## **COMMON REVALIDATION ISSUES & RESOLUTIONS**

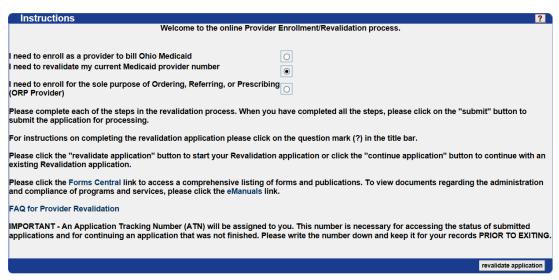


FIGURE 1 I NEED TO REVALIDATE MY CURRENT PROVIDER NUMBER

## The following messages were generated: Can not proceed without a valid ATN. Search \*ATN 172687 \*Business OR Last Name WEAVER Search clear

FIGURE 2 CLICKING NEXT -> CANNOT PROCEED WITHOUT A VALID ATN

next

exit

previous



FIGURE 3 CLICKING SEARCH -> NO ROWS FOUND BECAUSE NAME IS NOT LISTED CORRECTLY ON ATN

FIGURE 4 NAME IS LISTED AS BUSINESS NAME ON PROVIDER FILE & ATN

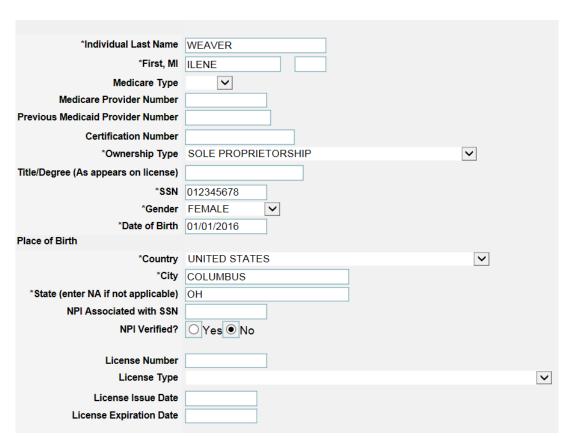


FIGURE 5 OWNERSHIP - SOLE PROPRIETERSHIP - NPI VERIFICATION DOESN'T MATTER - NO NPI IS REQUIRED



FIGURE 6 ALL INDIVIDUAL PROVIDERS SHOULD HAVE AN SSN ON FILE, NOT A TAX ID/FEIN



Figure 7 NO DEA IS REQUIRED - HIT NEXT TO SKIP PAGE

Figure 8 OOPS! I ADDED A LINE ON DEA PAGE

previous

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

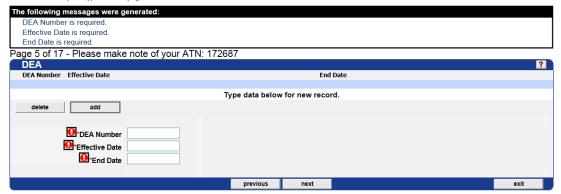


Figure 9 NOW IT WON'T LET ME CONTINUE WITHOUT PUTTING IN DEA INFORMATION

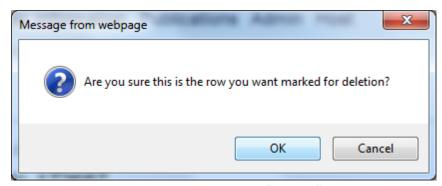


Figure 10 SELECT THE EMPTY LINE AND CLICK "DELETE" BUTTON TO REMOVE

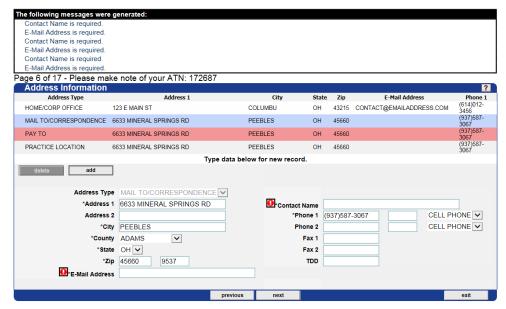


Figure 11 ADDRESS PAGE - ALL LINES MUST HAVE EMAIL ADDRESS & CONTACT NAME ENTERED OR YOU GET THIS ERROR

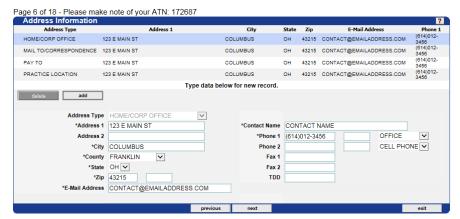


Figure 12 ALL LINES HAVE EMAIL ADDRESS AND CONTACT NAME - CLICK NEXT TO CONTINUE

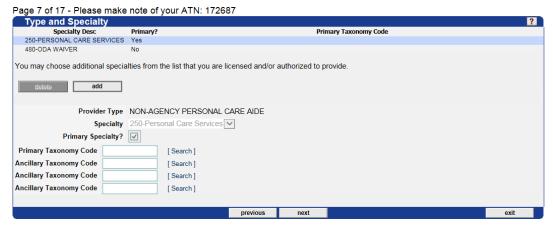


Figure 13 MUST CHECK PRIMARY SPECIALTY BOX - IF JFS WAIVER CONTRACT IS INACTIVE BECAUSE CONSUMER HAS BEEN CHANGED OVER TO TDD, THEN 490 SHOULD BE THE SPECIALTY

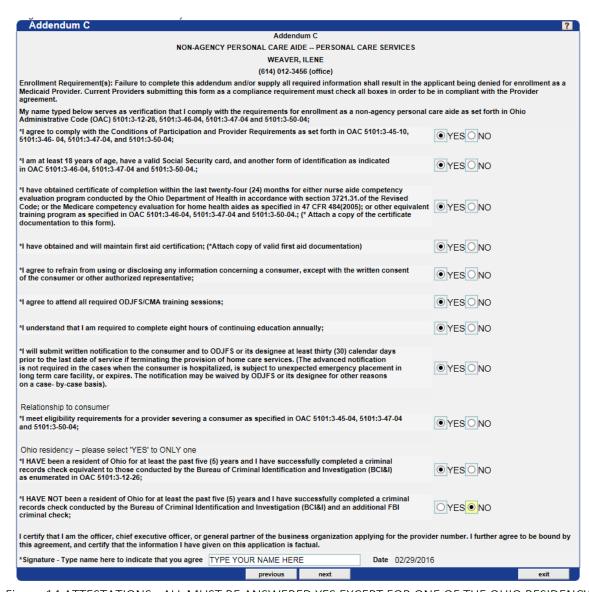


Figure 14 ATTESTATIONS - ALL MUST BE ANSWERED YES EXCEPT FOR ONE OF THE OHIO RESIDENCY QUESTIONS

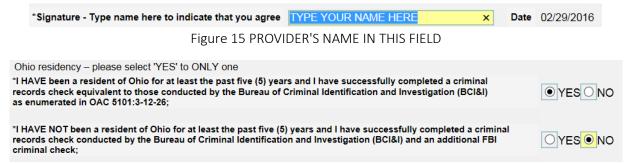


Figure 16 YES TO ONE OR THE OTHER - NOT BOTH

Certification		?
*Legal Entity Name	ENTER YOUR NAME HERE	
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	LAST NAME FIRST NAME	
Click this printable Enrollment Checkl	ist link to ensure a complete provider enrollment request.	
Legal Provider Primary Practice Addre	ess:	
*Address 1	123 E MAIN ST	
Address 2		
*City	COLUMBUS	
*State	OH V	
*Zip	43215	
E-Mail Address	CONTACT@EMAILADDRESS.COM	
*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.	<b>^</b>
	O 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.	Ç
	I do not accept the terms and conditions	
	I accept the terms and conditions	

Figure 17 MUST ACCEPT TERMS & CONDITIONS - EMAIL ADDRESS IS REQUIRED IF "EMAIL" IS PREFERRED CONTACT METHOD - LEGAL ENTITY SHOULD BE PROVIDER'S NAME

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		

Figure 18 INITIALLY ONLY 3 TERMS ARE VISIBLE - PROVIDER MUST 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							
	9. To follow the regulations and policies set for	th in the approp	riate 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".						
	personal care services, hospices, and HMOs s agreement may be canceled by either party up the individual practitioner who is applying for th chief executive officer, or general partner of the	pecified in 42 Cl on 30 days writt e provider numb business orgar	tals, nursing facilities, providers of home health care and FR 489, Subpart I and 42 CFR 417.436(d). This provider en notice prior to termination date. I further certify that I am per, or in the case of a business organization, I am the offic nization that is applying for the provider number. I further mation I have given on this application is factual.	er,			
			·	~			
	I do not accept the terms and conditio	ns					
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						
*Tyne Full Name Here	selecting the signature checkbox and submitting TYPE YOUR NAME HERE	the application,	I agree to abide by these terms. 02/29/2016				
Type I dil Name Here	previous	next	02/25/2010	exit			

Figure 19 ACCEPT/ATTEST TO TRUE & COMPLETE APPLICATION & NAME OF PROVIDER AS ELECTRONIC SIGNATURE

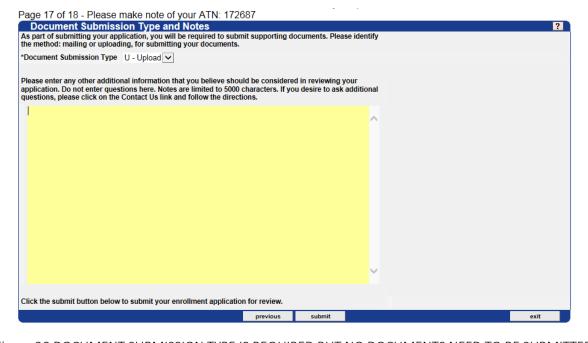


Figure 20 DOCUMENT SUBMISSION TYPE IS REQUIRED BUT NO DOCUMENTS NEED TO BE SUBMITTED



Figure 21 SUBMISSION CAN TAKE 1-2 MINUTES TO COMPLETE

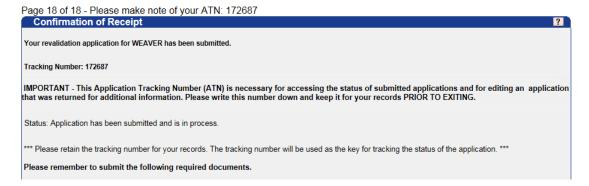


Figure 22 APPLICATION SUBMITTED SUCCESSFULLY

## 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 23 NO DOCUMENTATION IS REQUIRED