed, signed, and dated "Request for Taxpayer Identification Number and Certification" (Form W-9)	
A copy of the National Provider Identifier (NPI) assignment notification from the National Plan and Provider Enumeration System (NPPES). If the entering operator is assuming the exiting operator's NPI, a copy of the correspondence from NPPES confirming the transfer. The NPI information is required for all NFs, and required for ICFs-MR only if enumeration has been requested and received from NPPES.	
A completed, signed, and dated "Authorization Agreement for State Medicaid Payments" (form OBM 5678), including the requisite banking information as delineated on the form. This form may be submitted to the address given for the Office of Budget & Management on the form once the entering operator receives their new Medicaid number.	

2. The following documents are required for the Exiting Operator in order to terminate their enrollment and allow enrollment of the entering operator. These items apply to both NFs and ICFs-MR.

Document	Done
A completed, signed, and dated " Exiting Information And Forwarding Instructions From Long-Term Care Facility Operators/Providers (NFs and ICFs-MR) Discontinuing Participation in the Ohio Medicaid Program" (form JFS 03620)	
One completed, signed, and dated "Request for Taxpayer Identification Number and Certification" (Form W-9). THE COMPLETED FORM MUST BE RETURNED TO THE CHOP COORDINATOR AND MUST BE AN ORIGINAL SIGNATURE DOCUMENT.	
A completed, signed, and dated "Vendor Information Form" (OBM-5657). THE COMPLETED FORM MUST BE RETURNED TO THE CHOP COORDINATOR AND MUST BE AN ORIGINAL SIGNATURE DOCUMENT.	

3. Both the **Entering Operator** and the **Exiting Operator/Owner**, are jointly responsible for providing the following items.

Document	Done
Copies of all final and fully executed documents for the transaction(s) culminating in the CHOP. This includes: • Sales agreements (even if the operator was not the Seller or the Buyer), • Leases, • Assignments of leases, • Merger agreements, and • Other such documents (this includes any management agreements).	

With the exception of the forms requiring original signature and which must be returned to the CHOP Co-coordinator, these forms can be submitted electronically or mailed to the Provider Enrollment Unit:

If the documents are submitted **electronically**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal.
- Select the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process.
- Follow the instructions on the screen.

If the documents are submitted by **mail**:

- Complete the online Provider Enrollment process on the Ohio Medicaid Web Portal
- Include a Cover Page with: your name; Document Type: Provider; and Application Tracking Number (ATN).
- Mail to the Provider Enrollment Unit at:

  Ohio Department of Job and Family Services
  Office of Ohio Health Plans
  Bureau of Provider Services
  Network Management Section
  P.O. Box 182709
  Columbus, OH 43218-2709
  ATTN: CHOP Coordinator

Print a copy of the CHOP package for your records by clicking “Print Application” on the online “Confirmation Receipt” panel displayed at the end of the enrollment process.

If you need assistance completing the application, please call the **CHOP Coordinator in the Bureau of Provider Services, Network Management Section at 1-614-466-2365**. This line is available Monday through Friday from 8:00 am to 4:30 pm.