



Medicaid Information  
Technology System

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# **Provider Medicaid Portal User Manual**

## **Volume 3A**

**Enrollment - Individual Practitioners, Trading Partners,  
and Groups**

T4D027\_Provider\_Medicaid\_Portal\_UM\_03A\_Enrollment.doc

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# 1 PROVIDER ENROLLMENT – NEW INDIVIDUAL PRACTITIONERS, TRADING PARTNERS, AND GROUPS

Instructions for enrollment presented in this volume of the Provider Medicaid Portal User Manual address the following categories of new enrollment:

- Enrollment for individual practitioners.
- Enrollment for trading partners.
- Enrollment for group practices.

Individual practitioners, trading partners, and groups who have not previously worked with Ohio Department of Jobs and Family Services (ODJFS) under a Medicaid provider agreement can easily enroll via the Provider Medicaid Portal. Access to the Provider Medicaid Portal’s external Internet pages is necessary to begin the enrollment process.

## General Information

If assistance is needed while working through the enrollment panels for MITS, providers can contact ODJFS. Phone numbers are posted for assistance on the right side of the Welcome to Ohio Medicaid Banner:



**Providers should call 1-800-686-1516.** This is a toll-free number for Ohio Medicaid Information Systems and connects the caller to an interactive voice response system.

## Special Features

When working in the Provider Medicaid Portal application, special features are available. These features include icons and special characters that the system displays to assist with performing tasks. A brief description of each feature is shown next.

Icon	Meaning
	The value entered or selected in the field is in error. When this icon appears, a message that identifies the error appears at the top of the page.
	View more detailed information about a record in a list. <b>Note:</b> dependent on site setting selected from Account > Site Settings.
	Access online Help information for a panel. Located in the upper right corner of a panel, when this feature is available for that panel.
	Select or deselect a row of information for processing.

Special Character	Meaning
*	An asterisk next to a field name indicates that information is required in that field. Some fields will be required based on selections or values made in other fields; in these cases, an asterisk may not appear next to the field.
?	A bold question mark appears when the cursor hovers over a field label. The question mark indicates that online help is available for that field. When the question mark is visible, click on the field name to view its definition.

## Accessing the Provider Medicaid Portal

To provide and be reimbursed for Ohio Medicaid services, new enrollees must access the Ohio MITS online Provider Medicaid Portal system to manage and perform tasks using an individual provider account. To access the Ohio Provider Medicaid Portal, a provider must have:

- A computer with public Internet access via an Internet Service Provider (ISP).
- Microsoft Internet Explorer version 6.5 – 8.0 or Firefox 1.5 – 3.5 loaded as the browser on the computer that will be used to perform MITS tasks.

The steps below explain how to **access** the **ODJFS Ohio Medicaid Welcome** page.

1. Double-click the Internet Explorer icon  on the computer's desktop, or the Firefox icon  if using Firefox. The browser application opens and displays the provider's personal Internet home page.
2. Enter the ODJFS base page URL or Web address (<http://jfs.ohio.gov/OHP/index.stm>) in the address field at the top of the browser, and select the Enter key (or, click [here](#)).
3. The ODJFS Medicaid Welcome Page displays. The Provider Medicaid Portal can be accessed from the MITS link on the left side of this page after enrollment has been completed and a provider account has been established.

## ODJFS Medicaid Welcome Page

The Ohio Department of Job and Family Services Medicaid Welcome page is the gateway to the Provider Medicaid Portal.

Ohio.gov | Department of Job and Family Services

Search

About JFS | Our Services | Info Center | News & Events

Job & Family Services Ohio Medicaid

Medicaid Home  
MITS  
Consumer Info  
**Provider Info**  
Resources  
About Us  
Latest News

Acronyms  
ADA Compliance  
External Link Disclaimer  
Contact Us  
Feedback/  
Case-Specific Concerns  
Help/FAQs  
Media Inquiries  
Privacy Statement  
Recent Additions  
Site Index  
Site Map

**Welcome to Ohio Medicaid**  
Ohio's public health care program

**Need help?**  
Consumers: 1-800-324-8680  
Providers: 1-800-686-1516  
[Locate a county office](#)

**Important MITS Information:** If you have questions about MITS or recently filed claims, please call 1-800-686-1516 between the hours of 8:00 a.m. - 4:30 p.m. Monday through Friday.

For other contact information please [click here](#)

If you have already contacted the Provider Call Center for user ID and password issues, please be patient while your issue is being researched. We will respond as soon as possible. Please do not resubmit requests.

**Welcome to Ohio Medicaid**

**Consumers**

- Get coverage
- Already enrolled?
- Programs
- Other Resources

**Providers**

- Billing
- Enrollment & Support
- Provider Types
- Other Resources

**Resources**

- Publications
- Workgroups & Committees
- Helpful Links

**News**

[Coming January 1, 2012 federal mandated HIPAA 5010 Implementation](#)

[Medicaid Managed Care Quarterly News Letter](#)

[MITS](#)

**MITS IS LIVE!**  
[CLICK HERE](#)  
[Important MITS Information](#)

Home | Site Index | Food Assistance Non Discrimination Statement | Privacy Statement | Contact Us

Note that there are several links on the left side of the page, and boxes in the center of the page. These links and boxes provide quick access to additional Ohio Medicaid information.

To **begin** the **enrollment** process:

1. Click on the **Provider Info** link on the left side of the page, OR
2. Click in the **Providers** box in the center of the page.
3. The **Welcome Providers** page displays.

## Welcome Providers Page

The Welcome Providers page contains links to information for billing, enrollment, news, provider types, and other resources. On the left side, it also contains links to the Ohio Medicaid Home page, general information, and ODJFS contact information.



### Job & Family Services Ohio Medicaid

Medicaid Home  
MITS  
Consumer Info  
Provider Info  
Resources  
About Us  
Latest News

Acronyms  
ADA Compliance  
External Link Disclaimer  
Contact Us  
Feedback/  
Case-Specific Concerns  
Help/FAQs  
Media Inquiries  
Privacy Statement  
Recent Additions  
Site Index  
Site Map

## Welcome Providers

Resources for Ohio Medicaid Providers

Are you a provider in need of technical assistance?  
Call the IVR: 1-800-686-1516

**Billing**

- Direct Deposit
- Billing Instructions
- EDI, HIPAA & Code Sets
- Trading Partners & EDI Claims
- Updated** How to Refund Overpayments to The State
- Remittance Advice - (Pre MITS ONLY)
- New!** Answer Keys: Problems while submitting claims in MITS

**Enrollment & Support**

- New!** **Provider Enrollment**
- Provider Assistance
- Sanctioned/Terminated Providers
- Federal Requirement for Revalidation/Re-enrollment

**News**

- New!** COB & TPL Training Handouts and FAQs
- Log on to MITS
- MITS Provider Training begins 9/15 and ends 10/30. Register Now!
- More MITS Info
- Ohio Medicaid Provider Incentive Program for Electronic Health Records (MPIP)

**Provider Types**

- Clinic (FQHC, RHC, OHF)
- HME/DME
- Home Care
- Hospital
- Long-Term Care
- Managed Care
- Pharmacy
- Home Health Services

**Other Resources**

- Benefit Recovery & Coordination
- Fee Schedules/Rates
- Forms
  - MITS EDMS Cover Page
- Healthcheck Screening Forms
- e-Manuals
- Helpful Links
- Get an NPI
- Transmittal Letter Notification

**Basic Billing Training Notice:**

Due to MITS Go-Live the Ombudsman area will not be able to conduct basic billing training until further notice. Information will be available on the provider web page when these classes resume. If you feel you are in need of training, please contact an Ombudsman at 614-644-1399 to schedule a consultation.

### To proceed with enrollment:

1. Click the **Provider Enrollment** link in the center of the page in the Enrollment & Support area.
2. The **Provider Enrollment** page displays.

## Provider Enrollment Page

The Provider Enrollment page is the portal to the enrollment process.

**Provider Enrollment**

**CLICK HERE TO ENROLL**

**Important Enrollment Updates:**

Effective 8/2/2011: The Ohio Department of Job and Family Services (ODJFS) has implemented the new Medicaid Information Technology System (MITS). Please [click here](#) to enroll as a new Medicaid Provider, [click here](#) to check enrollment status or [click here](#) to login to the secure MITS portal to update demographic information as an existing provider.

NOTE: All paper enrollment documents received by ODJFS after June 28 have, or will be returned. All provider files in the old system have been transferred to MITS.

For additional information please contact us:

Provider Enrollment Unit  
P.O. Box 1461  
Columbus, Ohio 43216-1461

**Please listen to the entire message before making your selection**  
**Telephone: 1-800-686-1516, select option 3, then option 1, then option 1 again, then option 4**

Monday through Friday, 8:00 a.m. to 4:30 p.m

**Background Checks Required for Ohio Home Care Providers:**  
Non-agency Ohio Home Care waiver providers (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 can not 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.

Direct Deposit

To receive payments via direct deposit please complete the [Direct Deposit Authorization Agreement](#).

MITS

**Enroll as a New Provider**

**Check Provider Enrollment Status**

**Update Demographic Information**

**Contact Enrollment**  
Please listen to the entire message before making your selection

**1-800-686-1516, select option 3, then option 1, then option 1 again, then option 4**

**Documents:**

[Group Information Form](#)  
[CSTO-Other Equivalent Training Option-Forms](#)  
[IRS - W-9](#)  
[Executive Order #2007 - 01S](#)  
[Confirmation from Consumer - JFS 0624](#)  
[Documentation of Training if not STNA or recently completed nurse aide training - JFS 0622](#)  
[Home Care Attendant Addendum M - JFS 02391](#)  
[Home Care Attendant Skilled Task Authorization - JFS 02390](#)  
[Home Care Attendant Medication Authorization - JFS 2389](#)

To enter the public MITS portal and enroll:

1. Click the red rectangle at the top of the page with the link **CLICK HERE TO ENROLL**.
2. The **Instructions** panel displays, as detailed in Section 2 of this document.

## 2 ENROLLMENT TASKS

Tasks for enrollment presented in this volume of the Provider Medicaid Portal User Manual include a general overview of the following information:

- Enrollment for individual practitioners.
- Enrollment for trading partners.
- Enrollment for group practices.

### General Enrollment Instructions

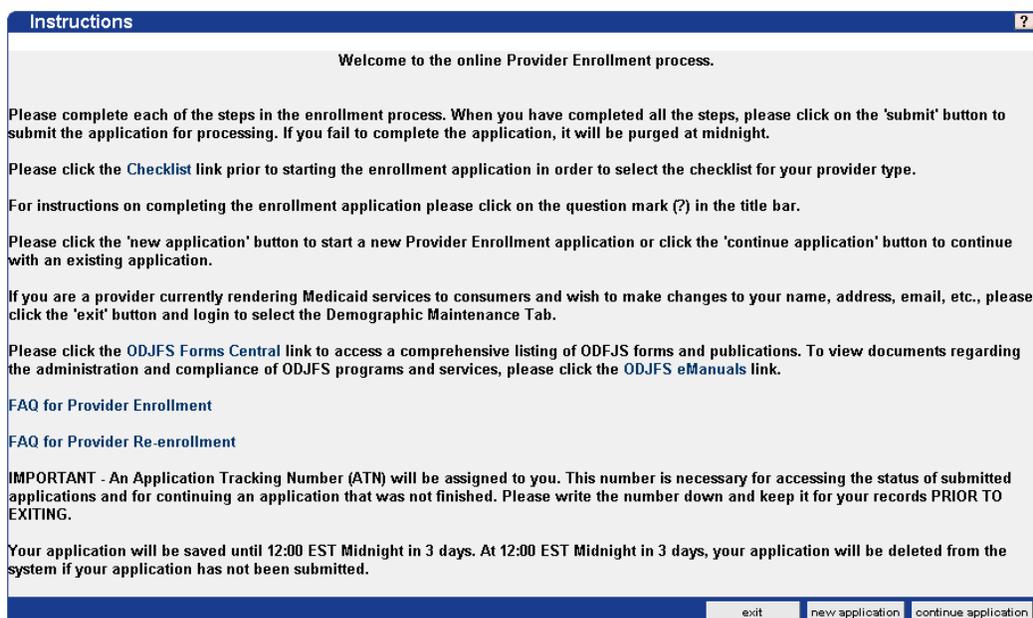
The **Instructions\*** panel is the first enrollment panel and provides detailed information regarding how to proceed with the enrollment process. From this panel, the remaining panels for the enrollment process are accessed. The basic steps necessary for completing the enrollment application are as follows:

1. Work through each panel by entering the required information.
2. Proceed to the next panel by selecting the **Next** button at the bottom of each panel.
3. To review information in a prior panel select the **Previous** button at the bottom of each panel.
4. Complete the information in each panel before proceeding to the next panel.
5. To exit the Provider Enrollment application and return to the **Instructions** panel, select the **exit** button.

\*Trading partners: see section 4 of this volume for information about the Instructions panel for trading partners.

### Instructions Panel

The Instructions panel displays instructions for the provider enrollment process.



## Tasks for this Panel

To **access** enrollment instructions and begin the enrollment process:

1. Click the **Checklist** hyperlink to access and select the correct provider type for enrollment.
2. Click the ? icon in the upper right corner of the panel to view instructions for completing the enrollment online application.
3. Click the **ODJFS Forms Central** link to view forms and publications.
4. Click the **ODJFS eManuals** link to review information regarding the administration of, and compliance with, ODJFS Medicaid programs and services.
5. Click the **FAQ for Provider Enrollment** or **FAQ for Provider Re-enrollment** link to find answers to frequently asked questions about provider enrollment and re-enrollment.
6. To proceed with a new enrollment, select the **new application** button.
7. To continue with an existing enrollment, select the **continue application** button.
8. To exit the application, select the **exit** button.

## Field Descriptions – Instructions Panel

Field	Description	Field Type	Data Type	Length
continue application	After the applicant has entered the Application Tracking Number and the Business or Last Name from the existing application, the application is displayed.	Button	N/A	0
exit	Exit the current panel and go back to the provider enrollment landing page.	Button	N/A	0
new application	Advance to the first page in the provider enrollment process to begin a new application.	Button	N/A	0
Checklist	Link to display checklists associated with different provider types.	Hyperlink	N/A	0
FAQ for Provider Enrollment	Link to an ODJFS PDF file that lists frequently asked questions about the provider enrollment process.	Hyperlink	N/A	0
FAQ for Provider Re-enrollment	Link to an ODJFS .PDF file that lists frequently asked questions about the re-enrollment process.	Hyperlink	N/A	0
ODJFS Forms Central	Link to the ODJFS Provider Forms Central website ( <a href="http://www.odjfs.state.oh.us/forms/inter.asp">http://www.odjfs.state.oh.us/forms/inter.asp</a> ).	Hyperlink	N/A	0
ODJFS eManuals	Link to the ODJFS Provider eManuals website ( <a href="http://emanuals.odjfs.state.oh.us/emanuals/">http://emanuals.odjfs.state.oh.us/emanuals/</a> ).	Hyperlink	N/A	0
Instructions	Instructions for the online provider enrollment wizard.	Label	N/A	0

## Field Edits – Instructions Panel

None.

## Continue Application Panel

The Continue Application panel is used by an applicant to search for existing applications by entering the Application Tracking Number (ATN) and business or last name on the application. The provider is then able to continue entry of an existing application by selecting a search result row.

ATN	Name	Document	Date Received	Status
401832	PECKOWITZ	ONLINE ENROLLMENT APPLICATION	03/05/2010	NOT SUBMITTED

## Tasks for this Panel

To **continue** an enrollment application:

1. Enter valid values in the **ATN** and **Business OR Last Name** fields.
2. Select the **search** button to search for a record matching the entered search criteria.
3. Select the **clear** button to reset the search criteria.
4. Select the **previous** button to return to the previous panel.
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application, select the **exit** button.

## Field Descriptions – Continue Application

Field	Description	Field Type	Data Type	Length
clear	Clears all the search criteria.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
search	Displays the Search Results based on the	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	criteria entered on the search panel.			
ATN	Unique code assigned to the application for identification purposes.	Field	Number	9
ATN (List)	Unique code assigned to the application for identification purposes.	Field	Number	9
Business OR Last Name	Business name or the last name if an individual.	Field	Character	50
Date Received	Date application received.	Listview	Date (MM/DD/CCYY)	10
Document	Name of the application.	Listview	Character	0
Name (List)	Business name or the last name if an individual.	Listview	Character	50
Status	Current status of the application.	Listview	Character	0

### Field Edits – Continue Application

Field	Field Type	Error Code	Error Message	To Correct
ATN	Field	0	Application Tracking Number (ATN) is required	This field must be completed.
Business OR Last Name	Field	0	Name of Business or Individual Last Name is required.	This field must be completed.

## Enrollment Tracking

A provider applicant can view the status of, or upload additional documentation for, an enrollment application.

### Enrollment Tracking Search Panel

The Enrollment Tracking Search panel is used by a provider to check the status of an enrollment application.

## Tasks for this Panel

To **check** the status of an enrollment:

1. Enter valid values in the **ATN** and **Business OR Last Name** fields.
2. Select the **search** button.
3. Select the **clear** button to reset the search criteria.

## Field Descriptions – Enrollment Tracking Search

Field	Description	Field Type	Data Type	Length
Clear	Clears all the search criteria.	Button	N/A	0
Search	Displays the Search Results based on the criteria entered on the search panel.	Button	N/A	0
ATN	Application Tracking Number (ATN). The system-assigned key that uniquely identifies a provider application. Is required.	Field	Number	9
Business OR Last Name	Business or last name on the enrollment application. Is required.	Field	Character	50

## Field Edits – Enrollment Tracking Search

Field	Field Type	Error Code	Error Message	To Correct
ATN	Field	0	ATN is required.	Enter a valid ATN.
Business OR Last Name	Field	0	Business or Last Name is required.	Enter a value for Business or Last Name.

## Enrollment Tracking Search Results Panel

The Enrollment Tracking Search Results panel displays a list of enrollment applications matching the search criteria entered on the Enrollment Tracking Search panel.

**Note:** Any attachment not uploaded during enrollment can be uploaded from this panel if the application has a status of Submitted.

Search Results				
ATN	Name	Document	Date Received	Status
401832	PECKOWITZ	ONLINE ENROLLMENT APPLICATION	03/05/2010	NOT SUBMITTED

## Tasks for this Panel

There are no tasks to perform in this panel.

## Field Descriptions – Enrollment Tracking Search Results

Field	Description	Field Type	Data Type	Length
ATN	Application tracking number that uniquely identifies a provider application.	Field	Number	9
Date Received	Date the enrollment was received.	Field	Date (MM/DD/CCYY)	10
Document	List of required documents.	Field	Character	25
Name	Name of enrolling provider.	Field	Character	50
Status	Status of the provider's enrollment.	Field	Character	24

## Field Edits – Enrollment Tracking Search Results

None

## Enrollment Request Type

The enrollment type selected by the enrolling provider, trading partner, or group may determine the information required to complete the enrollment, as well as the available possible actions the enroller can request. Actions that may be requested based on individual provider, trading partner, or group enrollment type are as follows:

- Initial Enrollment
- Change of Operator/Provider (CHOP)
- Out of State Provider

To enroll as a new provider, select **INITIAL ENROLLMENT** from the **Action Request** drop-down field.

## Request Type Panel

The Provider Enrollment-Request Type panel is used by a provider applicant to select the type of enrollment and provider type for the application. The image below shows an example value selected for an individual practitioner. Trading partners should select a value for trading partners, and groups should select a value that reflects their group.

### Tasks for this Panel

To specify **enrollment** and **provider** types:

1. Select the appropriate description for the enrolling provider from the **Enrollment Type** drop down list box. Providers who do not practice under any type of legal entity that includes multiple providers should select a provider type of "Individual Practitioner" in this field.
2. Select **INITIAL ENROLLMENT** value from the **Action Request** drop down list box.
3. Select the appropriate provider type for the enrolling provider from the **Provider Type** drop down list box.
4. Select **Yes** for the question **Are you a provider new to Ohio Medicaid?**
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application, select the **exit** button.

To continue the enrollment application process, detailed information about the type of enrollment for which the application is being made must be entered in the **Identifying Information** panel that is appropriate for the enrolling provider. This panel displays in several different views that request different information, depending on the provider type that was selected in the **Request Type** panel.

### Field Descriptions – Request Type Panel

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Action Request	Requested action to be taken with application. Valid values: Initial Enrollment, Re-enrollment, and Change of Ownership.	Field	Drop Down List Box	0

Field	Description	Field Type	Data Type	Length
Are you a provider new to Ohio Medicaid?	Indicates if the provider has been previously registered with Ohio Medicaid. Valid values: Yes or No.	Field	Radio Button	0
Enrollment Type	Indicates the type of enrollment application. Example valid value: Individual Practitioner.	Field	Drop Down List Box	0
Provider Type	Provider type of the applicant. Valid values: Clinic, Physician, Pharmacy, Dentist, Hospital, and Other.	Field	Drop Down List Box	0

### Field Edits – Request Type Panel

Field	Field Type	Error Code	Error Message	To Correct
Provider Type	Field	0	A valid Provider Type is required.	Select a provider type from the drop-down list box.

### 3 INDIVIDUAL PRACTITIONER ENROLLMENT

Detailed information about the individual practitioner must be entered in the **Identifying Information** panel.

#### Identifying Information Panel – Individual Practitioner

The Identifying Information panel allows an individual practitioner applicant to enter identifying information, including provider numbers, certification and license information, and Federal identification numbers.

The screenshot shows a web form titled "Identifying Information" with a question mark icon in the top right corner. The form contains the following fields and controls:

- \*Individual Last Name: Text input field
- First, MI: Text input field
- Medicare Type: Dropdown menu
- Medicare Provider Number: Text input field
- Medicaid Provider Number: Text input field
- Certification Number: Text input field
- \*Ownership Type: Dropdown menu
- \*Title/Degree (As appears on license): Text input field
- \*Type: Dropdown menu
- \*SSN/FEIN: Text input field
- \*Gender: Dropdown menu
- Date of Birth: Text input field
- NPI Associated with SSN: Text input field
- \*NPI Verified?: Radio buttons for Yes and No
- DEA Number: Text input field
- \*License Number: Text input field
- \*License Type: Dropdown menu
- \*License Issue Date: Text input field
- \*License Expiration Date: Text input field

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

#### Tasks for this Panel

To enter identifying information:

1. Enter valid values in the **Individual Last Name**, **Title/Degree**, **SSN/FEIN**, **License Number**, **License Issue Date**, and **License Expiration Date** fields.
2. Select values from the **Ownership Type**, **Type**, **Gender**, and **License Type** drop down list boxes.
3. Select **Yes** or **No** for **NPI Verified?**
4. Enter values in the **First, MI**, **Medicare Provider Number**, **Medicaid Provider Number**, **Certification Number**, **Date of Birth**, **NPI Associated with SSN**, and **DEA Number** fields, if applicable.
5. Select a value from the **Medicare Type** drop down list box, if applicable.
6. Select the **previous** button to review information entered in previous panels, if desired.

7. Select the **next** button to proceed to the next enrollment panel.
8. Select the **exit** button to exit the application.

**Note:** When required fields are completed and the **next** button is selected, a Microsoft Internet Explorer pop-up opens with the ATN number. This ATN number should be noted for future reference.

### Field Descriptions – Identifying Information – Individual Practitioner

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Saves the updated information on the panel and navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard	Button	N/A	0
Certification Number	Certification Number	Field	Number	7
DEA Number	Drug Enforcement Agency number.	Field	Number	15
Date of Birth	Date of birth.	Field	Date (MM/DD/CCYY)	8
First, MI	First name and middle initial of the individual.	Field	Character	13
Gender	Code to describe gender.	Field	Drop Down List Box	0
Individual Last Name	If not using a business name, enter the last name for the record.	Field	Alphanumeric	25
License Expiration Date	Expiration Date of License.	Field	Date (MM/DD/CCYY)	8
License Issue Date	Issue Date of the License.	Field	Date (MM/DD/CCYY)	8
License Number	License number.	Field	Character	10
License Type	Type of license or accreditation.	Field	Drop Down List Box	0
Medicaid Provider Number	Medicaid Provider Number	Field	Number	10
Medicare Provider	Medicare Provider Number.	Field	Number	10

Field	Description	Field Type	Data Type	Length
Number				
Medicare Type	Medicare type PTAN/CCN.	Field	Drop Down List Box	0
NPI Associated with SSN	National Provider Identifier number.	Field	Number	10
NPI Verified?	NPI Verified Yes/No.	Field	Radio Button	0
Ownership Type	Type of ownership.	Field	Drop Down List Box	0
SSN/ FEIN	Social Security number or Federal Employer Identification Number.	Field	Number	9
Title/Degree (As appears on license)	Title or degree as it appears on the license.	Field	Character	15
Type	Type of tax ID. Valid values: SSN or FEIN.	Field	Drop Down List Box	0

### Field Edits – Identifying Information – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
First, MI (for Individual)	Field	1	First Name is required.	Enter a first name.
	Field	2	Cannot have a First Name, MI and business name.	Delete the First Name, MI or the Business Name.
Gender	Field	1	Gender is required.	This field must be completed.
Individual Last Name	Field	1	Legal Entity Name or Individual Last Name is required.	This field must be completed.
Individual Last Name (for Individual)	Field	1	Last Name is required.	Enter a Last Name.
	Field	2	Cannot have a Last Name and Business Name.	Delete either Last Name or Business Name.
License Expiration Date	Field	1	License Expiration Date is required.	This field must be completed.
License Issue Date	Field	1	License Issue Date is required.	This field must be completed.
	Field	2	License Issue Date[1/1/2010 12:00:00 AM] must be less than or	Enter a date less than or equal to

Field	Field Type	Error Code	Error Message	To Correct
			equal to License Expiration Date[10/10/2009 12:00:00 AM]	the Expiration Date
License Number	Field	1	License Number is required.	This field must be completed.
Medicare Provider Number	Field	1	When Medicare Type is selected Medicare Provider Number is required.	Enter Medicare Provider Number.
Medicare Type	Field	1	When Medicare Provider Number is selected Medicare Type is required.	Enter Medicare Type.
NPI	Field	1	NPI is required.	This field must be completed.
NPI Verified?	Field	1	This field must be completed.	This field must be completed.
SSN/ FEIN	Field	1	SSN/FEIN is required.	This field must be completed.
Title/Degree (As appears on license)	Field	0	Title/Degree (As appears on license) is required.	This field must be completed.
Type	Field	1	Type is required	This field must be completed.

## Tax ID – Individual Practitioner

Individual providers enter their tax information in this panel.

### Tasks for this panel

To enter tax information:

1. Select values from the **IRS Tax Type**, **Tax ID Exempt**, **W9 Form**, **Form 147**, and **State** drop down list boxes.

**Note:** When a value of **SSN** is selected from the **IRS Tax Type** drop down list box, the provider's SSN may be entered for the **IRS Tax ID**.

2. Enter valid values in the **IRS Tax ID**, **Name**, **Address 1**, **City**, **Zip**, and **IRS Effective Date** fields.

3. Enter values in the **Address 2**, 4-digit **ZIP** extension, **IRS End Date**, **Phone**, and **Phone extension** fields, if applicable.
4. Select the **previous** button to review information entered in previous panels, if desired.
5. Select the **next** button to proceed to the next enrollment panel.

**Note:** Depending on which **Provider Type** was selected in the **Request Type** panel, the next panel will be either the **AP Nurse Provider Information** OR the **Address Information** panel.

6. To exit the application, select the **exit** button.

### Field Descriptions – Tax ID – Individual Practitioner

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
State	Provider's state.	Combo Box	Character	2
Address 1	Provider's street address 1.	Field	Character	60
Address 2	Provider's street address 2. (Optional)	Field	Alphanumeric	60
City	Provider's city.	Field	Character	15
Ext	Provider's phone number extension.	Field	Number	4
Form 147	Indicates whether the provider has submitted Form 147, stating name and tax identification number.	Field	Drop Down List Box	1
IRS Effective Date	Effective date of IRS tax ID.	Field	Date (MM/DD/CCYY)	8
IRS End Date	End date of IRS tax ID.	Field	Date (MM/DD/CCYY)	8
IRS Tax ID	Provider's tax ID.	Field	Number	9
IRS Tax Type	Identifies the identification number as either Social Security Number or Federal	Field	Character	1

Field	Description	Field Type	Data Type	Length
	Employee/Employer Identification Number			
Name	Provider's name.	Field	Character	50
Phone	Provider's phone number.	Field	Number	10
Tax ID Exempt	Indicates whether the provider is exempt from receiving a 1099 statement.	Field	Drop Down List Box	1
W9 Form	Indicates whether the provider provided a W-9 form.	Field	Drop Down List Box	1
Zip	Provider zip code.	Field	Number	5
Zip+4	Provider 4-character zip code extension.	Field	Number	4

### Field Edits – Tax ID – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
State	Combo Box	1	A valid State is required.	Select a State.
Address 1	Field	1	Address 1 is required.	Enter an Address 1.
City	Field	1	City is required.	Enter a City.
Form 147	Field	1	Form 147 is required.	Select Yes or No.
Form 147	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for Tax ID Exempt, W9 Form, or Form 147 fields.
IRS Effective Date	Field	1	IRS Effective Date is required.	Enter an IRS Effective Date.
IRS Effective Date	Field	2	IRS Effective Date must be less than or equal to IRS End Date.	IRS Effective Date must be less than or equal to IRS End Date.
IRS End Date	Field	1	IRS End Date is required.	Enter an IRS End Date.
IRS End Date	Field	2	IRS Effective Date must be less than or equal to IRS End Date.	IRS Effective Date must be less than or equal to IRS End Date.
IRS Tax ID	Field	1	IRS Tax ID is required.	Enter a valid Tax ID.
IRS Tax ID	Field	2	Tax ID must be 9 digits.	Enter a valid Tax ID.
IRS Tax	Field	4	IRS Tax Type is required.	Select a Tax ID Type.

Field	Field Type	Error Code	Error Message	To Correct
Type				
Phone	Field	1	Phone must be 10 digits in length.	Enter phone with 10 digits.
Tax ID Exempt	Field	1	Tax ID Exempt is required.	Select Yes or No.
Tax ID Exempt	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for Tax ID Exempt, W9 Form, or Form 147 fields.
W9 Form	Field	1	W9 Form is required.	Select Yes or No.
W9 Form	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for Tax ID Exempt, W9 Form, or Form 147 fields.
Zip	Field	1	Zip is required.	Enter a 5 digit zip.
Zip	Field	2	Zip must be 5 digits in length.	Enter a 5 digit zip.
Zip+4	Field	1	Zip must be 4 digits in length.	Enter 4 digit zip code extension.

## AP Nurse Information – Individual Practitioner

The AP Nurse Information panel is used by a provider applicant to document the collaboration agreement for an individual Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, Certified Registered Nurse Anesthetist (CRNA), or Registered Nurse First Assistant. This panel will only display for specific Nurse Provider types.

AP Nurse Information ?

CRNA Certificate Number

Certificate of Authority (COA) No.

COA Issue Date

COA Renewal Date

Prescriptive Authority Certificate No.

Prescriptive Authority Issue Date

Prescriptive Authority Renewal Date

Masters Degree In Nursing?  Yes  No

Name of School

\*National Specialty/Certification

previous
next
exit

### Tasks for this panel

To enter **collaboration agreement** information:

1. Select a value from the **National Specialty/Certification** drop down field.

2. Enter values in the following fields, if applicable: **CRNA Certificate Number, Certificate of Authority (COA) No., COA Issue Date, COA Renewal Date, Prescriptive Authority Certificate No, Prescriptive Authority Issue Date, Prescriptive Authority Renewal Date, Masters Degree In Nursing?, and Name of School.**
3. Select the **previous** button to review information entered in previous panels, if desired.
4. Select the **next** button to proceed to the next enrollment panel.
5. To exit the application, select the **exit** button.

**Field Descriptions – AP Nurse Information – Individual Practitioner**

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
National Specialty/Certification	Pick list of values for National Specialty/Certification. For Provider Type CRNA, the only pick list value is "CRNA Certification from Nurse's Board" For Provider Type Nurse Practitioner, the pick list values shown are: Adult Health Gerontological Psychiatric Palliative Care Acute Care Pediatric Oncology Family OB/GYN Women's Health Neonatal For provider type Clinical Nurse Specialist, the pick list values shown are: Adult Health Gerontological Psychiatric Palliative Care Acute Care Pediatric For provider type Nurse Midwife, the pick list values shown are: American College of Nurse Midwives Certification American Midwifery Certification Board	Combo Box	Character	80
COA Issue Date	Certificate of Authority issue date.	Field	Date (MM/DD/CCYY)	8

Field	Description	Field Type	Data Type	Length
COA Renewal Date	Certificate of Authority renewal date.	Field	Date (MM/DD/CCYY)	8
CRNA Certificate Number	CRNA certificate number.	Field	Character	20
Certificate of Authority (COA) No.	Certificate of Authority number.	Field	Character	20
Masters Degree In Nursing?	Indicates if individual practitioner has a Masters Degree In Nursing. Valid values: Yes or No.	Field	Radio Button	0
Name of School	Name of school where the Master of Nursing degree was earned.	Field	Character	40
Prescriptive Authority Certificate No.	Prescriptive Authority Certificate number.	Field	Character	20
Prescriptive Authority Issue Date	Prescriptive Authority issue date.	Field	Date (MM/DD/CCYY)	8
Prescriptive Authority Renewal Date	Prescriptive Authority renewal date.	Field	Date (MM/DD/CCYY)	8

**Field Edits – AP Nurse Information – Individual Practitioner**

Field	Field Type	Error Code	Error Message	To Correct
National Specialty/Certification	Combo Box	1	National Specialty/Certification is required.	Select a value for National Specialty/Certification.
All fields	Field	0	Invalid number / Invalid date / Invalid character data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum length.
COA Issue Date	Field	0	COA Issue Date is required.	If COA Renewal Date or Certificate Of Authority No. is entered, this field is required.

Field	Field Type	Error Code	Error Message	To Correct
				Correct COA Renewal Date and/or Certificate Of Authority No., or enter valid date for this field.
COA Issue Date	Field	1	COA Issue Date must be less than or equal to COA Renewal Date.	Enter a COA Issue Date less than COA Renewal Date.
COA Renewal Date	Field	0	COA Renewal Date is required.	If COA Issue Date or Certificate Of Authority No. is entered, this field is required. Correct COA Issue Date and/or Certificate Of Authority No., or enter valid date for this field.
CRNA Certificate Number	Field	0	CRNA Certificate Number is required.	If Certified Nurse Aide question is answered in the affirmative, this field is required. Correct Certified Nurse Aide question or enter valid data for this field.
Certificate of Authority (COA) No.	Field	0	Certificate of Authority (COA) No. is required.	If COA Issue Date or COA Renewal Date is entered, this field is required. Correct COA Issue Date and/or COA Renewal Date, or enter valid data for this field.
Date Degree Earned	Field	0	Date Degree Earned is required.	If Master Degree In Nursing or Name Of School is entered, this field is required. Correct Master Degree In Nursing question response and/or Name Of School, or enter valid date for this field.
Date Degree Earned	Field	1	Date Degree Earned must be less than or equal to today.	Enter Date Degree Earned that is less than or equal to today's date.
Masters Degree In Nursing?	Field	0	The response to Masters Degree In Nursing question must be 'Yes'.	If Date Degree Earned or Name Of School is entered, this field is required. Correct Date Degree Earned and/or Name Of School, or enter valid response for this field.
Name of School	Field	0	Name of School is required.	If Master Degree in Nursing question answered in the

Field	Field Type	Error Code	Error Message	To Correct
				affirmative or Date Degree Earned is entered, this field is required. Correct Master Degree in Nursing question response and/or Date Degree Earned, or enter valid data for this field.
Prescriptive Authority Certificate No.	Field	0	Prescriptive Authority Certificate No. is required.	If Prescriptive Issue Date or Prescriptive Renewal Date is entered, this field is required. Correct Prescriptive Issue Date and/or Prescriptive Renewal Date, or enter valid data for this field.
Prescriptive Authority Issue Date	Field	0	Prescriptive Authority Issue Date is required.	If Prescriptive Authority Certificate No. or Prescriptive Authority Renewal Date is entered, this field is required. Correct Prescriptive Authority Certificate No. and/or Prescriptive Authority Renewal Date, or enter valid date for this field.
Prescriptive Authority Issue Date	Field	1	Prescriptive Authority Issue Date must be less than or equal to Prescriptive Authority Renewal Date.	Enter a Prescriptive Authority Issue Date less than or equal to the Prescriptive Authority Renewal Date.
Prescriptive Authority Renewal Date	Field	0	Prescriptive Authority Renewal Date is required.	If Prescriptive Authority Certificate No. or Prescriptive Authority Issue Date is entered, this field is required. Correct Prescriptive Authority Certificate No. and/or Prescriptive Authority Issue Date, or enter valid date for this field.
State Certified Nurse Aide?	Field	0	The response to State Certified Nurse Aide question must be 'Yes'.	If CRNA Certificate Number is entered, this field is required. Correct CRNA Certificate Number or enter valid response for this field.

## Respiratory Care Information – Individual Practitioner

For Respiratory Care Provider Types, this panel will display to collect Respiratory License information.

### Tasks for this Panel

To enter **respiratory license** information:

1. Enter valid values in the **Respiratory Care Board License Number**, **Respiratory Care Board License Issue Date**, and **Respiratory Care Board License Expiration Date** fields.
2. Select the **previous** button to review information entered in previous panels, if desired.
3. Select the **next** button to proceed to the next enrollment panel.
4. To exit the application, select the **exit** button.

### Field Descriptions – Respiratory Care Information – Individual Practitioner

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the Provider Enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the Provider Enrollment wizard.	Button	N/A	0
Respiratory Care Board License Expiration Date	Date that the Respiratory Care certification will expire.	Field	Date (MM/DD/CCYY)	10
Respiratory Care Board License Issue Date	Date that the Respiratory Care license was issued.	Field	Date (MM/DD/CCYY)	10
Respiratory Care Board License Number	A number issued to the provider indicating they are certified to perform Respiratory Care services.	Field	Number	11

## Field Edits – Respiratory Care Information – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
Respiratory Care Board License Expiration Date	Field	1	Respiratory Care Board License Expiration Date is required.	Enter a valid Respiratory Care Board License Expiration Date.
Respiratory Care Board License Expiration Date	Field	2	Respiratory Care Board License Expiry Date must be greater than Respiratory Care Board License Issue Date.	Enter Respiratory Care Board License Expiry Date greater than Respiratory Care Board License Issue Date.
Respiratory Care Board License Issue Date	Field	1	Respiratory Care Board License Issue Date is required.	Enter a valid Respiratory Care Board License Issue Date.
Respiratory Care Board License Issue Date	Field	2	Respiratory Care Board License Issue Date must be earlier than or equal to Today	Enter Respiratory Care Board License Issue Date earlier than or equal to Today.
Respiratory Care Board License Number	Field	1	Respiratory Care Board License Number is required.	Enter a valid Respiratory Care Board License Number.

## Address Information – Individual Practitioner

The Address Information panel is used by an enrolling individual provider applicant to provide address information. At least one practice location address must be entered.

The screenshot shows the 'Address Information' panel with a header bar containing 'Address Type', 'Address 1', 'City', 'State', 'Zip', and 'Phone 1'. Below the header, there is a section for 'PRACTICE LOCATION' with a 'Type data below for new record.' instruction. The form includes several input fields and dropdown menus:
 

- \*Address Type: PRACTICE LOCATION (dropdown)
- \*Address 1: [Text Input]
- Address 2: [Text Input]
- \*City: [Text Input]
- \*County: [Dropdown]
- \*State: [Dropdown]
- \*Zip: [Text Input]
- \*E-Mail Address: [Text Input]
- \*Contact Name: [Text Input]
- \*Phone 1: [Text Input] [Text Input] CELL PHONE (dropdown)
- Phone 2: [Text Input] [Text Input] CELL PHONE (dropdown)
- Fax 1: [Text Input]
- Fax 2: [Text Input]
- TDD: [Text Input]

 At the bottom of the panel are 'previous', 'next', and 'exit' buttons.

### Tasks for this panel

To enter **address** information:

1. Select values from the **Address Type**, **County**, and **State** drop down list boxes.

2. Enter valid values in the **Address 1, City, Zip, E-Mail Address, Contact Name, and Phone 1** fields.
3. Enter values in the **Address 2, 4-digit Zip extension, Phone 2, Fax 1, Fax 2, and TDD** fields, if applicable.
4. Select values from the **Phone 1 and Phone 2** phone type drop down list boxes, if applicable.
5. Select the **add** button to add another address information record.
6. Select the **delete** button to delete a selected address information record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Address Information – Individual Practitioner

Field	Description	Field Type	Data Type	Length
add	Inserts a new address record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Address 1	First line of the address specified by Address Type.	Field	Character	60
Address 2	Second line of the address specified by Address Type.	Field	Character	60
Address Type	Type of address.	Field	Drop Down List Box	0
City	City of the address specified by Address Type.	Field	Character	30
Contact Name	Name of the contact at the specified address.	Field	Character	40
County	County of the address specified by	Field	Drop Down List	0

Field	Description	Field Type	Data Type	Length
	Address Type.		Box	
E-mail Address	Email address for the business.	Field	Character	50
Fax 1	First fax number for provider at the specified Address Type.	Field	Number	10
Fax 2	Second fax number for provider at the specified Address Type.	Field	Number	10
Phone 1	First phone number for the provider at the address specified by Address Type.	Field	Number	10
Phone 2	Second phone number for the provider at the address specified by Address Type.	Field	Number	10
Phone Ext 1	First phone extension for the provider (no label on panel).	Field	Number	4
Phone Ext 2	Second phone extension for the provider (no label on panel).	Field	Number	4
Phone Type 1	First phone type (no label on panel).	Field	Drop Down List Box	0
Phone Type 2	Second phone type (no label on panel).	Field	Drop Down List Box	0
State	State of the address specified by Address Type.	Field	Drop Down List Box	0
TDD	Telecommunications Device for the Deaf number of the address specified by Address Type.	Field	Number	10
Zip	Zip code of the address specified by Address Type.	Field	Number	5
Zip + 4	Zip code extension of the address specified by Address Type (no label on panel).	Field	Number	4
Address 1 (List)	First line of the address specified by Address Type.	Listview	Character	60
Address Type (List)	Type of address.	Listview	Character	20
City (List)	City of the address specified by Address Type.	Listview	Character	30
Phone 1 (List)	First phone number for the provider at the address specified by Address Type.	Listview	Number	10

Field	Description	Field Type	Data Type	Length
State (List)	State of the address specified by Address Type.	Listview	Character	2
Zip (List)	Zip code of the address specified by Address Type.	Listview	Number	5

### Field Edits – Address Information – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required.	This field must be completed.
Address Type	Field	0	Address Type is required.	This field must be completed.
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum length.
City	Field	0	City is required.	This field must be completed.
Contact Name	Field	1	Contact Name is required.	Enter a name in the field.
County	Field	0	County is required.	This field must be completed.
E-mail Address	Field	1	E-mail Address is required.	Enter a valid email address.
Phone 1	Field	0	Phone is required.	This field must be completed.
State	Field	0	State is required.	This field must be completed.
Zip	Field	0	Zip is required.	This field must be completed.

### Type and Specialty – Individual Practitioner

The Type and Specialty panel is used by an applicant to specify applicant’s primary specialty and any additional specialties. If the option is available to choose a primary specialty, the applicant must select one before continuing the enrollment.

### Tasks for this panel

To specify **provider type** and **specialty**:

1. Select values from the **Specialty** and **License Type** drop down list boxes.  
**Note:** Depending on the provider type chosen, the **Specialty** drop down list box and **Primary Specialty?** check box may or may not display.
2. Select the **Primary Specialty?** check box.
3. Enter valid values in the **License Number**, **License Issue Date**, **License Expiration Date**, and **Primary Taxonomy Code** fields.
4. To search for a primary taxonomy code, click the **[Search]** hyperlink adjacent to the **Primary Taxonomy Code** field.
5. A secondary search panel for **Primary Taxonomy Code** displays.

- a. Enter a value for the **Taxonomy** code, **Description** of the taxonomy, or both.
- b. Select the **search** button. Taxonomy information that matches the search criteria displays in the Search Results area.

Taxonomy	Description
103TC1900X	PSYCHOLOGIST - COUNSELING
103TC2200X	PSYCHOLOGIST - CLINICAL CHILD & ADOLESCENT
103TE1000X	PSYCHOLOGIST - EDUCATIONAL
103TE1100X	PSYCHOLOGIST - EXERCISE & SPORTS
103TF0000X	PSYCHOLOGIST - FAMILY
103TF0200X	PSYCHOLOGIST - FORENSIC
103TH0004X	PSYCHOLOGIST - HEALTH
103TH0100X	PSYCHOLOGIST - HEALTH SERVICE
103TM1700X	PSYCHOLOGIST - MEN & MASCULINITY
103TM1800X	PSYCHOLOGIST - MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES

- c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.
  - d. Select the **line** with the taxonomy code that is appropriate for the enrolling provider.
  - e. The selected code displays in the Primary **Taxonomy Code** field in the **Type and Specialty** panel.
  - f. Select **[Close]** in the upper right corner of the Primary **Taxonomy Code** search panel.
6. If desired, enter a valid value in one or more of the **Ancillary Taxonomy Code** fields.
  7. To search for an ancillary taxonomy code, click the **[Search]** hyperlink adjacent to the **Ancillary Taxonomy Code** field.
  8. A secondary search panel for **Ancillary Taxonomy Code** displays.

- a. Enter a value for the **Taxonomy** code, **Description** of the taxonomy, or both.
- b. Select the **search** button. Taxonomy information that matches the search criteria displays in the Search Results area.

- c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.
  - d. Select the **line** with the taxonomy code that is appropriate for the enrolling provider.
  - e. The selected code displays in the **Ancillary Taxonomy Code** field in the **Type and Specialty** panel.
  - f. Select **[Close]** in the upper right corner of the **Ancillary Taxonomy Code** search panel.
9. Select the **previous** button to review information entered in previous panels, if desired.
10. Select the **next** button to proceed to the next enrollment panel.
11. To exit the application, select the **exit** button.

### Field Descriptions – Type and Specialty – Individual Practitioner

Field	Description	Field Type	Data Type	Length
add	Inserts a new specialty record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Ancillary Taxonomy Code	Ancillary taxonomy code of the specified specialty. Up to three ancillary taxonomy codes may be entered per record. Click [Search] to search for and select an ancillary taxonomy code.	Field	Alphanumeric	9
Ancillary Taxonomy Code	Ancillary taxonomy code of the specified specialty. Up to three ancillary taxonomy codes may be entered per record. Click [Search] to search for and select an ancillary taxonomy code.	Field	Alphanumeric	9
Ancillary Taxonomy Code	Ancillary taxonomy code of the specified specialty. Up to three ancillary taxonomy codes may be entered per record. Click [Search] to search for and select an ancillary taxonomy code.	Field	Alphanumeric	9
Effective Date	Effective date of the specified specialty.	Field	Date (MM/DD/CCYY)	8
End Date	Expiration date of the specified specialty.	Field	Date (MM/DD/CCYY)	8
License Expiration Date	Expiration date of the specified license.	Field	Date (MM/DD/CCYY)	8
License Issue Date	Date when the specified specialty license was issued.	Field	Date (MM/DD/CCYY)	8
License Number	Applicant's license number.	Field	Character	15
License Type	Type of license specified. Example valid value: Nursing Board.	Field	Drop Down List Box	0
Primary Specialty?	Indicator of applicant's primary specialty.	Field	Check Box	1
Primary Taxonomy Code	Primary taxonomy code of the specified specialty. Click [Search] to search for and select a taxonomy code.	Field	Alphanumeric	9
Specialty	Applicant's specialty. Example valid value: 929-Physician Assistant.	Field	Drop Down List Box	0
Provider Type	Type of provider.	Label	Character	0

Field	Description	Field Type	Data Type	Length
Effective Date [List]	Effective date of the specified specialty.	Listview	Date (MM/DD/CCYY)	8
End Date [List]	Expiration date of the specified specialty.	Listview	Date (MM/DD/CCYY)	8
License Expiration Date [List]	Expiration date of the specified license.	Listview	Date (MM/DD/CCYY)	8
License Issue Date [List]	Date when the specified specialty license was issued.	Listview	Date (MM/DD/CCYY)	8
License Number [List]	Applicant's license number.	Listview	Character	15
Primary? [List]	Indicator of applicant's primary specialty.	Listview	Character	0
Specialty Desc [List]	Applicant's specialty. Example valid value: 929-Physician Assistant.	Listview	Character	10

**Field Edits – Type and Specialty – Individual Practitioner**

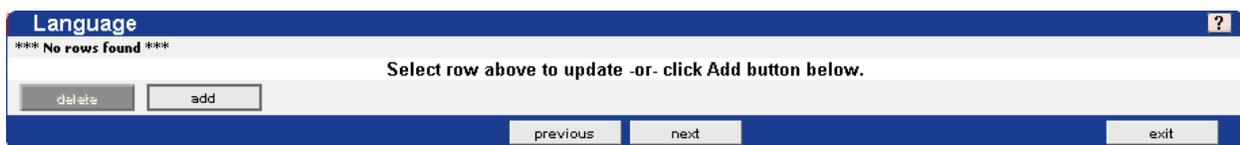
Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum length.
Ancillary Taxonomy Code	Field	1	Second Ancillary Taxonomy Code	Enter a valid Taxonomy Code.

Field	Field Type	Error Code	Error Message	To Correct
			entered is not valid.	
	Field	1	First Ancillary Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
	Field	1	Third Ancillary Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
	Field	2	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
	Field	2	Previous Ancillary Taxonomy Code is required when next Ancillary Taxonomy Code is entered.	Enter the Previous Ancillary Taxonomy Code before the next.
	Field	2	Previous Ancillary Taxonomy Code is required when next Ancillary Taxonomy Code is entered.	Enter the Previous Ancillary Taxonomy Code before the next.
	Field	3	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
	Field	3	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
License Expiration Date	Field	0	License Expiration Date is required.	This field must be completed if enrollment type is Individual Practitioner.
License Issue Date	Field	0	License Issue Date [MM/DD/CCYY HH:MM AM or PM] must be less than or equal to License Expiration Date MM/DD/CCYY HH:MM AM or PM]	Ensure that Issue Date is on or before Expiration Date.
	Field	1	License Issue Date is required.	This field must be completed if

Field	Field Type	Error Code	Error Message	To Correct
				enrollment type is Individual Practitioner.
License Number	Field	1	License Number is required.	This field must be completed if enrollment type is Individual Practitioner.
License Type	Field	0	License Type is required.	This field must be completed if enrollment type is Individual Practitioner.
Primary Specialty?	Field	0	Primary Specialty not found.	A primary specialty must be selected.
	Field	1	More than 1 Primary Specialty found.	Ensure that Primary Specialty isn't selected for more than one specialty.
Primary Taxonomy Code	Field	1	A valid Primary Taxonomy Code is required.	Enter a valid Taxonomy Code.
	Field	2	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
Specialty	Field	0	Specialty is required.	This field must be completed.

## Language – Individual Practitioner

The Language panel allows an applicant to specify language information for the provider.



### Tasks for this panel

To specify **language** information:

1. If the enrolling provider does not conduct business in a language other than English, select the **next** button,
2. Select the **add** button to add a language record. The **Language** panel redisplay with active fields.

3. Select the preferred language for the enrolling provider from the **Language** drop down list box.
4. Enter the **Effective Date** for use of the selected language.
5. Enter the **End Date** for use of the selected language.
6. Select the **add** button to add another language record.
7. Select the **delete** button to delete a selected language record.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

### Field Descriptions – Language – Individual Practitioner

Field	Description	Field Type	Data Type	Length
add	Adds a new language record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Effective Date	Date when the specified language becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	Date when the specified language is no longer used.	Field	Date (MM/DD/CCYY)	8
Language	Description of the language.	Field	Drop Down List Box	0

Field	Description	Field Type	Data Type	Length
Effective Date [List]	Date when the specified language becomes effective.	Listview	Date (MM/DD/CCYY)	8
End Date [List]	Date when the specified language is no longer used.	Listview	Date (MM/DD/CCYY)	8
Language [List]	Description of the language.	Listview	Character	0

### Field Edits – Language – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
next	Button	0	Duplicate selected Language.	Duplication of selected languages. Correct or remove the duplicated languages.
Effective Date	Field	0	Effective Date is required.	Enter an Effective Date.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Verify entry. The Effective Date must be less than or equal to End Date.
End Date	Field	0	End Date is required.	Enter a valid End Date.
Language	Field	0	Language is required.	Select a language from the drop-down-list box.
Language	Field	1	Duplicate selected Languages.	Remove the duplicate language.

### Group Affiliations – Individual Practitioner

The Group Affiliations panel allows the user to add or update associated group information during the enrollment process.

**Group Affiliations** ?

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

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

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

#### Tasks for this panel

To **add** or **update** associated group member information:

1. If the enrolling provider is not affiliated with a group, select the **next** button.

- If the enrolling provider is affiliated with a group, select the **add** button. The **Group Affiliations** panel redisplay with active fields.

- Enter values for the **Group ID**, **Effective Date**, and **End Date**.
- Select the **add** button to add another group affiliation record
- Select the **delete** button to delete a selected group affiliation record.
- Select the **previous** button to review information entered in previous panels, if desired.
- Select the **next** button to proceed to the next enrollment panel.
- To exit the application, select the **exit** button.

### Field Descriptions – Group Affiliations – Individual Practitioner

Field	Description	Field Type	Data Type	Length
add	Inserts a new group record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Effective Date [Panel]	Effective date of the group.	Field	Date (MM/DD/CCYY)	8
End Date [Panel]	End date of the group.	Field	Date (MM/DD/CCYY)	8
Group ID	Group ID associated with the	Field	Character	15

Field	Description	Field Type	Data Type	Length
[Panel]	member.			
Group Name [Panel] (Read Only)	Name of the group associated with the member.	Field	Character	50
Effective Date [List]	Effective date of the group.	Listview	Date (MM/DD/CCYY)	8
End Date [List]	End date of the group.	Listview	Date (MM/DD/CCYY)	8
Group ID [List]	Group ID associated with the member.	Listview	Character	15
Group Name [List] (Read Only)	Name of the group associated with the member.	Listview	Character	50
Group Type [List] (Read Only)	Type of group ID.	Listview	Character	3

### Field Edits – Group Affiliations – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
Effective Date [Panel]	Field	0	Effective Date must be less than or equal to End Date.	Ensure Effective Date is less than or equal to End Date.
Effective Date [Panel]	Field	1	Effective Date is required.	Enter a valid Effective Date.
Effective Date [Panel]	Field	2	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date less than or equal to 12/31/2299.
Effective Date [Panel]	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date greater than or equal to 01/01/1900.
Effective Date [Panel]	Field	4	Effective Date: Invalid date. Format is mm/dd/ccyy.	Enter a valid Effective Date with the format mm/dd/ccyy.
End Date [Panel]	Field	0	End Date is Required.	Enter a valid End Date.

Field	Field Type	Error Code	Error Message	To Correct
End Date [Panel]	Field	1	End Date must be less than or equal to 12/31/2299.	Enter an End Date less than or equal to 12/31/2299.
End Date [Panel]	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date greater than or equal to 01/01/1900.
End Date [Panel]	Field	3	End Date: Invalid date. Format is mm/dd/ccyy.	Enter an End Date with the format mm/dd/ccyy.
Group ID [Panel]	Field	0	Group ID is required.	Enter a valid Group ID.
Group ID [Panel]	Field	1	Group ID does not exist.	Enter a valid Group ID.

## Criminal Offense I – Individual Practitioner

The Criminal Offense I panel is used by Group, Organization, and Individual providers to add or update associated criminal information during the enrollment process.

### Tasks for this panel

To **add** or **update** associated criminal information:

1. If neither the enrolling provider nor an owner or controlling interest has ever been indicted or convicted, select the **No** option, then the **next** button.
2. If either the enrolling provider or an owner or controlling interest has ever been indicted or convicted, select the **Yes** option to activate the panel fields.
3. Enter valid values in the **Name**, **Offense**, **SSN/FEIN**, and **Date of Offense** fields.
4. Select values from the **Type**, **Role**, and **Disposition** drop down list boxes.

5. Select the **add** button to add another criminal offense record.
6. Select the **delete** button to delete a selected criminal offense record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

**Field Descriptions – Criminal Offense I – Individual Practitioner**

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Criminal Offense I [Panel] - Group/Individual	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?	Field	Radio Button	1
Criminal Offense I [Panel] - Organization	Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5	Field	Radio Button	1

Field	Description	Field Type	Data Type	Length
	percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such person or organizations in any of the programs established by the Titles XVII, XIX, or XX? Choose Yes or No.			
Date of Offense [Panel]	Date of offense.	Field	Date (MM/DD/CCYY)	10
Disposition [Panel]	Disposition of offense.	Field	Drop Down List Box	0
Name [Panel]	Name of individual or organization.	Field	Character	50
Offense [Panel]	Type of criminal offense.	Field	Character	30
Role [Panel] - Individual/Organization	Role of individual or organization charged with criminal offense.	Field	Drop Down List Box	0
SSN/FEIN [Panel] - Individual/Organization	Social Security number or Federal Employer Identification number of individual or organization charged with criminal offense.	Field	Number	9
Type [Panel] - Individual/Organization	Type of Tax ID. Valid values are: SSN and FEIN.	Field	Drop Down List Box	1
Click here for Role Definitions [Panel]	Link to see role definitions.	Hyperlink	N/A	0
Answer [List]	Answer to criminal offense question.	Listview	Character	0
Date of Offense [List]	Date of offense.	Listview	Date (MM/DD/CCYY)	10
Disposition [List]	Disposition of offense.	Listview	Drop Down List Box	0
Name [List]	Name of individual or organization.	Listview	Character	50

Field	Description	Field Type	Data Type	Length
Offense [List]	Type of criminal offense.	Listview	Character	30
Role [List] - Individual/Organization	Role of individual or organization charged with criminal offense.	Listview	Drop Down List Box	0
SSN/FEIN [List] - Individual/Organization	Social Security number or Federal Employer Identification number of individual or organization charged with criminal offense.	Listview	Number	9

**Field Edits – Criminal Offense I – Individual Practitioner**

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date. Format is mm/dd/ccyy / Invalid character data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.
Criminal Offense I [Panel] - Organization	Field	0	YES/NO response to this question is required.	Choose Yes or No.
Criminal Offense I [Panel] - Organization	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Criminal Offense I [Panel] - Organization	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
Date of Offense [Panel]	Field	0	Date of Offense is required.	Enter a valid date of offense.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.

Field	Field Type	Error Code	Error Message	To Correct
Name [Panel]	Field	0	Name is required.	Enter an individual or organization name.
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Role [Panel] - Individual/Organization	Field	0	Role is required.	Select a role from the drop-down list box.
SSN/FEIN [Panel] - Individual/Organization	Field	0	SSN/FEIN is required.	Enter a valid Social Security number or Federal Employer Identifier number.
Type [Panel] - Individual/Organization	Field	0	Type is required.	Choose SSN or FEIN.

## Criminal Offense II – Individual Practitioner

The Criminal Offense II panel is used by Group, Organization, and Individual providers to add or update associated criminal information during the enrollment process.

### Tasks for this panel

To **add** or **update** associated criminal information:

1. If the enrolling provider or any employees have never been indicted or convicted, select the **No** option, then the **next** button.
2. If the enrolling provider or any employees have ever been indicted or convicted, select the **Yes** option to activate the panel fields.

3. Enter valid values in the **Name**, **Offense**, **SSN/FEIN**, and **Date of Offense** fields.
4. Select values from the **Type**, **Role**, and **Disposition** drop down list boxes.
5. Select the **add** button to add another criminal offense record.
6. Select the **delete** button to delete a selected criminal offense record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Criminal Offense II – Individual Practitioner

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Criminal Offense II [Panel]	Are there any directors, officers, agents, or managing employees of the institution, agency organization, or practice who have ever been indicted or convicted of a criminal offense related to the involvement in such programs established by Titles XVII, XIX, or XX? Choose Yes or No.	Field	Radio Button	1
Date Of Offense [Panel]	Date of offense.	Field	Date (MM/DD/CCYY)	10
Disposition [Panel]	Disposition of offense.	Field	Drop Down List Box	0
Name [Panel]	Name of director, officer, agent, or managing employee.	Field	Character	50
Offense [Panel]	Type of criminal offense.	Field	Character	30
Role [Panel]	Role in criminal offense.	Field	Drop Down List	35

Field	Description	Field Type	Data Type	Length
			Box	
SSN/FEIN [Panel]	Social Security number or Federal Employer Identification number of director, officer, agent, or managing employee.	Field	Number	9
Type [Panel]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	4
Click here for Role Definitions [Panel]	Link to see role definitions.	Hyperlink	N/A	0
Answer [List]	Answer to criminal offense question.	Listview	Character	0
Date of Offense [List]	Date of offense.	Listview	Date (MM/DD/CCYY)	10
Disposition [List]	Disposition of offense.	Listview	Drop Down List Box	0
Name [List]	Name of director, officer, agent, or managing employee.	Listview	Character	50
Offense [List]	Type of criminal offense.	Listview	Character	30
Role [List]	Role in criminal offense.	Listview	Drop Down List Box	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of director, officer, agent, or managing employee.	Listview	Number	9

### Field Edits – Criminal Offense II – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
Criminal Offense II [Panel]	Field	0	YES/NO response to this question is required.	Choose Yes or No.
Criminal Offense II [Panel]	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Criminal	Field	2	Only answer NO to this	You cannot have multiple No

Field	Field Type	Error Code	Error Message	To Correct
Offense II [Panel]			question once.	answers.
Date Of Offense [Panel]	Field	0	Date is required.	Enter a valid date.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.
Name [Panel]	Field	0	Name is required.	Enter the name of the director, officer, agent, or managing employee.
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Role [Panel]	Field	0	Role is required.	Select a role from the drop-down list box.
SSN/FEIN [Panel]	Field	0	SSN/FEIN is required.	Enter a valid Social Security number or Federal Employer Identification number.
Type [Panel]	Field	0	Type is required.	Choose SSN or FEIN.

## Violations of State or Federal Law – Individual Practitioner

The Violations of State or Federal Law panel is used to enter information regarding violations of State or Federal laws.

### Tasks for this panel

To **enter** information regarding violations of state or federal laws:

1. If neither the enrolling provider, any of the individual's employees, nor any other business associates has ever had a State or Federal violation, select the **No** option, then the **next** button.

2. If the enrolling provider, any of the individual's employees, or any other business associates has ever had a State or Federal violation, select the **Yes** option.
3. The **Name, Offense, Disposition, and Date of Offense** fields become active.
4. Enter valid values in the **Name, Offense, and Date of Offense** fields.
5. Select a value from the **Disposition** drop down list box.
6. Select the **add** button to add another violation of State or Federal law record.
7. Select the **delete** button to delete a selected State or Federal law record.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

### Field Descriptions – Violations of State or Federal Law – Individual Practitioner

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date of offense [Panel]	Date of the offense.	Field	Date (MM/DD/CCYY)	8
Disposition [Panel]	Disposition of the offense.	Field	Drop Down List Box	0
Name [Panel]	Name of the individual, group, or organization.	Field	Character	50
Offense [Panel]	Type of criminal offense.	Field	Character	50
Have you as Provider, or any Owner, Authorized Agent, Associate, Manager,	Indicates if practitioner has ever violated State or Federal law. Valid values: Yes or No.	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
Employee, Directors, or Officers of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?				
Answer	Answer to State or Federal law violation question.	Listview	Character	0
Date of offense [List]	Date of the offense.	Listview	Date (MM/DD/CCYY)	8
Disposition [List]	Disposition of the offense.	Listview	Drop Down List Box	0
Name [List]	Name of the individual, group, or organization.	Listview	Character	50
Offense [List]	Type of criminal offense.	Listview	Character	50

**Field Edits – Violations of State or Federal Law – Individual Practitioner**

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.
Date of offense [Panel]	Field	0	Date of Offense is required.	Enter a valid date.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.
Name [Panel]	Field	0	Name is required.	Enter an individual, group, or organization name.

Field	Field Type	Error Code	Error Message	To Correct
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Have you as Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.

## Previously Participated – Individual Practitioner

The Previously Participated – Individual Practitioner panel is used to capture the previous provider IDs for Long Term Care provider applicants.

### Tasks for this panel

To enter information on previous provider IDs for Long Term Care provider applicants:

1. Select a **Yes** or **No** response to the question **Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID?**

2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Previous Provider ID** field becomes active.
4. Enter the provider ID previously used for Medicaid business in the **Previous Provider ID** field.
5. Select the **add** button to add another previous provider ID record.
6. Select the **delete** button to delete a selected previous provider ID record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Previously Participated – Individual Practitioner

Field	Description	Field Type	Data Type	Length
add	Inserts a new previous provider ID record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform an delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Previous Provider ID Question	Acknowledgement of previous Ohio Medicaid provider ID number. Valid choices: Yes or No.	Field	Radio Button	1
Previous Provider ID [Detail]	Previous provider identification number of the applicant.	Field	Character	10
Answer	Answer to Previously Participated Question.	Listview	Character	0
Previous Provider ID [List]	Previous provider identification number of the applicant.	Listview	Character	10

### Field Edits – Previously Participated – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
Previous	Field	0	YES/NO response to this	Choose Yes or No.

Field	Field Type	Error Code	Error Message	To Correct
Provider ID Question			question is required.	
Previous Provider ID Question	Field	1	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
Previous Provider ID Question	Field	2	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Previous Provider ID [Detail]	Field	0	Previous Provider ID is required.	Enter a Previous Provider ID.
Previous Provider ID [Detail]	Field	1	Previous Provider ID must be 7 or 10 digits in length.	Enter a value for Previous Provider ID.

## Medicare Sanctions – Individual Practitioner

The Medicare Sanctions panel is used to capture information pertaining to Medicare sanctions for all providers.

The screenshot shows a software window titled "Medicare Sanctions". At the top, there is a table with columns: Provider Name, Date Occurred, From Date, To Date, and SSN/FEIN. The first row contains the value "YES". Below the table, there are "delete" and "add" buttons. A prompt says "Type data below for new record." Below this are several form fields: a question with "YES" and "NO" radio buttons, a text field for "Name", a dropdown for "Type" (set to "SSN"), a text field for "SSN/FEIN", and date pickers for "Date Occurred", "Sanction From Date", and "Sanction To Date". At the bottom, there are "previous", "next", and "exit" buttons.

### Tasks for this panel

To **enter** information pertaining to Medicare sanctions of all providers:

1. Select the **add** button. The Medicare sanctions question and associated fields display in the panel.
2. Select a **Yes** or **No** response to the question **Have you the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers, of the Institution, Agency, Organization, Entity, or Practice ever been sanctioned by the Medicare Program?**

3. If **No** is selected, select the **next** button to proceed to the next enrollment panel.
4. If **Yes** is selected, enter values for the **Name, Type, SSN/FEIN, Date Occurred, Sanction From Date,** and **Sanction To Date** fields.
5. Select the **add** button to add a new Medicare sanctions record.
6. Select the **delete** button to delete a selected Medicare sanctions record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Medicare Sanctions – Individual Practitioner

Field	Description	Field Type	Data Type	Length
add	Inserts a new row	Button	N/A	0
delete	Deletes the selected row	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date Occurred [Detail]	Date of sanction against the individual.	Field	Date (MM/DD/CCYY)	10
Name [Detail]	Name of the sanctioned individual.	Field	Character	50
Question	Have you the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers, of the Institution, Agency, Organization, Entity or Practice ever been sanctioned by the Medicare Program? Choose Yes or No.	Field	Radio Button	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the sanctioned individual. Only pertains to "Individual" providers.	Field	Character	9
Sanction From Date [Detail]	Begin date of the sanction period.	Field	Date (MM/DD/CCYY)	10
Sanction To	End date of the sanction period. Defaults to	Field	Date	10

Field	Description	Field Type	Data Type	Length
Date [Detail]	12/31/2299 on a new entry as well as when the date is blanked out on a change.		(MM/DD/CCYY)	
Type	Type of tax ID. Valid values: SSN or FEIN. Only pertains to "Individual" providers.	Field	Drop Down List Box	0
Date Occurred [List]	Date of sanction against the individual.	Listview	Date (MM/DD/CCYY)	10
Name [List]	Name of the sanctioned individual.	Listview	Character	50
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the sanctioned individual. Only pertains to "Individual" providers.	Listview	Character	9
Sanction From Date [List]	Begin date of the sanction period.	Listview	Date (MM/DD/CCYY)	10
Sanction To Date [List]	End date of the sanction period.	Listview	Date (MM/DD/CCYY)	10
Answer [List]	Represents the answer to the question - "Yes" or "No"	Menu Item	Character	3

### Field Edits – Medicare Sanctions – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
add	Button	51001	A "Yes" or "No" response to the question is required.	Click on "Yes" or "No"
Date Occurred [Detail]	Field	5100	Date Occurred is required.	Enter date occurred in mm/dd/ccyy format
Name [Detail]	Field	5100	Name is required.	Enter Name
Question	Field	5100	YES/NO response to this question is required.	Click "Yes" or "No"
SSN/FEIN [Detail]	Field	5100	SSN/FEIN is required.	Enter SSN/FEIN
Sanction From Date [Detail]	Field	5100	Sanction From Date is required.	Enter Date From
Sanction	Field	5116	Sanction From Date[1/1/2010	Enter Sanction From

Field	Field Type	Error Code	Error Message	To Correct
From Date [Detail]			12:00:00 AM] must be less than or equal to Sanction To Date[1/1/2010 12:00:00 AM].	Date as less than or equal to Sanction To Date

## Certification – Individual Practitioner

The Certification panel contains a legal certification agreement to ensure that the information provided by the applicant is true, accurate, and complete.

**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 <input type="text"/>	*Social Security Number <input type="text"/>
Address 2 <input type="text"/>	*Tax Identification Number <input type="text"/>
*City <input type="text"/>	
*State <input type="text"/>	
*Zip <input type="text"/>	
E-Mail Address <input type="text"/>	
*Preferred Contact Method <input type="text"/>	

**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.

do not accept the terms and conditions  
 accept the terms and conditions

A copy of the Executive Order can be found on our website at <http://jfs.ohio.gov/ohp>

**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 ODJFS may deny the request to participate or, if the entity already participates, may terminate the agreement or contract as appropriate.

do not accept the terms and conditions  
 accept the terms and conditions

**Ohio Medicaid Provider Agreement**

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider 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

do not accept the terms and conditions  
 accept the terms and conditions

**Agreement Date**

Certain provider agreements may be retroactive (up to 12 months) to encompass dates on which the provider 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 ODJFS to mean that you waive your rights to a retroactive period of months prior to the date ODJF approves your application. This agreement is limited to 3 years from the effective date.

\*Type Full Name Here

previous
next
exit



## Tasks for this panel

To **certify** the enrollment information:

1. Enter values in the **Legal Entity Name, Individual Last Name, Address 1, City, Zip, Social Security Number, Tax Identification Number, and Type Full Name Here** fields.
2. Select values from the **State** and **Preferred Contact Method** drop down list boxes.
3. If desired, enter values in the **First, MI, Address 2, and E-Mail Address** fields.
4. Check the **terms and conditions** radio buttons, as applicable.
5. Check the **ProvisionCheck** checkbox as described on the panel.
6. Select the **previous** button to review information entered in previous panels, if desired.
7. Select the **next** button to proceed to the next enrollment panel.
8. To exit the application, select the **exit** button.

## Field Descriptions – Certification – Individual Practitioner

Field	Description	Field Type	Data Type	Length
exit	Exits the provider enrollment process.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Abbreviated Organization Name	Abbreviated name of the applying organization. (This field to be determined.)	Field	Character	25
Address 1	First line of the address.	Field	Character	60
Address 2	Second line of the address.	Field	Character	60
Agreement Date	Date the applicant certified the application.	Field	Date (MM/DD/CCYY)	10
City	City of the address.	Field	Character	30
Doing Business As Name	Operating name of the business or organization that is different than the legal name. (This field to be determined.)	Field	Character	25
E-Mail Address	Email address of the applicant.	Field	Character	50
Electronic Signature Date	Pre-populated current date associated with the electronic signature. Please note that there is no label associated with this field on	Field	Date (MM/DD/CCYY)	10

Field	Description	Field Type	Data Type	Length
	the panel.			
Employer Identification Number	Employer ID number of applicant. (This field to be determined.)	Field	Number	9
Executive Order 2007-01S Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the Executive Order 2007-01S Agreement.	Field	Radio Button	1
False Statement Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the False Statement Agreement.	Field	Radio Button	1
First	Applicant's first name.	Field	Character	25
Individual Last Name	Applicant's last name.	Field	Character	50
Legal Entity Name	Applicant or organization legal entity name.	Field	Character	50
Middle Name	Applicant's middle initial.	Field	Character	1
Occupational Therapist Specific Qualifying Statement	Applicant selects a radio button option to accept or decline the terms of the Occupational Therapist Statement. (This field to be determined.)	Field	Radio Button	1
Ohio Medicaid Provider Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the Enrollment Agreement.	Field	Radio Button	1
Organization Name	Name of the applying organization. (This field to be determined.)	Field	Character	50
Preferred Contact Method	Preferred method of contact for the applicant. Default value: E-Mail.	Field	Drop Down List Box	0
Primary Business Address	Primary business address of business.	Field	Character	60
Proprietor Social Security Number	Social Security number of the business proprietor. (This field to be determined.)	Field	Number	9

Field	Description	Field Type	Data Type	Length
ProvisionCheck	Indicates that the provider has covered services to a Medicaid consumer and the service has not been billed to Medicaid in the last 12 months. This checkbox is not visible during the re-enrollment process.	Field	Check Box	0
Social Security Number	Social Security number of the applicant.	Field	Number	9
State	State of the address.	Field	Drop Down List Box	0
Tax Identification Number	Tax ID number of the applicant.	Field	Number	9
Type Full Name Here	Individual, Group, or Organization name used to certify the enrollment details.	Field	Character	50
Zip	Zip code of the address.	Field	Character	5
Zip + 4	Zip code extension of the address.	Field	Character	4
Enrollment Checklist	Link to display checklists associated with different provider types.	Hyperlink	N/A	0
Website Address	Link to the Ohio Department of Job and Family Services Web site.	Hyperlink	N/A	0

**Field Edits – Certification – Individual Practitioner**

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required	This field must be completed.
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.

Field	Field Type	Error Code	Error Message	To Correct
	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum length.
City	Field	0	City is required	This field must be completed.
Doing Business As Name	Field	1	Doing Business As Name is required.	This field must be completed.
Employer Identification Number	Field	0	Employer Identification Number is required	This field must be completed
Legal Entity Name	Field	0	Legal Entity Name is required.	This field must be completed.
Occupational Therapist Specific Qualifying Statement	Field	0	If Occupational/Therapist 'I do not accept the terms and conditions' is selected you are not allowed to continue.	Click the I accept terms and conditions radio button.
Ohio Medicaid Provider Agreement	Field	0	If Provider Agreement 'I do not accept the terms and conditions' is selected you are not allowed to continue.	Click the I accept terms and conditions radio button.
Social Security Number	Field	0	Social Security Number is required	This field must be completed
State	Field	0	State is required	This field must be completed
Type Full Name Here	Field	0	Provider's Full Name is required.	This field must be completed.
Zip	Field	0	Zip code is required	This field must be completed

## Addendum – Individual Practitioner

The Addendum panel is used by an individual provider applicant to indicate compliance with the eligibility requirements necessary to become a certified provider. The agreement is electronically signed by entering the name of the enrolling provider in the **Signature** field.

The Addendum panel that displays is specific to the specialty(s) chosen on the **Type and Specialty** panel.

Addendum	
<b>Addendum A</b> 60 - MC Home Health Agency -- MEDICARE CERTIFIED HHA SMITH, JOHN D (675) 675-6756 (cell)	
Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliant with the Provider agreement.	
My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver provider for the provision of Medicare-Certified Home Health as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04, including the provision of personal care and nursing services;	
*The entity agrees to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity is a Medicare-certified Home Health Agency (*Attach Medicare Certification letter with effective date);	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will comply with federal non-discrimination regulations as set forth in 42 CFR Part 80(1964);	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will be a part of an interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's All Services Plan;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will maintain a record keeping system which includes information necessary for carrying out the goals of the All Services Plan;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will have available back-up staff to provide services when the entity's regularly scheduled staff cannot or do not meet their obligation to provide services to a consumer;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will have at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity is operated under a single administrative unit responsible for the overall management and conduct of program activities;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity has a set of written policies and procedures which reflect the objectives of the program and govern the provision of services to consumers;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will provide appropriate training and supervision of staff to ensure adherence to the consumer's All Services Plan AND will ensure Personal Care Aides complete eight hours of continuing education annually;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/> YES <input type="checkbox"/> NO
*I attest that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Investigation (BCI) for individuals under final consideration for employment with a home health agency. As enumerated in OAC 5101:3-12-25 (*Attach copy of background check policy);	<input type="checkbox"/> YES <input type="checkbox"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization 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.	
*Signature - Type name here to indicate that you agree	Date 04/24/2009

Addendum		?
<b>Addendum B</b>		
<b>16 - Other Accredited Home Health Agency -- OTHER ACCREDITED HOME HEALTH AGENCY</b>		
SMITH, JOHN D		
(675) 675-6756 (cell)		
<p>Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliant with the Provider agreement.</p>		
<p>My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver provider for the provision of Other Accredited Home Health Agency as set forth in Ohio Administrative Code (OAC) 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04, including the provision of personal care and nursing services;</p>		
*The entity will comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will comply with federal nondiscrimination regulations as set forth in 42 CFR Part 80(1964);	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity has and maintains a Joint Commission on Accreditation of Healthcare (JCAHO) Certificate of Accreditation for the provision of both home health services and personal care and support services (Attach a copy of certification); And/Or The entity has and maintains a Community Health Accreditation Program (CHAPS) Certificate of Accreditation for the provision of nursing, homemaker and home health aide services (Attach a copy of certification); And/Or The entity has and maintains any other certification of accreditation if the entity does not have JCAHO or CHAP certification (Attach a copy of certification).	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity agrees refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will have at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity is a part of an interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's all services plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will maintain a record keeping system which includes information necessary for carrying out the goals of the all services plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity is operated under a single administrative unit responsible for the overall management and conduct of program activities;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity has a set of written policies and procedures which reflect the objectives of the program and govern the provision of services to consumers;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will provide appropriate training and supervision of staff to ensure adherence to the consumer's all services plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advance notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case-by-case basis);	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I attest that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Investigation (BCI) for individuals under final consideration for employment with a home health agency as enumerated in OAC 5101:3-12-25. (*Attach copy of background check policy)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>I certify that I am the officer, chief executive officer, or general partner of the business organization 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.</p>		
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date 04/24/2009

Addendum		?
<b>Addendum C</b>		
<b>25 - Non-Agency Personal Care Aide -- ODJFS WAIVER</b>		
SMITH, JOHN D (675) 675-6756 (cell)		
<b>Enrollment Requirement(s):</b> Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliant with the Provider agreement.		
My name typed below serves as verification that I comply with the requirements for enrollment as a non-agency personal care aide as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04;		
*I agree to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="radio"/> YES	<input type="radio"/> NO
*I am at least 18 years of age, have a valid Social Security card, and another form of identification as indicated in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04;	<input type="radio"/> YES	<input type="radio"/> NO
*I have obtained certificate of completion within the last twenty-four (24) months for either nurse aide competency evaluation program conducted by the Ohio Department of Health in accordance with section 3721.31 of the Revised Code; or the Medicare competency evaluation for home health aides as specified in 47 CFR 484(2005); or other equivalent training program as specified in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04.; (* Attach a copy of the certificate documentation to this form).	<input type="radio"/> YES	<input type="radio"/> NO
*I have obtained and will maintain first aid certification; (* Attach copy of valid first aid documentation)	<input type="radio"/> YES	<input type="radio"/> NO
*I agree to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="radio"/> YES	<input type="radio"/> NO
*I agree to attend all required ODJFS/CMA training sessions;	<input type="radio"/> YES	<input type="radio"/> NO
*I understand that I am required to complete eight hours of continuing education annually;	<input type="radio"/> YES	<input type="radio"/> NO
*I will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="radio"/> YES	<input type="radio"/> NO
Relationship to consumer		
*I meet eligibility requirements for a provider severing a consumer as specified in OAC 5101:3-45-04, 5101:3-47-04 and 5101:3-50-04;	<input type="radio"/> YES	<input type="radio"/> NO
Ohio residency – please select 'YES' to ONLY one		
*I HAVE been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="radio"/> YES	<input type="radio"/> NO
*I HAVE NOT been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check conducted by the Bureau of Criminal Identification and Investigation (BCI&I) and an additional FBI criminal check;	<input type="radio"/> YES	<input type="radio"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization 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.		
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date 04/24/2009

Addendum	
<b>Addendum E</b>	
<b>38 - Private Duty Nurse -- LPN - PDN AND/OR WAIVER HOME CARE NURSING</b>	
SMITH, JOHN D (675) 675-6756 (cell)	
<b>Enrollment Requirement(s):</b> Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a requirement must check all applicable boxes in order to be in compliance with their Provider Agreement.	
My name typed below serves as verification that I comply with the requirements for enrollment as a ODJFS Non-agency Waiver Service Provider – Non-agency RN/Non-agency LPN as a provider of home and community-based nursing as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04;	
*I agree to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*I agree to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*I agree to attend all required ODJFS/CMA training sessions;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*I agree to be part of the interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's all service's plan;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*I am an Ohio Licensed Registered Nurse (RN) OR an Ohio Licensed Practical Nurse (LPN) under the direction of an RN practicing within the scope of my nursing license pursuant to Chapter 4723 of the Revised Code (* Attach a copy of license);	<input type="checkbox"/> YES <input type="checkbox"/> NO
*If LPN, give RN Supervisor	<input type="checkbox"/> YES <input type="checkbox"/> NO
	Supervisor Name <input type="text"/>
	License # RN <input type="text"/>
*I will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/> YES <input type="checkbox"/> NO
Relationship to consumer	
*I meet eligibility requirements for a provider severing a consumer as specified in OAC 5101:3-45-04, 5101:3-47-04 and 5101:3-50-04;	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ohio residency – please select 'YES' to ONLY one	
*I HAVE been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*I HAVE NOT been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check conducted by the Bureau of Criminal Identification and Investigation (BCI&I) and an additional FBI criminal check;	<input type="checkbox"/> YES <input type="checkbox"/> NO
I certify that I am the individual practitioner who 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.	
*Signature - Type name here to indicate that you agree <input type="text"/>	Date 04/24/2009

Addendum	
<b>Addendum F</b>	
<b>45 - Waived Services -- ADULT DAY HEALTH</b>	
SMITH, JOHN D (675) 675-6756 (cell)	
Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.	
My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver Service Provider – Adult Day Health Center Services Provider as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04, including the provision of personal care and nursing services;	
*The entity will comply with all the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity is not eligible to enroll as either a Medicare Certified Home Health Agency or JCAHO Accredited Home Health Agency;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will comply with federal non-discrimination regulations as set forth in 42 CFR Part 80(1964);	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will be a part of an interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's All Services Plan;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will maintain a record keeping system which includes information necessary for carrying out the goals of the All Services Plan;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity is operated under a single administrative unit responsible for the overall management and conduct of program activities;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity has a set of written policies and procedures which reflect the objectives of the program and govern the provision of services to consumers;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity provides appropriate training and supervision of staff to ensure adherence to the consumer's All Services Plan;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/> YES <input type="checkbox"/> NO
*I attest that all employees who have personal contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26.;	<input type="checkbox"/> YES <input type="checkbox"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization 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.	
*Signature - Type name here to indicate that you agree	Date 04/24/2009

Addendum		?	
<b>Addendum G</b>			
<b>45 - Waived Services -- HOME DELIVERED MEALS</b>			
SMITH, JOHN D (675) 675-6756 (cell)			
<b>Enrollment Requirement(s):</b> Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.			
My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver Service Provider – Home Delivered Meal Services Provider in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;			
*The entity will comply with all the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46- 04, 5101:3-47-04, and 5101:3-50-4;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity holds a valid food vendor's license;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity is aware that all meals are prepared and delivered in compliance with all applicable federal, state, county, and local laws and regulations concerning the preparation, handling and transportation of food;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity will maintain documentation as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity will maintain a record for each consumer service that contains a copy of the initial and all subsequent All Services Plans and all dietary instructions prepared by the dietician as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity will comply with all of the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity has at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity must have available back-up staff to provide service with the entity's regularly scheduled staff cannot or do not meet their obligation to provide services to a consumer;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
*The entity attests that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="checkbox"/>	YES <input type="checkbox"/>	NO
I further certify that I am the officer, chief executive officer, or general partner of the business organization 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.			
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date	04/25/2009

Addendum	
<b>Addendum H</b>	
45 - Waived Services -- HOME MODIFICATIONS	
SMITH, JOHN D	
(675) 675-6756 (cell)	
<b>Enrollment Requirement(s):</b> Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.	
My typed name below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver Service Provider – Home Modification Services Provider in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	
*The entity will comply with all of the Conditions of Participation and Provider Requirements of as set forth in OAC 5101:3-45-10, 5101:3-46- 04, 5101:3-47-04, and 5101:3-50-04;	<input type="radio"/> YES <input type="radio"/> NO
*The entity is insured and bonded for general contracting services within Ohio and have submitted proof of insurance;	<input type="radio"/> YES <input type="radio"/> NO
*The entity has knowledge and experience with general contracting principles and concepts pertaining to the home modification project;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will ensure that the work performance is consistent with prevailing trade standards and in conformance with state and local building codes and complies with the ADA;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will assure that home modification are completed in accordance with the agreed upon specifications using all the materials and equipment cited in the bid. The entity will also obtain a final written approval from the consumer and the designated Case Management Agency after completion of the home modification service;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will maintain documentation on consumers as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="radio"/> YES <input type="radio"/> NO
*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will comply with the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="radio"/> YES <input type="radio"/> NO
*The entity attests that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="radio"/> YES <input type="radio"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization 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.	
*Signature - Type name here to indicate that you agree <input type="text"/>	Date 04/25/2009

Addendum		?
<b>Addendum I</b> 45 - Waived Services -- JFS WAIVER TRANSPORT SERVICES SMITH, JOHN D (675) 675-6756 (cell)		
<p><b>Enrollment Requirement(s):</b> Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.</p>		
<p><b>My name typed below serves as verification that the entity complies with the enrollment requirements as an ODJFS Waiver Service Provider – Supplemental Transportation Provider in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;</b></p>		
*The entity will comply with all the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-4;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity has agreed to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity has at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity is responsible for having available back-up staff to provide service when the entity’s regularly scheduled staff cannot or do not meet their obligation to provide services to a consumer;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity will maintain log with documentation as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it’s designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity will comply with all of the standards of the “patients rights” Medicare Conditions of Participation as found in 42 CFR 484;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity is aware the transportation provider must assist in transferring the consumer from the point of pick-up to the vehicle and from the vehicle to the destination point;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*I attest that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/>	YES <input type="checkbox"/> NO
*The entity must: 1) provide ODJFS with a current list of drivers and a copy of the Ohio Driver’s license for each driver; 2) possess collision and liability insurance for each vehicle and driver used in the provision of supplemental transportation services; and 3) have valid motor vehicle inspection from the Ohio Highway Patrol for each vehicle to be used in the provision of supplemental transportation services.	<input type="checkbox"/>	YES <input type="checkbox"/> NO
<p>I certify that I am the officer, chief executive officer, or general partner of the business organization 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.</p>		
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date 04/25/2009

**Addendum** ?

**Addendum J**  
45 - Waived Services -- JFS OUT OF HOME RESPITE  
SMITH, JOHN D  
(675) 675-6756 (cell)

**Enrollment Requirement(s):** Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all applicable boxes in order to be in compliance with their Provider agreement.

My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver Provider for the provision of out-of-home Respite Services as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04, including the provision of personal care and nursing services;

\*The entity will comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;  YES  NO

\*The entity will comply with federal nondiscrimination regulations as set forth in 42 CFR Part 80(1964);  YES  NO

\*The Conditions of Participation for ODJFS-administered waiver providers as set forth in OAC 5101:3-45-10;  YES  NO

\*The entity is not eligible to enroll as either a Medicare-certified Home Health Agency or JCAHO/CHAP- accredited Home Health Agency;  YES  NO

\*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;  YES  NO

\*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;  YES  NO

\*For ICF-MR and NF settings, the entity meets the licensure and certification standards for the facility, including Requirements set forth in OAC 5101:3-3-02 and 5101:3-3-02.3;  YES  NO

\*The entity is a part of an interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's all services plan;  YES  NO

\*The entity will maintain a record keeping system which includes information necessary for carrying out the goals of the All Services Plan;  YES  NO

\*The entity will have at least one representative attend all required ODJFS/CMS provider training sessions;  YES  NO

\*The entity will have available back-up staff to provide service when the entity's regularly scheduled staff cannot or do not meet their obligation to provide services to a consumer;  YES  NO

I certify that I am the officer, chief executive officer, or general partner of the business organization 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.

\*Signature - Type name here to indicate that you agree  Date 04/25/2009

Addendum	
<b>Addendum K</b>	
45 - Waived Services -- JFS EMERGENCY RESPONSE SYSTEM	
SMITH, JOHN D	
(675) 675-6756 (cell)	
<b>Enrollment Requirement(s):</b> Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.	
My name typed below serves as verification that the entity, agency or organization complies with the requirement for enrollment as an Waiver Service Provider – Emergency Response Services Provider in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	
*The entity will comply with all the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46- 04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will operate an emergency response center that is staffed 24-hours-a-day, 365-days-a-year to receive and respond to emergency signals and assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will assure that the emergency response systems meet all applicable quality assurance/quality control industry standards and conduct monthly testing of emergency response systems to assure proper operation;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will provide consumers, their authorized representatives, and caregivers with initial and ongoing training/assistance regarding the use of the emergency response system;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will assure that emergency response center staff respond to alarm messages within 60 seconds of receipt and furnish a replacement emergency response system or an activation device within 24 hours of notification of a malfunction;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity maintain documentation on consumers as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will comply with all of the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity has at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity attests that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="checkbox"/> YES <input type="checkbox"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization 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.	
*Signature - Type name here to indicate that you agree <input type="text"/>	Date 04/25/2009

**Addendum L**

45 - Waived Services -- SPECIALIZED MEDICAL EQUIPMENT  
 SMITH, JOHN D  
 (675) 675-6756 (cell)

Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all applicable boxes in order to be in compliance with their Provider agreement.

My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver provider for the provision of Supplemental Adaptive and Assistive Devices as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04;

\*The entity agrees to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;  YES  NO

\*The entity is not eligible to enroll as either a Medicare-Certified Home Health Agency or JCAHO-Accredited Home Health Agency;  YES  NO

\*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;  YES  NO

\*The entity will have at least one representative attend all required ODJFS/CMA provider training sessions;  YES  NO

\*The entity will assure that the supplemental adaptive and assistive device is tested and is in proper working order, and is subject to warranty in accordance with industry standards prior to submitting a claim;  YES  NO

\*The entity will maintain a clinical record for each consumer served in the manner that protects the confidentiality of these records as outlined in OAC 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04.  YES  NO

\*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;  YES  NO

\*The entity will comply with all of the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;  YES  NO

\*I attest that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Investigation (BCI) for individuals under final consideration for employment with a home health agency.;  YES  NO

I certify that I am the officer, chief executive officer, or general partner of the business organization 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.

\*Signature - Type name here to indicate that you agree  Date 04/25/2009

### Tasks for this panel

To **indicate** compliance with necessary eligibility requirements:

1. Read each question, and then select a **Yes** or **No** response.
2. Type the enrolling provider's name in the **Signature** field.

### Field Descriptions – Addendums – Individual Practitioner

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date	Current date that agreement	Field	Date	0

Field	Description	Field Type	Data Type	Length
	was signed.		(MM/DD/CCYY)	
Signature	Entry of the provider's name to serve as an electronic signature for the agreement.	Field	Character	0
Supername	Supervising Nurse Name	Field	Character	35
all fields	All Yes/No fields	Field	Radio Button	0
License # RN	Supervising Nurse License Number	Field	Alphanumeric	12
question1	1 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question10	10 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question11	11 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question13	13 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question14	14 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question15	15 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question16	16 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question17	17 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question2	2 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0

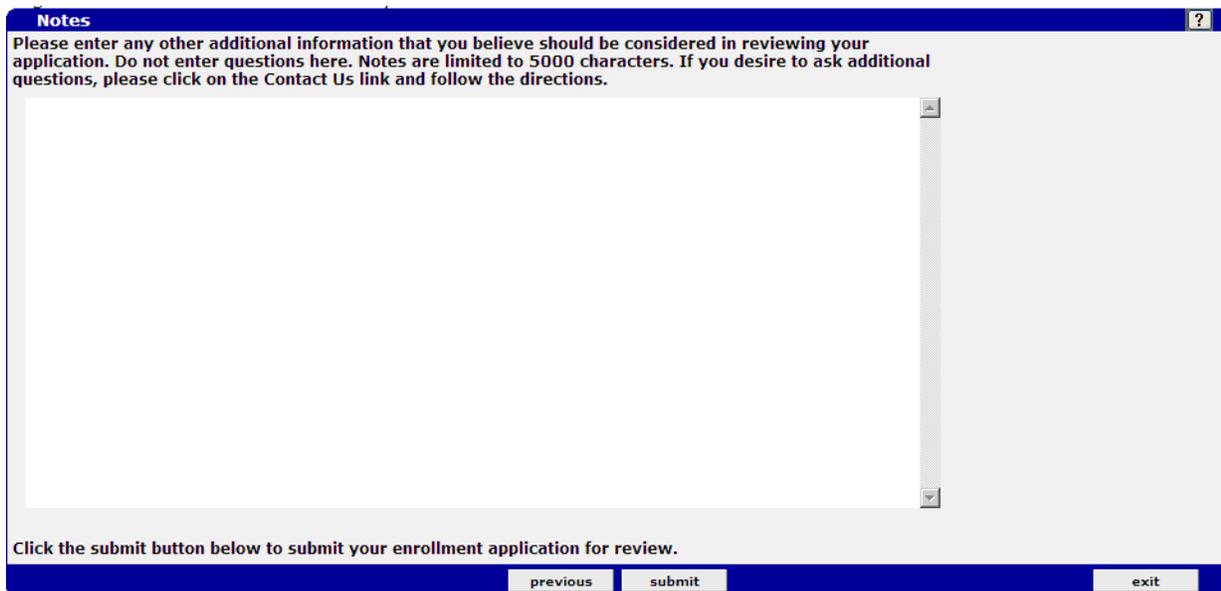
Field	Description	Field Type	Data Type	Length
question3	3 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question4	4 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question5	5 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question6	6 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question7	7 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question8	8 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question9	9 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question12	12 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
Phone Number	Contact Phone number from the Address panel.	Label	N/A	0
Provider Name	The Provider's Name as identified in the Identification panel.	Label	N/A	0
Provider Type and Specialty	The selected Provider Type and Specialty Description	Label	N/A	0
Title	The title of the Addendum, format is Addendum x	Label	N/A	0

### Field Edits – Addendums – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
all fields	Field	1	YES/NO response to this question is required.	Select Yes or No.
all fields	Field	2	You must answer 'YES' to all questions in order to proceed with Application.	Either select Yes to all questions or exit application without submitting.

### Notes – Individual Practitioner

The Notes panel is used to enter additional information or notes associated with the application for the enrolling provider. The body of the panel is a free-text area where any additional information can be typed.



### Tasks for this panel

To **submit** additional information associated with a provider application:

1. Enter any additional information that should be included for consideration in the request for enrollment.
2. Select the **previous** button to review information entered in previous panels, if desired.
3. Select the **submit** button to submit the enrollment request.
4. To exit the application, select the **exit** button.

### Field Descriptions – Notes – Individual Practitioner

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	the Provider Enrollment - Instructions panel.			
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Notes	Free form text of the notes.	Field	Character	5000

### Field Edits – Notes – Individual Practitioner

None.

## Confirmation of Receipt – Individual Practitioner

The Confirmation of Receipt panel displays the Application Tracking Number for the submitted application. It is important to retain this number. It is needed to check the status of the enrollment application, or to continue the enrollment process at a later time if exit was selected from any of the enrollment panels.

**Confirmation of Receipt** ?

Your enrollment application for QUINN has been submitted.

Tracking Number: **403015**

**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.

\*\*\* 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.

- Anticipated Change of Ownership or Control

**WHAT'S NEXT?**

- *Upload required documents.*
- You are required to print, sign and submit the agreement via mail.
- 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.

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

You can check the status of an application from the Check Application status link on the Enrollment Page.

### Tasks for this panel

To **complete** the enrollment:

1. Be sure to record the application **tracking number** shown in bold on the second line of the panel.

2. Note the document(s) listed under **Please remember to submit the following required documents:** that must be submitted.
3. Follow the **WHAT'S NEXT?** Instructions:
  - a. If electronically attaching supporting documents, click the **Upload required documents** link. [Reviewer Note: Instructions for uploading documents to be determined.]
  - b. Click the **Print Cover Page** link to print the required cover sheet for any documents that will be sent to ODJFS - Provider Enrollment Unit by mail. (See **Attachment Uploads** for further instructions on attaching supporting documents electronically.)
  - c. Click the **Print Application** link to print a copy of the enrollment application.
4. To exit the application, select the **exit** button.

### Field Descriptions – Confirmation of Receipt – Individual Practitioner

Field	Description	Field Type	Data Type	Length
exit	Exit to the provider enrollment landing page.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Agreement	Link to the provider enrollment agreement.	Hyperlink	N/A	0
MCP Addendum Terms	Link to MCP Addendum Terms	Hyperlink	N/A	0
Summary	Link to view summary of the provider enrollment application.	Hyperlink	N/A	0
Submit Information	Application tracking number that is assigned when the application is submitted.	Label	N/A	0

### Field Edits – Confirmation of Receipt – Individual Practitioner

None

### Attachment Uploads – Individual Practitioner

The Attachments Uploads panel enables the user to upload files for claims, prior authorizations, and provider enrollments.

Attachment Upload			
Type of Document	Reference		Received
EXPLANATION OF BENEFITS	2309351050001 017033877000014989101		YES
OPERATIVE NOTE	2309351050001 017033877000014989102		IN PROCESS
PERIODONTAL CHARTS	2309351050001 017033877000014989103		IN PROCESS
RADIOLOGY REPORTS	2309351050001 017033877000014989104		YES
SUPPORT DATA FOR CLAIM	2309351050001 017033877000014989105		NO

Please note the following important parameters when uploading files:

- File size cannot be greater than 50MB (51200KB).
- Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.
- For claim attachments: Select row from the list above and then use the below panel to select the file for upload.

Attachment Upload
?

upload attachment

Type of Document EXPLANATION OF BENEFITS

Reference 2309351050001 017033877000014989101

\* File to Upload

Browse...

### Tasks for this panel

To **upload** an attachment:

- Select a row in the **Attachment Upload** list section of the panel.
- Click the **browse** button and select the file to upload.
- Click the **upload attachment** button.

### Field Descriptions – Attachment Uploads – Individual Practitioner

Field	Description	Field Type	Data Type	Length
Browse	Allows the user to navigate and select a local file to upload.	Button	N/A	0
upload attachment	Initiate the file upload.	Button	N/A	0
File to Upload	The navigational path of the file to be uploaded including the file name. Is a required field.	Field	Character	256
Upload	Bound file input - for direction on which file to upload.	Field	Character	0
Reference	Control number assigned to the attachment for identification purposes.	Label	N/A	0
Type of Document	Description of the uploaded file.	Label	N/A	0
Received	Indicates if the attachment has been received (This field will visible only for Claims attachment).	Listview	Character	10
Reference	Control number assigned to the attachment for identification purposes.	Listview	Character	35
Type of Document	Description of the uploaded file.	Listview	Character	75

### Field Edits – Attachment Uploads – Individual Practitioner

Field	Field Type	Error Code	Error Message	To Correct
upload attachment	Button	0	File format must be one of the following: bmp, doc, gif, jpg, mdi, pdf, ppt, tiff, txt, xls.	Select a file of the proper format to be uploaded.
File to Upload	Field	0	Please select a file to upload.	Click the Browse button to select a file to upload into the Web Portal.

### Attachment Cover – Individual Practitioner

The Attachment Cover panel displays the provider enrollment attachment cover page. Providers should print this page and include it when mailing or faxing required documents to ODJFS.



## EDMS COVER SHEET

**Fax Information:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ No. of Pages: \_\_\_\_\_ (Including this cover sheet)  
 Phone: \_\_\_\_\_ To FAX documents, please set fax machine's quality settings to High or Fine. Failing to do so may result in a delay in processing of your documents.

**Document Type:**

Provider  
  Recipient  
  Correspondence  
  Prior authorization  
  Supporting documents for claim  
 Accounts receivable  
  Payment deduction  
  Expenditure  
  Hospital cost settlement  
  LTC cost settlement  
 Declaration of election of hospice benefit  
  Attending physician written certification  
  Revocation of hospice benefit  
 Statement of termination of hospice benefit  
  Selection of a different hospice provider  
  IDG written certification  
 Programs  
  RetroDUR patient profile  
  RetroDUR survey  
  RetroDUR reports  
  RetroDUR other documents

Sub Categories for Prior Authorization Documents

Compression Garments  
  Decubitus Care Equipment  
  Dental  
  Dressings, Surgical  
 Enteral Nutrition & Supplies  
  EPSDT  
  Hospital Beds  
  Hospital Inpatient  
  Hospital Outpatient  
  Hearing Aids  
 Incontinence Supplies  
  Increased State Plan Home Health  
  Misc Equipment  
  Orthodontics  
  Orthotics (MTA)  
 Orthotics/Prosthetics (Nurses)  
  PDN  
  Repairs  
  Respiratory (MTA)  
  Respiratory (Nurses)  
 Supplies (Misc)  
  Speech Generating Devices  
  Transportation  
  Therapies  
  Vision  
  Wheelchairs  
  Others

**Index Field & Values (if applicable):**

Application Tracking Number: Recipient ID: \_\_\_\_\_ Prior Authorization Number: \_\_\_\_\_  
 4 0 2 7 7 9 \_\_\_\_\_  
 NPI: \_\_\_\_\_ Medicaid Provider ID: \_\_\_\_\_ Use only if you do not have NPI.  
 ICN: \_\_\_\_\_ Contact Tracking Number: \_\_\_\_\_  
 Financial Record Number: \_\_\_\_\_ Status: \_\_\_\_\_ Program Control Number: \_\_\_\_\_  
 Hospice Enrollment ID: \_\_\_\_\_ Hospice Attachment ID: \_\_\_\_\_ Intervention ID: \_\_\_\_\_



**Confidentiality Notice:**

The sender of this facsimile transmission intends to communicate the contents of this transmission only to the Ohio Department of Job and Family Services. This transmission may contain information that is privileged, confidential or otherwise exempt from disclosure under applicable law. If you are not the designated recipient or the employee or agent responsible for delivering this transmission to the designated recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone at 1-800-686-1516 and promptly destroy the original transmission. Thank you for your assistance.

JFS 00000 (Rev. 02/23/2010)      Ohio Department of Job and Family Services



### Tasks for this panel

There are no tasks to perform in this panel.

### Field Descriptions – Attachments – Individual Practitioner

Field	Description	Field Type	Data Type	Length
Control Number	Control number assigned to the attachment for identification purposes.	Label	Number	80
Date Submitted	Date the enrollment application was submitted.	Label	Date (MM/DD/CCYY)	8
Name	Name of the provider or business.	Label	Character	30
SSN/FEIN	Social Security number or Federal Employer Identification number of the provider or business.	Label	Character	10

### Field Edits – Attachments – Individual Practitioner

None.

This is the end of the Individual Practitioner enrollment process.

## 4 ENROLLMENT FOR TRADING PARTNERS

The **Instructions** panel is the first enrollment panel and provides detailed information regarding how to proceed with the enrollment process. From this panel, the remaining panels for the enrollment process for trading partners are accessed. The basic steps necessary for completing the enrollment application are as follows:

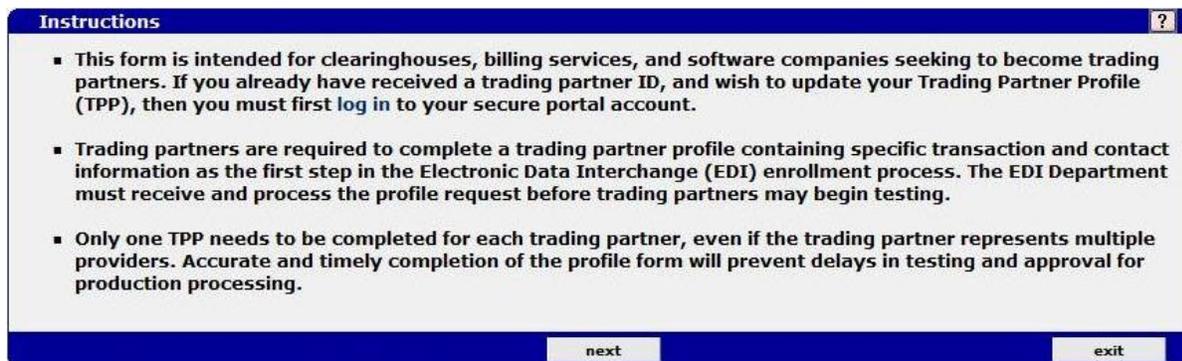
1. Work through each panel by entering the required information.
2. Proceed to the next panel by selecting the **Next** button at the bottom of each panel.
3. To review information in a prior panel select the **Previous** button at the bottom of each panel.
4. Complete the information in each panel before proceeding to the next panel.
5. To exit the Provider Enrollment application and return to the **Instructions** panel, select the **exit** button.

### About the Trading Partner Profile

The information provided during the enrollment process creates a Trading Partner Profile (TPP) that is saved in the system. After enrollment has been completed and the trading partner has established the online MITS account, the TPP can later be revised, as necessary.

### Trading Partner Instructions Panel

The Instructions panel displays instructions for the trading partner enrollment process.



#### Tasks for this Panel

To **begin** the enrollment process:

1. Select the **next** button to proceed to the **Trading Partner Information** panel.
2. To exit the application, select the **exit** button.

### Trading Partner Information Panel

The Trading Partner Enrollment-Information panel is used to enter the name, address and Tax ID for the trading partner's organization.

### Tasks for this Panel

To **enter** trading partner information:

1. Enter required information in the **Trading Partner Name, Address Line 1, Address Line 2, City, Zip,** and **Tax ID** fields.
2. Select a value from the **State** drop down list box.
3. Enter information in the **Address Line 2** and 4-digit **Zip** extension fields.
4. Select the **previous** button to review information entered in previous panels, if desired.
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application, select the **exit** button.

### Field Descriptions – Trading Partner Information

Field	Description	Field Type	Data Type	Length
clear	Clears all the enterable fields on this panel.	Button	N/A	0
exit	Exits the trading partner enrollment wizard.	Button	N/A	0
next	Navigate to the next panel in the trading partner enrollment wizard.	Button	N/A	0
previous	Navigate to the previous panel in the trading partner enrollment wizard.	Button	N/A	0
Address Line 1	First street address line of the trading partner organization.	Field	Character	55
Address Line 2	Second street address line of the trading partner organization.	Field	Character	55
City	City of the trading partner organization.	Field	Character	30
State	State of the trading partner organization.	Field	Drop Down List Box	0
Status	Indicates the current status of the trading partner. Values are Currently Active, Currently	Field	Drop Down List Box	0

Field	Description	Field Type	Data Type	Length
	Inactive, Testing, and Not Enrolled. The field cannot be updated by the user.			
Tax ID	Federal Tax Identification number for the trading partner organization.	Field	Character	9
Trading Partner Name	Trading partner organization name.	Field	Character	50
Zip	Zip code of the trading partner organization.	Field	Number	5
Zip 4	Zip code extension of the trading partner organization.	Field	Number	4

### Field Edits – Trading Partner Information

Field	Field Type	Error Code	Error Message	To Correct
Address Line 1	Field	0	Address Line 1 is required.	Enter an Address Line 1.
City	Field	0	City is required.	Enter a City.
State	Field	0	State is required.	Select a State.
Tax ID	Field	1	Tax ID is required.	Enter a Tax ID.
Trading Partner Name	Field	0	Trading Partner Name is required.	Enter a Trading Partner Name.
Zip	Field	0	Zip is required.	Enter a Zip Code.
	Field	1	Invalid Zip.	Verify entry. Zip code must be five digits long.
Zip 4	Field	0	Invalid Zip Ext.	Verify entry. Zip code extension must be four digits long.

## Trading Partner Enrollment – Contact Details Panel

The Trading Partner Enrollment – Contact Details panel is used to enter designated contact information for the trading partner's organization. It requires business, secondary, and technical contact information.

Contact Type	Contact Name	Contact Phone	Contact Email
BUSINESS	JOHN SMITH	(555)225-1234	JOHN.SMITH@TRADINGPARTNER.COM
SECONDARY	JANE DOE	(555)225-2223	JANE.DOE@TRADINGPARTNER.COM
TECHNICAL	JOHN DOE	(555)225-3333	JOHN.DOE@TRADINGPARTNER.COM

Select each row above and enter the required information for each contact type. Then select next to continue.

Contact Type:

\*Contact Name:

\*Contact Phone/Ext.:

\*Contact Email:

previous    next    exit    clear

### Tasks for this Panel

To enter trading partner contact information:

1. Select the row for the contact type about which information is to be entered.
2. Enter required information in the **Contact Name**, **Contact Phone**, and **Contact Email** fields.
3. Enter a value in the contact phone **Ext.** field, if applicable.
4. Repeat steps 1 and 2 for each listed contact type.
5. Select the **previous** button to review information entered in previous panels, if desired.
6. Select the **next** button to proceed to the next enrollment panel.
7. To exit the application, select the **exit** button.

### Field Descriptions – Trading Partner Contact Details

Field	Description	Field Type	Data Type	Length
add	Adds another contact to the data list.	Button	N/A	0
clear	Clears the contact list and all the fields on this panel.	Button	N/A	0
delete	Deletes the selected contact from the data list.	Button	N/A	0
exit	Exits the trading partner enrollment wizard.	Button	N/A	0
next	Navigate to the next panel in the trading partner enrollment wizard.	Button	N/A	0
previous	Navigate to the previous panel in the trading partner enrollment wizard.	Button	N/A	0
Contact Email	Email address of the trading partner or managed care trading partner contact.	Field	Alphanumeric	100
Contact Name	The name of the trading partner	Field	Character	50

Field	Description	Field Type	Data Type	Length
	or managed care trading partner contact.			
Contact Phone	Phone number of the trading partner or managed care trading partner contact.	Field	Number	15
Contact Phone Ext	Phone extension of the trading partner or managed care trading partner contact.	Field	Number	10
Contact Type	Contact Type of the trading partner or managed care trading partner contact. Valid Values include Business, Technical, and Secondary.	Field	Drop Down List Box	0

### Field Edits – Trading Partner Contact Details

Field	Field Type	Error Code	Error Message	To Correct
Contact Email	Field	1	Contact Email is required.	Enter a valid Contact Email.
	Field	2	Contact Email is invalid.	Enter a valid Contact Email address. It must be in an x@x.xxx format.
Contact Name	Field	1	Contact Name is required.	Enter a Contact Name.
Contact Phone	Field	1	Contact Phone is required.	Enter a valid Contact Phone.
	Field	2	Contact Phone is invalid.	Enter a valid Contact Phone. It must be 10 digits and can be in the 999-999-9999 or (999) 999-9999 format.
Contact Phone Ext	Field	1	Phone Ext is invalid.	Enter a valid Phone Extension. It must be numeric.

### Trading Partner Transaction Sets Panel

The Trading Partner Transaction Sets panel is used by a trading partner to select the EDI transactions they want supported. This panel is read-only on the Secure Portal.



## Tasks for this Panel

To **select** the desired EDI transactions:

1. Select the checkbox(es) corresponding to the desired EDI transaction(s).
2. Select the **clear** button to clear all selected checkboxes (**NOTE:** 277, 824, and 997 transactions are selected by default and cannot be cleared).
3. Select the **previous** button to review information entered in previous panels, if desired.
4. Select the **next** button to proceed to the next enrollment panel.
5. To exit the application, select the **exit** button.

## Field Descriptions – Trading Partner Transaction Sets

Field	Description	Field Type	Data Type	Length
clear	Clears all the enabled checkboxes on the panel.	Button	N/A	0
exit	Exits the trading partner enrollment wizard.	Button	N/A	0
next	Navigate to the next panel in the trading partner enrollment wizard.	Button	N/A	0
previous	Navigate to the previous panel in the trading partner enrollment wizard.	Button	N/A	0
270/271 Healthcare Eligibility Benefit Inquiry/Response	Indicates that the trading partner supports 270/271 Healthcare Eligibility Benefit Inquiry/Response	Field	Check Box	0
276/277 Healthcare Claim Status Inquiry/Response	Indicates that the trading partner supports 276/277 Healthcare Claim Status Inquiry/Response	Field	Check Box	0
277 Unsolicited	Indicates that the trading partner	Field	Check Box	0

Field	Description	Field Type	Data Type	Length
Healthcare Claim Status Notification	supports 277 Unsolicited Healthcare Claim Status Notification. (checked by default). Disabled.			
820 Payroll Deducted and Other Group Premium Payment for Insurance	Indicates that the trading partner supports 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.	Field	Check Box	0
824 Application Advice	Indicates that the trading partner supports the 824 Application Advice. (checked by default). Disabled.	Field	Check Box	0
834 Benefit Enrollment and Maintenance	Indicates that the trading partner supports 834 Benefit Enrollment and Maintenance.	Field	Check Box	0
835 Healthcare Claim Payment/Remittance Advice	Indicates that the trading partner supports 835 Healthcare Claim Payment/Remittance Advice.	Field	Check Box	0
837 Healthcare Claim - Dental	Indicates that the trading partner supports 837 Healthcare Claim - Dental.	Field	Check Box	0
837 Healthcare Claim - Institutional	Indicates that the trading partner supports 837 Healthcare Claim - Institutional.	Field	Check Box	0
837 Healthcare Claim - Professional	Indicates that the trading partner supports 837 Healthcare Claim - Professional.	Field	Check Box	0
997 Functional Acknowledgement	Indicates that the trading partner supports 997 Functional Acknowledgement (checked by default). Disabled.	Field	Check Box	0

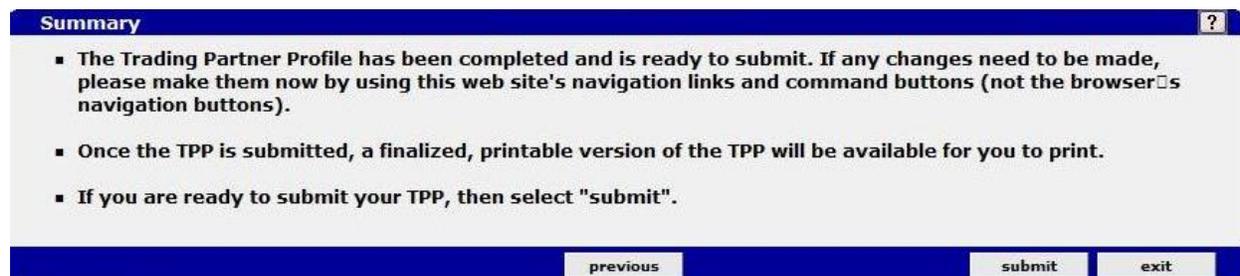
### Field Edits - Trading Partner Transaction Sets

Field	Field Type	Error Code	Error Message	To Correct
270/271 Healthcare Eligibility Benefit Inquiry/Response	Field	0	At least one selection is required.	Please select at least one transaction.
	Field	1	A 837 txn must be selected in order to enroll in Eligibility	Check one of the 837 transactions in addition to the 270/271 checkbox.

Field	Field Type	Error Code	Error Message	To Correct
			Verification.	
276/277 Healthcare Claim Status Inquiry/Response	Field	1	A 837 txn must be selected in order to enroll in Claims Status Inquiry.	Check one of the 837 transactions in addition to the 276/277 checkbox.

## Trading Partner Summary Panel

Trading Partner Summary panel presents final instructions for the trading partner’s enrollment application and creation of a TPP.



### Tasks for this Panel

To **submit** a completed Trading Partner Profile and complete enrollment:

1. Select the **submit** button.
2. Select the **previous** button to review information entered in previous panels, if desired.
3. To exit the application, select the **exit** button.

This is the end of the Trading Partner enrollment process.

## 5 ENROLLMENT FOR A GROUP PRACTICE

Providers who practice under a legal entity that includes multiple providers use a provider type of "Group Practice" for enrollment to use the Provider Medicaid Portal.

### Identifying Information Panel – Group Practice

This version of the Identifying Information panel allows a group practice applicant to enter identifying information, including provider numbers, certification and license information, and federal identification numbers

#### Group Practice

The screenshot shows a web form titled "Identifying Information" with a blue header and a question mark icon. The form contains the following fields and controls:

- \*Group Legal Name: Text input field
- Medicare Type: Drop-down menu
- Medicare Provider Number: Text input field
- Previous Medicaid Provider Number: Text input field
- \*Ownership Type: Drop-down menu
- Doing Business As Name: Text input field
- \*Type: Drop-down menu
- \*SSN/FEIN: Text input field
- NPI: Text input field
- CLIA Number: Text input field

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

#### Tasks for this panel:

To **enter** identifying information:

1. Enter valid values in the **Group Legal Name** and **SSN/FEIN** fields.
2. Select values from the **Ownership Type** and **Type** drop down list boxes.
3. Select a value from the **Medicare Type** drop down list box, if applicable.
4. Enter values in the **Medicare Provider Number**, **Previous Medicaid Provider Number**, **Doing Business As Name**, **NPI**, and **CLIA Number**, if applicable.
5. Select the **previous** button to review information entered in previous panels, if desired.
6. Select the **next** button to proceed to the next enrollment request.
7. To exit the application, select the **exit** button.

#### Field Descriptions – Identifying Information – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Saves the updated information on	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	the panel and navigates to the next panel in the provider enrollment wizard.			
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
CLIA Number	Clinical Laboratory Improvement Act (CLIA) number assigned to the group.	Field	Number	10
Doing Business As Name	Name for individual or entity applicants doing business under a trade or company name.	Field	Character	50
Group Legal Name	Legal Name of the Group.	Field	Character	50
Medicare Provider Number	Medicare Provider Number of the group.	Field	Number	10
Medicare Type	Medicare Type PTAN/CCN.	Field	Drop Down List Box	4
NPI	National Provider Identifier number. If an individual, enter NPI associated with SSN.	Field	Number	10
Ownership Type	Type of ownership.	Field	Drop Down List Box	1
Previous Medicaid Provider Number	Previous Medicaid Provider Number of the group.	Field	Number	10
SSN/ FEIN	SSN Number or Federal Employer Identification Number.	Field	Number	9
Type	Type of tax ID. Valid values: SSN or FEIN.	Field	Character	4

**Field Edits – Identifying Information – Group Practice**

Field	Field Type	Error Code	Error Message	To Correct
CLIA Number	Field	1	CLIA Number is required.	This field must be completed when provider type is Independent Laboratory.
Doing Business As Name	Field	0	Doing Business As (D/B/A) is required.	This field must be completed.
Group Legal Name	Field	1	Legal Entity Name or Individual Last Name is	This field must be completed.

Field	Field Type	Error Code	Error Message	To Correct
			required.	
Medicare Provider Number	Field	1	When Medicare Type is selected Medicare Provider Number is required.	Enter Medicare Provider Number.
Medicare Type	Field	1	When Medicare Provider Number is selected Medicare Type is required.	Enter Medicare Type.
NPI	Field	1	NPI is required.	This field must be completed.
SSN/ FEIN	Field	1	SSN/FEIN is required.	This field must be completed.
Type	Field	1	Type is required	This field must be completed.

## Tax ID – Group Practice

Group practice providers enter their tax information in this panel.

### Tasks for this panel

To enter tax information:

1. Select values from the **IRS Tax Type**, **Tax ID Exempt**, **W9 Form**, **Form 147**, and **State** drop down list boxes.
2. Enter valid values in the **IRS Tax ID**, **Name**, **Address 1**, **City**, **Zip** and **IRS Effective Date** fields.
3. Enter values in the **Address 2**, 4-digit **ZIP** extension, **IRS End Date**, **Phone** and **Phone** extension fields, if applicable.
4. Select the **previous** button to review information entered in previous panels, if desired.
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application, select the **exit** button.

### Field Descriptions – Tax ID – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment -	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	Instructions panel			
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
State	Provider's state.	Combo Box	Character	2
Address 1	Provider's street address 1.	Field	Character	60
Address 2	Provider's street address 2. (Optional)	Field	Alphanumeric	60
City	Provider's city.	Field	Character	15
Ext	Provider's phone number extension.	Field	Number	4
Form 147	Indicates whether the provider has submitted Form 147, stating name and tax identification number.	Field	Drop Down List Box	1
IRS Effective Date	Effective date of IRS tax ID.	Field	Date (MM/DD/CCYY)	8
IRS End Date	End date of IRS tax ID.	Field	Date (MM/DD/CCYY)	8
IRS Tax ID	Provider's tax ID.	Field	Number	9
IRS Tax Type	Identifies the identification number as either Social Security Number or Federal Employee/Employer Identification Number	Field	Character	1
Name	Provider's name.	Field	Character	50
Phone	Provider's phone number.	Field	Number	10
Tax ID Exempt	Indicates whether the provider is exempt from receiving a 1099 statement.	Field	Drop Down List Box	1
W9 Form	Indicates whether the provider provided a W-9 form.	Field	Drop Down List Box	1
Zip	Provider zip code.	Field	Number	5
Zip+4	Provider 4-character zip code extension.	Field	Number	4

### Field Edits – Tax ID – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
State	Combo Box	1	A valid State is required.	Select a State.
Address 1	Field	1	Address 1 is required.	Enter an Address 1.
City	Field	1	City is required.	Enter a City.
Form 147	Field	1	Form 147 is required.	Select Yes or No.
Form 147	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for Tax ID Exempt, W9 Form, or Form 147 fields.
IRS Effective Date	Field	1	IRS Effective Date is required.	Enter an IRS Effective Date.
IRS Effective Date	Field	2	IRS Effective Date must be less than or equal to IRS End Date.	IRS Effective Date must be less than or equal to IRS End Date.
IRS End Date	Field	1	IRS End Date is required.	Enter an IRS End Date.
IRS End Date	Field	2	IRS Effective Date must be less than or equal to IRS End Date.	IRS Effective Date must be less than or equal to IRS End Date.
IRS Tax ID	Field	1	IRS Tax ID is required.	Enter a valid Tax ID.
IRS Tax ID	Field	2	Tax ID must be 9 digits.	Enter a valid Tax ID.
IRS Tax Type	Field	4	IRS Tax Type is required.	Select a Tax ID Type.
Phone	Field	1	Phone must be 10 digits in length.	Enter phone with 10 digits.
Tax ID Exempt	Field	1	Tax ID Exempt is required.	Select Yes or No.
Tax ID Exempt	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for Tax ID Exempt, W9 Form, or Form 147 fields.
W9 Form	Field	1	W9 Form is required.	Select Yes or No.
W9 Form	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for Tax ID Exempt, W9 Form, or Form 147 fields.
Zip	Field	1	Zip is required.	Enter a 5 digit zip.
Zip	Field	2	Zip must be 5 digits in length.	Enter a 5 digit zip.

Field	Field Type	Error Code	Error Message	To Correct
Zip+4	Field	1	Zip must be 4 digits in length.	Enter 4 digit zip code extension.

## Address Information – Group Practice

The Address Information panel is used by an enrolling provider group practice applicant to provide address information. At least one Practice Location address must be entered.

### Address Information – Group Practice

### Tasks for this panel

To enter **address** information:

1. Select values from the **Address Type**, **County**, and **State** drop down list boxes.
2. Enter valid values in the **Address 1**, **City**, **Zip**, **E-Mail Address**, **Contact Name**, and **Phone 1** fields.
3. Enter values in the **Address 2**, 4-digit **Zip** extension, **Phone 2**, **Fax 1**, **Fax 2**, and **TDD** fields, if applicable.
4. Select a value from the **Phone 1** and **Phone 2** phone type drop down list boxes, if applicable.
5. Select the **add** button to add another address information info record.
6. Select the **delete** button to delete a selected address information record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Address Information – Group Practice

Field	Description	Field Type	Data Type	Length
add	Inserts a new address record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Address 1	First line of the address specified by Address Type.	Field	Character	60
Address 2	Second line of the address specified by Address Type.	Field	Character	60
Address Type	Type of address.	Field	Drop Down List Box	0
City	City of the address specified by Address Type.	Field	Character	30
Contact Name	Name of the contact at the specified address.	Field	Character	40
County	County of the address specified by Address Type.	Field	Drop Down List Box	0
E-mail Address	Email address for the business.	Field	Character	50
Fax 1	First fax number for provider at the specified Address Type.	Field	Number	10
Fax 2	Second fax number for provider at the specified Address Type.	Field	Number	10
Phone 1	First phone number for the provider at the address specified by Address Type.	Field	Number	10
Phone 2	Second phone number for the provider at the address specified by Address Type.	Field	Number	10
Phone Ext 1	First phone extension for the provider (no label on panel).	Field	Number	4
Phone Ext 2	Second phone extension for the provider (no label on panel).	Field	Number	4

Field	Description	Field Type	Data Type	Length
Phone Type 1	First phone type (no label on panel).	Field	Drop Down List Box	0
Phone Type 2	Second phone type (no label on panel).	Field	Drop Down List Box	0
State	State of the address specified by Address Type.	Field	Drop Down List Box	0
TDD	Telecommunications Device for the Deaf number of the address specified by Address Type.	Field	Number	10
Zip	Zip code of the address specified by Address Type.	Field	Number	5
Zip + 4	Zip code extension of the address specified by Address Type (no label on panel).	Field	Number	4
Address 1 (List)	First line of the address specified by Address Type.	Listview	Character	60
Address Type (List)	Type of address.	Listview	Character	20
City (List)	City of the address specified by Address Type.	Listview	Character	30
Phone 1 (List)	First phone number for the provider at the address specified by Address Type.	Listview	Number	10
State (List)	State of the address specified by Address Type.	Listview	Character	2
Zip (List)	Zip code of the address specified by Address Type.	Listview	Number	5

**Field Edits – Address Information – Group Practice**

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required.	This field must be completed.
Address Type	Field	0	Address Type is required.	This field must be completed.
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum length.

Field	Field Type	Error Code	Error Message	To Correct
City	Field	0	City is required.	This field must be completed.
Contact Name	Field	1	Contact Name is required.	Enter a name in the field.
County	Field	0	County is required.	This field must be completed.
E-mail Address	Field	1	E-mail Address is required.	Enter a valid email address.
Phone 1	Field	0	Phone is required.	This field must be completed.
State	Field	0	State is required.	This field must be completed.
Zip	Field	0	Zip is required.	This field must be completed.

## Type and Specialty – Group Practice

The Type and Specialty panel is used by a group practice applicant to specify the applicant's primary specialty and any additional specialties. If the option is available to choose a primary specialty, the applicant must select one before continuing the enrollment.

### Tasks for this panel

To specify **provider type** and **specialty**:

1. Select values from the **Specialty** and **License Type** drop down list boxes.

**Note:** Depending on the provider type chosen, the **Specialty** drop down list box and **Primary Specialty?** check box may or may not display.

2. Select the **Primary Specialty?** check box.
3. Enter valid values in the **License Number**, **License Issue Date**, **License Expiration Date**, and **Taxonomy Code** fields.

4. To search for a primary taxonomy code, click the **[Search]** hyperlink adjacent to the **Primary Taxonomy Code** field.
5. A secondary search panel for **Primary Taxonomy Code** displays.

- a. Enter a value for the **Taxonomy** code, **Description** of the taxonomy, or both.
- b. Select the **search** button. Taxonomy information that matches the search criteria displays in the Search Results area.

Taxonomy	Description
103TC1900X	PSYCHOLOGIST - COUNSELING
103TC2200X	PSYCHOLOGIST - CLINICAL CHILD & ADOLESCENT
103TE1000X	PSYCHOLOGIST - EDUCATIONAL
103TE1100X	PSYCHOLOGIST - EXERCISE & SPORTS
103TF0000X	PSYCHOLOGIST - FAMILY
103TF0200X	PSYCHOLOGIST - FORENSIC
103TH0004X	PSYCHOLOGIST - HEALTH
103TH0100X	PSYCHOLOGIST - HEALTH SERVICE
103TM1700X	PSYCHOLOGIST - MEN & MASCULINITY
103TM1800X	PSYCHOLOGIST - MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES

< Previous 1 2 3 Next >

- c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.
  - d. Select the **line** with the taxonomy code that is appropriate for the enrolling provider.
  - e. The selected code displays in the **Primary Taxonomy Code** field in the **Type and Specialty** panel.
  - f. Select **[Close]** in the upper right corner of the **Taxonomy Code Search** panel.
6. If desired, enter a valid value in one or more of the **Ancillary Taxonomy Code** fields.
  7. To search for an ancillary taxonomy code, click the **[Search]** hyperlink adjacent to the **Ancillary Taxonomy Code** field.
  8. A secondary search panel for **Ancillary Taxonomy Code** displays.

- a. Enter a value for the **Taxonomy** code, **Description** of the taxonomy, or both.
- b. Select the **search** button. Taxonomy information that matches the search criteria displays in the Search Results area.

- c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.
  - d. Select the **line** with the taxonomy code that is appropriate for the enrolling provider.
  - e. Select **[Close]** in the upper right corner of the **Ancillary Taxonomy Code** search panel.
  - f. The selected code displays in the **Ancillary Taxonomy Code** field in the **Type and Specialty** panel.
9. Select the **previous** button to review information entered in previous panels, if desired.
  10. Select the **next** button to proceed to the next enrollment panel.
  11. To exit the application, select the **exit** button.

### Field Descriptions – Type and Specialty – Group Practice

Field	Description	Field Type	Data Type	Length
add	Inserts a new specialty record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Effective Date	Effective date of the specified specialty.	Field	Date (MM/DD/CCYY)	8
End Date	Expiration date of the specified specialty.	Field	Date (MM/DD/CCYY)	8
License Expiration Date	Expiration date of the specified license.	Field	Date (MM/DD/CCYY)	8
License Issue Date	Date when the specified specialty license was issued.	Field	Date (MM/DD/CCYY)	8
License Number	Applicant's license number.	Field	Character	15
Primary Specialty?	Indicator of applicant's primary specialty.	Field	Check Box	1
Primary Taxonomy Code	Primary taxonomy code of the specified specialty. Click [Search] to search for and select a taxonomy code.	Field	Alphanumeric	9
Specialty	Applicant's specialty. Example valid value: 929-Physician Assistant.	Field	Drop Down List Box	0
Provider Type	Type of provider.	Label	Character	0
Effective Date [List]	Effective date of the specified specialty.	Listview	Date (MM/DD/CCYY)	8
End Date [List]	Expiration date of the specified specialty.	Listview	Date (MM/DD/CCYY)	8
Primary? [List]	Indicator of applicant's primary specialty.	Listview	Character	0
Specialty Desc [List]	Applicant's specialty. Example valid value: 929-Physician Assistant.	Listview	Character	10

### Field Edits – Type and Specialty – Group Practice

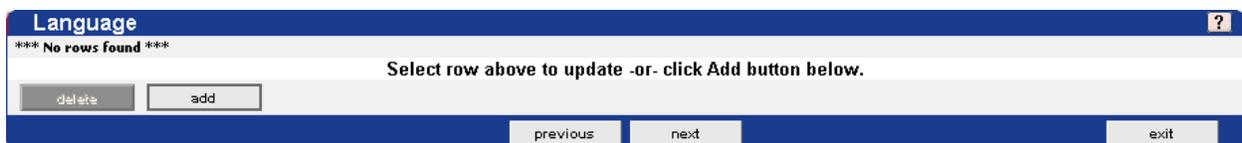
Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must

Field	Field Type	Error Code	Error Message	To Correct
			alphanumeric data.	only contain valid dates; character fields must only contain A - Z and 0 - 9.
	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum length.
Ancillary Taxonomy Code	Field	1	Second Ancillary Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
	Field	1	First Ancillary Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
	Field	1	Third Ancillary Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
	Field	2	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
	Field	2	Previous Ancillary Taxonomy Code is required when next Ancillary Taxonomy Code is entered.	Enter the Previous Ancillary Taxonomy Code before the next.
	Field	2	Previous Ancillary Taxonomy Code is required when next Ancillary Taxonomy Code is entered.	Enter the Previous Ancillary Taxonomy Code before the next.
	Field	3	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
	Field	3	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
License Expiration Date	Field	0	License Expiration Date is required.	This field must be completed if enrollment type is Individual Practitioner.
License Issue Date	Field	0	License Issue Date [MM/DD/CCYY HH:MM AM or PM] must be less than or equal to License Expiration Date MM/DD/CCYY HH:MM AM or PM]	Ensure that Issue Date is on or before Expiration Date.

Field	Field Type	Error Code	Error Message	To Correct
	Field	1	License Issue Date is required.	This field must be completed if enrollment type is Individual Practitioner.
License Number	Field	1	License Number is required.	This field must be completed if enrollment type is Individual Practitioner.
License Type	Field	0	License Type is required.	This field must be completed if enrollment type is Individual Practitioner.
Primary Specialty?	Field	0	Primary Specialty not found.	A primary specialty must be selected.
	Field	1	More than 1 Primary Specialty found.	Ensure that Primary Specialty isn't selected for more than one specialty.
Primary Taxonomy Code	Field	1	A valid Primary Taxonomy Code is required.	Enter a valid Taxonomy Code.
	Field	2	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
Specialty	Field	0	Specialty is required.	This field must be completed.

## Language – Group Practice

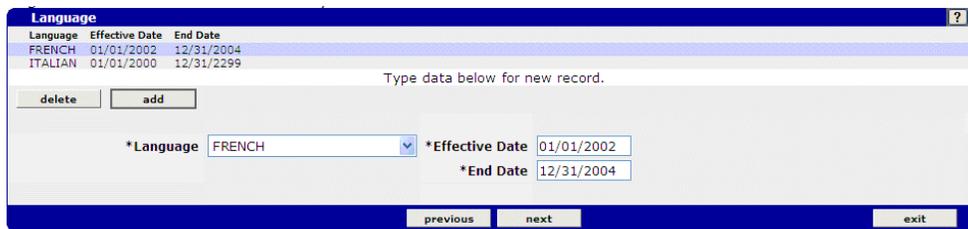
The Language panel allows a group practice applicant to specify language information.



### Tasks for this panel

To specify **language** information:

1. If the enrolling provider does not conduct business in a language other than English, select the **next** button,
2. Select the **add** button to add a language record. The **Language** panel redisplay with active fields.



3. Select the preferred language for the enrolling provider from the **Language** drop down list box.
4. Enter the **Effective Date** for use of the selected language.
5. Enter the **End Date** for use of the selected language.
6. Select the **add** button to add another language record.
7. Select the **delete** button to delete a selected language record.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

### Field Descriptions – Language – Group Practice

Field	Description	Field Type	Data Type	Length
add	Adds a new language record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Effective Date	Date when the specified language becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	Date when the specified language is no longer used.	Field	Date (MM/DD/CCYY)	8
Language	Description of the language.	Field	Drop Down List Box	0
Effective	Date when the specified language	Listview	Date	8

Field	Description	Field Type	Data Type	Length
Date [List]	becomes effective.		(MM/DD/CCYY)	
End Date [List]	Date when the specified language is no longer used.	Listview	Date (MM/DD/CCYY)	8
Language [List]	Description of the language.	Listview	Character	0

### Field Edits – Language – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
next	Button	0	Duplicate selected Language.	Duplication of selected languages. Correct or remove the duplicated languages.
Effective Date	Field	0	Effective Date is required.	Enter an Effective Date.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Verify entry. The Effective Date must be less than or equal to End Date.
End Date	Field	0	End Date is required.	Enter a valid End Date.
Language	Field	0	Language is required.	Select a language from the drop-down-list box.
Language	Field	1	Duplicate selected Languages.	Remove the duplicate language.

### Group Members – Group Practice

The Group Members panel allows a provider applicant to add or update associated group member information during the enrollment process. This panel is read-only for the re-enrollment process.

The screenshot shows a web application window titled "Group Members". At the top, there is a header with the following columns: Member ID, Member Type, Member Name, Effective Date, and End Date. Below the header, there is a text prompt: "Type data below for new record." To the left of this prompt are two buttons: "delete" and "add". Below the prompt, there are four input fields arranged in a 2x2 grid:
 

- Top-left: \*Member ID (with an asterisk indicating it is required)
- Top-right: \*Effective Date (with an asterisk indicating it is required)
- Bottom-left: Member Name
- Bottom-right: \*End Date (with an asterisk indicating it is required)

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

**Tasks for this panel**

To **add** or **update** associated group member information:

1. Select the **add** button. The **Group Members** panel redispays with active fields.
2. Enter values for the **Group ID**, **Effective Date**, and **End Date** fields.
3. Select the **add** button to add another group members record.
4. Select the **previous** button to review information entered in previous panels, if desired.
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application, select the **exit** button.

**Field Descriptions – Group Members – Group Practice**

Field	Description	Field Type	Data Type	Length
add	Inserts a new group provider record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Effective Date [Panel]	Effective date of the group.	Field	Date (MM/DD/CCYY)	8
End Date [Panel]	End date of the group.	Field	Date (MM/DD/CCYY)	8
Member ID [Panel]	Member ID associated with the group.	Field	Number	15
Member Name [Panel] (Read Only)	Name of the member associated with the group.	Field	Character	50
Effective Date [List]	Effective date of the group.	Listview	Date (MM/DD/CCYY)	8
End Date [List]	End date of the group.	Listview	Date (MM/DD/CCYY)	8
Member ID [List]	Member ID associated with	Listview	Character	15

Field	Description	Field Type	Data Type	Length
	the group.			
Member Name [List] (Read Only)	Name of the member associated with the group.	Listview	Character	50
Member Type [List] (Read Only)	Type of member ID.	Listview	Character	3

**Field Edits – Group Members – Group Practice**

Field	Field Type	Error Code	Error Message	To Correct
Effective Date [Panel]	Field	0	Effective Date must be less than or equal to End Date.	Ensure Effective Date less than or equal to End Date.
	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	2	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date less than or equal to 12/31/2299.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date greater than or equal to 01/01/1900.
	Field	4	Effective Date: Invalid date. Format is mm/dd/ccyy.	Enter an Effective Date with the format mm/dd/ccyy.
End Date [Panel]	Field	0	End Date is required.	Enter a valid End Date.
	Field	1	End Date must be less than or equal to 12/31/2299.	Enter an End Date less than or equal to 12/31/2299.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date greater than or equal to 01/01/1900.
	Field	3	End Date: Invalid date. Format is mm/dd/ccyy.	Enter an End Date with the format mm/dd/ccyy.
Member ID [Panel]	Field	0	Member ID is required.	Enter a valid Member ID
	Field	1	Member ID does not exist.	Enter a valid Member ID.
	Field	2	Member ID must be at least 9 characters in length.	Enter a valid Member ID

## Criminal Offense I – Group Practice

The Criminal Offense I panel is used by Group, Organization, and Individual providers to add or update associated criminal information during the enrollment process.

### Tasks for this panel

To **add** or **update** associated criminal information:

1. If neither the enrolling provider nor an owner or controlling interest has ever been indicted or convicted, select the **No** option, then the **next** button.
2. If either the enrolling provider or an owner or controlling interest has ever been indicted or convicted, select the **Yes** option to activate the panel fields.
3. Enter valid values in the **Name**, **Offense**, and **Date of Offense** fields.
4. Select a value from the **Disposition** drop down list box.
5. Select the **add** button to add another criminal offense record.
6. Select the **delete** button to delete a selected criminal offense record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Criminal Offense I – Group Practice

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	Proper permissions are required to perform a delete.			
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Criminal Offense I [Panel] - Group/Individual	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?	Field	Radio Button	1
Criminal Offense I [Panel] - Organization	Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5 percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such person or organizations in any of the programs established by the Titles XVII, XIX, or XX? Choose Yes or No.	Field	Radio Button	1
Date of Offense [Panel]	Date of offense.	Field	Date (MM/DD/CCYY)	10

Field	Description	Field Type	Data Type	Length
Disposition [Panel]	Disposition of offense.	Field	Drop Down List Box	0
Name [Panel]	Name of individual or organization.	Field	Character	50
Offense [Panel]	Type of criminal offense.	Field	Character	30
Role [Panel] - Individual/Organization	Role of individual or organization charged with criminal offense.	Field	Drop Down List Box	0
SSN/FEIN [Panel] - Individual/Organization	Social Security number or Federal Employer Identification number of individual or organization charged with criminal offense.	Field	Number	9
Type [Panel] - Individual/Organization	Type of Tax ID. Valid values are: SSN and FEIN.	Field	Drop Down List Box	1
Click here for Role Definitions [Panel]	Link to see role definitions.	Hyperlink	N/A	0
Answer [List]	Answer to criminal offense question.	Listview	Character	0
Date of Offense [List]	Date of offense.	Listview	Date (MM/DD/CCYY)	10
Disposition [List]	Disposition of offense.	Listview	Drop Down List Box	0
Name [List]	Name of individual or organization.	Listview	Character	50
Offense [List]	Type of criminal offense.	Listview	Character	30
Role [List] - Individual/Organization	Role of individual or organization charged with criminal offense.	Listview	Drop Down List Box	0
SSN/FEIN [List] - Individual/Organization	Social Security number or Federal Employer Identification number of individual or organization charged with criminal offense.	Listview	Number	9

### Field Edits – Criminal Offense I – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date. Format is mm/dd/ccyy / Invalid character data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.
Criminal Offense I [Panel] - Organization	Field	0	YES/NO response to this question is required.	Choose Yes or No.
Criminal Offense I [Panel] - Organization	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Criminal Offense I [Panel] - Organization	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
Date of Offense [Panel]	Field	0	Date of Offense is required.	Enter a valid date of offense.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.
Name [Panel]	Field	0	Name is required.	Enter an individual or organization name.
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Role [Panel] - Individual/Organization	Field	0	Role is required.	Select a role from the drop-down list box.
SSN/FEIN [Panel] - Individual/Organization	Field	0	SSN/FEIN is required.	Enter a valid Social Security number or Federal Employer Identifier number.
Type [Panel] - Individual/Organization	Field	0	Type is required.	Choose SSN or FEIN.

## Criminal Offense II – Group Practice

The Criminal Offense II panel is used by Group, Organization, and Individual providers to add or update associated criminal information during the enrollment process.

### Tasks for this panel

To **add** or **update** associated criminal information:

1. If the enrolling provider or any employees have never been indicted or convicted, select the **No** option, then the **next** button.
2. If the enrolling provider or any employees have ever been indicted or convicted, select the **Yes** option to activate the panel fields.
3. Enter valid values in the **Name**, **Offense**, **SSN/FEIN**, and **Date of Offense** fields.
4. Select values from the **Type**, **Role**, and **Disposition** drop down list boxes.
5. Select the **add** button to add another criminal offense record.
6. Select the **delete** button to delete a selected criminal offense record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Criminal Offense II – Group Practice

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	delete.			
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Criminal Offense II [Panel]	Are there any directors, officers, agents, or managing employees of the institution, agency organization, or practice who have ever been indicted or convicted of a criminal offense related to the involvement in such programs established by Titles XVII, XIX, or XX? Choose Yes or No.	Field	Radio Button	1
Date Of Offense [Panel]	Date of offense.	Field	Date (MM/DD/CCYY)	10
Disposition [Panel]	Disposition of offense.	Field	Drop Down List Box	0
Name [Panel]	Name of director, officer, agent, or managing employee.	Field	Character	50
Offense [Panel]	Type of criminal offense.	Field	Character	30
Role [Panel]	Role in criminal offense.	Field	Drop Down List Box	35
SSN/FEIN [Panel]	Social Security number or Federal Employer Identification number of director, officer, agent, or managing employee.	Field	Number	9
Type [Panel]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	4
Click here for Role Definitions [Panel]	Link to see role definitions.	Hyperlink	N/A	0
Answer [List]	Answer to criminal offense question.	Listview	Character	0
Date of Offense	Date of offense.	Listview	Date	10

Field	Description	Field Type	Data Type	Length
[List]			(MM/DD/CCYY)	
Disposition [List]	Disposition of offense.	Listview	Drop Down List Box	0
Name [List]	Name of director, officer, agent, or managing employee.	Listview	Character	50
Offense [List]	Type of criminal offense.	Listview	Character	30
Role [List]	Role in criminal offense.	Listview	Drop Down List Box	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of director, officer, agent, or managing employee.	Listview	Number	9

### Field Edits – Criminal Offense II – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
Criminal Offense II [Panel]	Field	0	YES/NO response to this question is required.	Choose Yes or No.
Criminal Offense II [Panel]	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Criminal Offense II [Panel]	Field	2	Only answer NO to this question once.	You cannot have multiple No answers.
Date Of Offense [Panel]	Field	0	Date is required.	Enter a valid date.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.
Name [Panel]	Field	0	Name is required.	Enter the name of the director, officer, agent, or managing employee.
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Role [Panel]	Field	0	Role is required.	Select a role from the drop-down list box.
SSN/FEIN [Panel]	Field	0	SSN/FEIN is required.	Enter a valid Social Security number or Federal Employer

Field	Field Type	Error Code	Error Message	To Correct
				Identification number.
Type [Panel]	Field	0	Type is required.	Choose SSN or FEIN.

## Type of Entity or Practice – Group Practice

The Type of Entity panel captures the type of business that is represented in the application for group enrollment.

### Tasks for this panel

To **enter** information on the type of business:

1. Select a value for the type of group enrolling in the **Type of Entity or Practice** drop down list box.
2. If the type of group does not appear in the **Type of Entity or Practice** list, enter text for the type of group enrolling in the **If Other, specify** field.
3. Select the **previous** button to review information entered in previous panels, if desired.
4. Select the **next** button to proceed to the next enrollment panel.
5. To exit the application, select the **exit** button.

### Field Descriptions – Type of Entity – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
If Other, specify	Different description that is used when Other (Specify) is selected.	Field	Character	50
Type of Entity or Practice	Type of business.	Field	Drop Down List Box	0

### Field Edits – Type of Entity – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
If Other, specify	Field	1	If Other, specify is required.	Enter a value in this field when Other (Specify) is selected.
Type of Entity or Practice	Field	1	Type of Entity or Practice is required.	Select a value for Entity or Practice.

### Change of Ownership or Control – Group Practice

The Change of Ownership or Control panel captures information pertaining to a change of ownership or control.

#### Tasks for this panel

To **capture** information pertaining to a change of ownership or control:

1. Select a **Yes** or **No** response to the question **Has there been any change in ownership or control within the year?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Date of Transaction**, **Is Explanation Attached?** and **Explanation** fields become active.
4. Enter the expected date of the change of ownership in the **Date of Transaction** field.
5. Select **Yes** or **No** from the **Is Explanation Attached?** drop down list box.
6. Select **Yes** if the explanation will be included as a mailed or faxed attachment to the enrollment application.
7. If **No** is selected, enter text in the **Explanation** field to explain why no explanation is attached with the enrollment application.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

### Field Descriptions – Change of Ownership or Control – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date of Transaction	Date transaction occurred.	Field	Date (MM/DD/CCYY)	8
Enter Explanation Here	Description of the change in ownership or control.	Field	Character	300
Is Explanation Attached?	Indicates if an attachment will be appended to the application with an explanation of the change of ownership or control. Valid values: Yes or No	Field	Drop Down List Box	1
Has there been any change in ownership or control within the year?	Indicates if practice owner has changed in last year. Valid values: Yes or No.	Field	Radio Button	0

### Field Edits – Change of Ownership or Control – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
Date of Transaction	Field	1	Date is required.	Enter a valid date.
Date of Transaction	Field	2	Date is invalid.	Enter a valid date.
Date of Transaction	Field	3	Date of Transaction must be between today and year from today.	Enter a valid date.
Enter Explanation Here	Field	1	Enter Explanation Here is required.	Enter a value in this field or select Explanation Attached.
Is Explanation	Field	1	Explanation Attached is	Select YES or NO.

Field	Field Type	Error Code	Error Message	To Correct
Attached?			required.	
Has there been any change in ownership or control within the year?	Field	1	Change of Ownership is required.	Select YES or NO.

## Anticipated Change of Ownership or Control – Group Practice

The Anticipated Change of Ownership or Control panel captures information pertaining to an expected change of ownership or control.

### Tasks for this panel

To **enter** information pertaining to an expected change of ownership or control:

1. Select a **Yes** or **No** response to the question Do you anticipate any change in ownership or control within the year?
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Anticipated Date of Transaction**, **Is Explanation Attached?** and **Explanation** fields become active.
4. Enter the expected date of the change of ownership in the **Anticipated Date of Transaction** field.
5. Select **Yes** or **No** from the **Is Explanation Attached?** drop down list box.
6. Select **Yes** if the explanation will be included as a mailed or faxed attachment to the enrollment application.
7. If **No** is selected, enter text in the **Explanation** field to explain why no explanation is attached with the enrollment application.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.

10. To exit the application, select the **exit** button.

### Field Descriptions – Anticipated Change of Ownership or Control – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Anticipated Date of Transaction	Date anticipated transaction will occur.	Field	Date (MM/DD/CCYY)	8
Enter Explanation Here	Description of the anticipated change in ownership or control.	Field	Character	300
Is Explanation Attached?	Indicates if an attachment will be appended to the application with an explanation in the change of ownership or control? Valid values: Yes or No	Field	Drop Down List Box	1
Do you anticipate any change in ownership or control within the year?	Indicates if practice owner is expected to change in next year. Valid values: Yes or No.	Field	Radio Button	0

### Field Edits – Anticipated Change of Ownership or Control – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
Anticipated Date of Transaction	Field	1	Date is required.	Enter a valid date.
Anticipated Date of Transaction	Field	2	Date is invalid.	Enter a valid date.
Anticipated Date of Transaction	Field	3	Anticipated Date of Transaction must be between today and year from today.	Enter a valid date.

Field	Field Type	Error Code	Error Message	To Correct
Enter Explanation Here	Field	1	Enter Explanation Here is required.	Enter a value in this field or select Explanation Attached.
Is Explanation Attached?	Field	1	Is Explanation Attached? is required.	Select YES or NO.
Do you anticipate any change in ownership or control within the year?	Field	1	Change of Ownership is required.	Select YES or NO.

## Management Company or Leased – Group Practice

The Management Company or Leased panel captures information about whether the business is owned by a management company or is leased.

### Tasks for this panel

To **enter** information on whether the business is owned by a management company or leased:

1. Select a **Yes** or **No** response to the question **Is this entity or practice operated by a management company, or leased in whole or part by another organization?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Change of Operations Date** field becomes active.
4. Enter the date the management lease became effective in the **Change of Operations Date** field.
5. Select the **previous** button to review information entered in previous panels, if desired.
6. Select the **next** button to proceed to the next enrollment panel.
7. To exit the application, select the **exit** button.

### Field Descriptions – Management Company or Leased – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Change of Operations Date	Date of the change of operations.	Field	Date (MM/DD/CCYY)	8
Is this entity or practice operated by a management company, or leased in whole or part by another organization?	Indicates if practice is operated by an outside entity. Valid values: Yes or No.	Field	Radio Button	0

### Field Edits – Management Company or Leased – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
Change of Operations Date	Field	1	Change of Operations Date is required.	Enter a valid date.
	Field	2	Change of Operations Date is invalid.	Enter a valid date.
	Field	3	Change of Operations Date must be past or current date.	Enter a valid date
Is this entity or practice operated by a management company, or leased in whole or part by another organization?	Field	1	Question is required.	Select YES or NO

### Medicare Sanctions – Group Practice

The Medicare Sanctions panel captures information pertaining to Medicare sanctions for all providers.

### Tasks for this panel

To **enter** information pertaining to Medicare sanctions of all providers:

1. Select the **add** button. The Medicare sanctions question and associated fields display in the panel.
2. Select a **Yes** or **No** response to the question **Have you the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers, of the Institution, Agency, Organization, Entity, or Practice ever been sanctioned by the Medicare Program?**
3. If **No** is selected, select the **next** button to proceed to the next enrollment panel.
4. If **Yes** is selected, enter values for the **Name, Type, SSN/FEIN, Date Occurred, Sanction From Date, and Sanction To Date** fields.
5. Select the **add** button to add a new Medicare sanctions record.
6. Select the **delete** button to delete a selected Medicare sanctions record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Medicare Sanctions – Group Practice

Field	Description	Field Type	Data Type	Length
add	Inserts a new row	Button	N/A	0
delete	Deletes the selected row	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date Occurred [Detail]	Date of sanction against the individual.	Field	Date (MM/DD/CCYY)	10
Name [Detail]	Name of the sanctioned individual.	Field	Character	50
Question	Have you the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers, of the Institution, Agency, Organization, Entity or Practice ever been sanctioned by the Medicare Program? Choose Yes or No.	Field	Radio Button	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the sanctioned individual. Only pertains to "Individual" providers.	Field	Character	9
Sanction From Date [Detail]	Begin date of the sanction period.	Field	Date (MM/DD/CCYY)	10
Sanction To Date [Detail]	End date of the sanction period. Defaults to 12/31/2299 on a new entry as well as when the date is blanked out on a change.	Field	Date (MM/DD/CCYY)	10
Type	Type of tax ID. Valid values: SSN or FEIN. Only pertains to "Individual" providers.	Field	Drop Down List Box	0
Date Occurred [List]	Date of sanction against the individual.	Listview	Date (MM/DD/CCYY)	10
Name [List]	Name of the sanctioned individual.	Listview	Character	50
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the sanctioned individual. Only pertains to "Individual" providers.	Listview	Character	9
Sanction From Date [List]	Begin date of the sanction period.	Listview	Date (MM/DD/CCYY)	10
Sanction To Date [List]	End date of the sanction period.	Listview	Date (MM/DD/CCYY)	10
Answer	Represents the answer to the question -	Menu	Character	3

Field	Description	Field Type	Data Type	Length
[List]	"Yes" or "No"	Item		

### Field Edits – Medicare Sanctions – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
add	Button	51001	A "Yes" or "No" response to the question is required.	Click on "Yes" or "No"
Date Occurred [Detail]	Field	5100	Date Occurred is required.	Enter date occurred in mm/dd/ccyy format
Name [Detail]	Field	5100	Name is required.	Enter Name
Question	Field	5100	YES/NO response to this question is required.	Click "Yes" or "No"
SSN/FEIN [Detail]	Field	5100	SSN/FEIN is required.	Enter SSN/FEIN
Sanction From Date [Detail]	Field	5100	Sanction From Date is required.	Enter Date From
Sanction From Date [Detail]	Field	5116	Sanction From Date[1/1/2010 12:00:00 AM] must be less than or equal to Sanction To Date[1/1/2010 12:00:00 AM].	Enter Sanction From Date as less than or equal to Sanction To Date

### Previously Participated – Group Practice

The Previously Participated panel captures the previous provider IDs for group practice provider applicants.

**Previously Participated** ?

Answer	Previous Provider ID
Yes	1234567890

Type data below for new record.

delete    add

\*Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID?  Yes  No

\* Previous Provider ID    1234567890

previous    next    exit

## Tasks for this panel

To **enter** information on previous provider IDs for Long Term Care provider applicants:

1. Select a **Yes** or **No** response to the question **Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Previous Provider ID** field becomes active.
4. Enter the provider ID previously used for Medicaid business in the **Previous Provider ID** field.
5. Select the **add** button to add another previous provider ID record.
6. Select the **delete** button to delete a selected previous provider ID record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

## Field Descriptions – Previously Participated – Group Practice

Field	Description	Field Type	Data Type	Length
add	Inserts a new previous provider ID record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform an delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID?	Indicates if practice has previously been issued a Medicaid or Provider ID. Valid values: Yes or No.	Field	Radio Button	0
Previous Provider ID [Detail]	Previous provider identification number of the applicant.	Field	Character	10
Answer	Answer to Previously Participated Question.	Listview	Character	0
Previous Provider	Previous provider identification number of the	Listview	Character	10

Field	Description	Field Type	Data Type	Length
ID [List]	applicant.			

### Field Edits – Previously Participated – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID?	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
	Field	2	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Previous Provider ID [Detail]	Field	0	Previous Provider ID is required.	Enter a Previous Provider ID.
Previous Provider ID [Detail]	Field	1	Previous Provider ID must be 7 or 10 digits in length.	Enter a value for Previous Provider ID.

### Violations of State or Federal Law – Group Practice

The Violations of State or Federal Law panel is used to enter information regarding violations of state or federal laws.

## Tasks for this panel

To **enter** information regarding violations of state or federal laws:

1. If neither the enrolling group practice, any of its employees, nor any other business associates has ever had a State or Federal violation, select the **No** option, then the **next** button.
2. If the enrolling group practice, any of its employees, or any other business associates has ever had a State or Federal violation, select the **Yes** option.
3. The **Name**, **Offense**, **Disposition**, and **Date of Offense** fields become active.
4. Enter values in the **Name**, **Offense**, and **Date of Offense** fields.
5. Select a value from the **Disposition** drop down list box.
6. Select the **add** button to add another violation of State or Federal law record.
7. Select the **delete** button to delete a selected violation of State or Federal law record.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

## Field Descriptions – Violations of State or Federal Law – Group Practice

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date of offense [Panel]	Date of the offense.	Field	Date (MM/DD/CCYY)	8
Disposition [Panel]	Disposition of the offense.	Field	Drop Down List Box	0
Name [Panel]	Name of the individual, group, or organization.	Field	Character	50
Offense	Type of criminal offense.	Field	Character	50

Field	Description	Field Type	Data Type	Length
[Panel]				
Role [Panel]	Role of individual or organization charged with criminal offense.	Field	Drop Down List Box	0
SSN/FEIN [Panel]	Social Security number or Federal Employer Identification number of the individual or organization charged with criminal offense.	Field	Number	9
Type [Panel]	Type of Tax ID. Valid values are: SSN and FEIN.	Field	Drop Down List Box	0
Have you or any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?	Indicates if individual with practice has ever been indicted under, or convicted of, State or Federal law violation. Valid values: Yes or No.	Field	Radio Button	0
Answer	Answer to violation of State or Federal law question.	Listview	Character	0
Date of offense [List]	Date of the offense.	Listview	Date (MM/DD/CCYY)	8
Disposition [List]	Disposition of the offense.	Listview	Drop Down List Box	0
Name [List]	Name of the individual, group, or organization.	Listview	Character	50
Offense [List]	Type of criminal offense.	Listview	Character	50
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual or organization charged with criminal offense.	Listview	Number	9

### Field Edits – Violations of State or Federal Law – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.
Date of offense [Panel]	Field	0	Date of Offense is required.	Enter a valid date.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.
Name [Panel]	Field	0	Name is required.	Enter an individual, group, or organization name.
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Role [Panel]	Field	0	Role is required.	Select a role from the drop-down list box.
SSN/FEIN [Panel]	Field	0	SSN/FEIN is required.	Enter a valid Social Security number or Federal Employer Identification number.
Type [Panel]	Field	0	Type is required.	Choose SSN or FEIN.
Have you or any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to	You cannot have a mix of No and Yes

Field	Field Type	Error Code	Error Message	To Correct
			this question once.	answers or multiple No answers.
	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.

## Certification – Group Practice

The Certification panel contains a legal certification agreement to ensure that the information provided by the applicant is true, accurate, and complete.

**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.

do not accept the terms and conditions  
 accept the terms and conditions

A copy of the Executive Order can be found on our website at <http://jfs.ohio.gov/ohp>

**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 ODJFS may deny the request to participate or, if the entity already participates, may terminate the agreement or contract as appropriate.

do not accept the terms and conditions  
 accept the terms and conditions

**Ohio Medicaid Provider Agreement**

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider 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

do not accept the terms and conditions  
 accept the terms and conditions

**Agreement Date**

Certain provider agreements may be retroactive (up to 12 months) to encompass dates on which the provider 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 ODJFS to mean that you waive your rights to a retroactive period of months prior to the date ODJF approves your application. This agreement is limited to 3 years from the effective date.

**\*Type Full Name Here**

previous
next
exit



## Tasks for this panel

To **certify** the enrollment information:

1. Enter values in the **Legal Entity Name, Individual Last Name, Address 1, City, Zip, Social Security Number, Tax Identification Number, and Type Full Name Here** fields.
2. Select values from the **State** and **Preferred Contact Method** drop down list boxes.
3. If desired, enter values in the **First, MI, Address 2, and E-Mail Address** fields.
4. Check the **terms and conditions** radio buttons, as applicable.
5. Check the **ProvisionCheck** checkbox as described on the panel.
6. Select the **previous** button to review information entered in previous panels, if desired.
7. Select the **next** button to proceed to the next enrollment panel.
8. To exit the application, select the **exit** button.

## Field Descriptions – Certification – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Exits the provider enrollment process.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Abbreviated Organization Name	Abbreviated name of the applying organization. (This field to be determined.)	Field	Character	25
Address 1	First line of the address.	Field	Character	60
Address 2	Second line of the address.	Field	Character	60
Agreement Date	Date the applicant certified the application.	Field	Date (MM/DD/CCYY)	10
City	City of the address.	Field	Character	30
Doing Business As Name	Operating name of the business or organization that is different than the legal name. (This field to be determined.)	Field	Character	25
E-Mail Address	Email address of the applicant.	Field	Character	50
Electronic Signature Date	Pre-populated current date associated with the electronic signature. Please note that there is no label associated with this field on	Field	Date (MM/DD/CCYY)	10

Field	Description	Field Type	Data Type	Length
	the panel.			
Employer Identification Number	Employer ID number of applicant. (This field to be determined.)	Field	Number	9
Executive Order 2007-01S Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the Executive Order 2007-01S Agreement.	Field	Radio Button	1
False Statement Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the False Statement Agreement.	Field	Radio Button	1
First	Applicant's first name.	Field	Character	25
Individual Last Name	Applicant's last name.	Field	Character	50
Legal Entity Name	Applicant or organization legal entity name.	Field	Character	50
Middle Name	Applicant's middle initial.	Field	Character	1
Occupational Therapist Specific Qualifying Statement	Applicant selects a radio button option to accept or decline the terms of the Occupational Therapist Statement. (This field to be determined.)	Field	Radio Button	1
Ohio Medicaid Provider Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the Enrollment Agreement.	Field	Radio Button	1
Organization Name	Name of the applying organization. (This field to be determined.)	Field	Character	50
Preferred Contact Method	Preferred method of contact for the applicant. Default value: E-Mail.	Field	Drop Down List Box	0
Primary Business Address	Primary business address of business.	Field	Character	60
Proprietor Social Security Number	Social Security number of the business proprietor. (This field to be determined.)	Field	Number	9
ProvisionCheck	Indicates that the provider has covered services to a Medicaid consumer and the service has not	Field	Check Box	0

Field	Description	Field Type	Data Type	Length
	been billed to Medicaid in the last 12 months. This checkbox is not visible during the re-enrollment process.			
SSN/Tax Identification Number	SSN/Tax Identification Number of the applicant.	Field	Number	9
Social Security Number	Social Security number of the applicant.	Field	Number	9
State	State of the address.	Field	Drop Down List Box	0
Tax Identification Number	Tax ID number of the applicant.	Field	Number	9
Type	Type of SSN/Tax ID. Valid values are: SSN and Tax Identification Number.	Field	Drop Down List Box	0
Type Full Name Here	Individual, Group, or Organization name used to certify the enrollment details.	Field	Character	50
Zip	Zip code of the address.	Field	Character	5
Zip + 4	Zip code extension of the address.	Field	Character	4
Enrollment Checklist	Link to display checklists associated with different provider types.	Hyperlink	N/A	0
Website Address	Link to the Ohio Department of Job and Family Services Web site.	Hyperlink	N/A	0

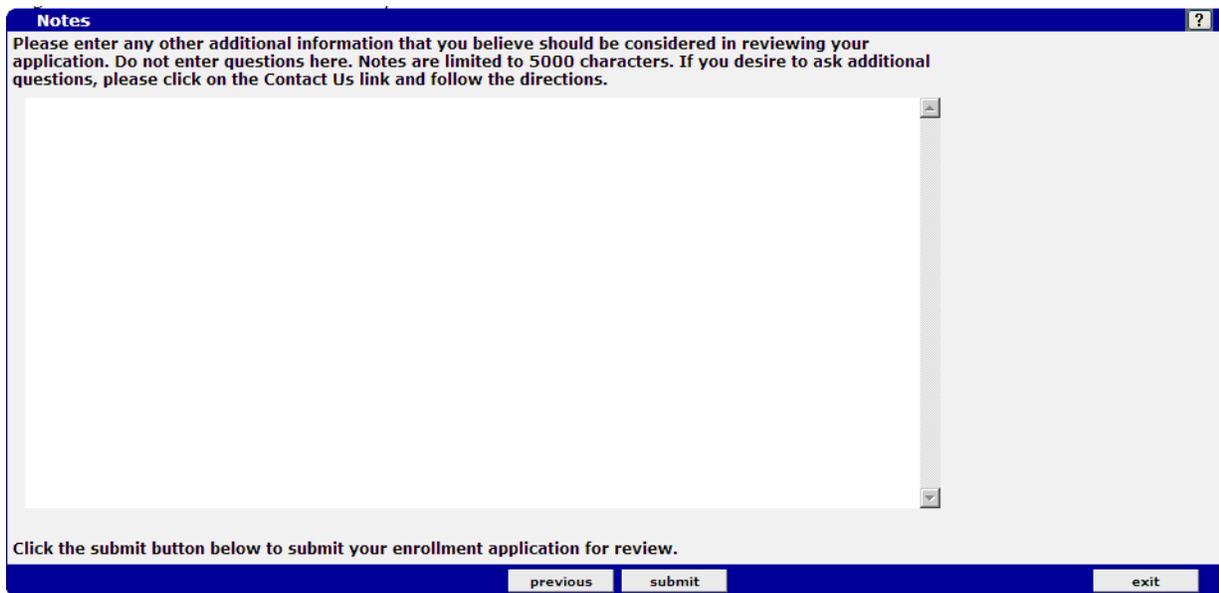
### Field Edits – Certification – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required	This field must be completed.
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum

Field	Field Type	Error Code	Error Message	To Correct
				length.
City	Field	0	City is required	This field must be completed.
Doing Business As Name	Field	1	Doing Business As Name is required.	This field must be completed.
E-Mail Address	Field	1	E-Mail Address is required.	For Preferred Contact Method E-Mail, E-Mail address is required.
Employer Identification Number	Field	0	Employer Identification Number is required	This field must be completed
Legal Entity Name	Field	0	Legal Entity Name is required.	This field must be completed.
Occupational Therapist Specific Qualifying Statement	Field	0	If Occupational/Therapist 'I do not accept the terms and conditions' is selected you are not allowed to continue.	Click the I accept terms and conditions radio button.
Ohio Medicaid Provider Agreement	Field	0	If Provider Agreement 'I do not accept the terms and conditions' is selected you are not allowed to continue.	Click the I accept terms and conditions radio button.
SSN/Tax Identification Number	Field	1	SSN/Tax Identification Number is required.	This field must be completed.
Social Security Number	Field	0	Social Security Number is required	This field must be completed
State	Field	0	State is required	This field must be completed
Type	Field	0	Type is required.	Choose SSN or Tax Identification Number.
Type Full Name Here	Field	0	Provider's Full Name is required.	This field must be completed.
Zip	Field	0	Zip code is required	This field must be completed

## Notes – Group Practice

The Notes panel is used to enter additional information or notes associated with the application for the enrolling group practice. The body of the panel is a free-text area where any additional information can be typed.



### Tasks for this panel

To **submit** additional information associated with a provider application:

1. Enter any additional information that should be included for consideration in the request for enrollment.
2. Select the **previous** button to review information entered in previous panels, if desired.
3. Select the **submit** button to submit the enrollment request.
4. To exit the application, select the **exit** button.

### Field Descriptions – Notes – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Notes	Free form text of the notes.	Field	Character	5000

### Field Edits – Certification – Group Practice

None.

## Confirmation of Receipt – Group Practice

The Confirmation of Receipt panel displays the Application Tracking Number for the submitted application. It is important to retain this number. It is needed to check the status of the enrollment application, or to continue the enrollment process at a later time if exit was selected from any of the enrollment panels.

**Confirmation of Receipt** ?

Your enrollment application for QUINN has been submitted.

Tracking Number: 403015

**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.**

\*\*\* 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.

- Anticipated Change of Ownership or Control

**WHAT'S NEXT?**

- [Upload required documents.](#)
- You are required to print, sign and submit the agreement via mail.
- 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.

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

You can check the status of an application from the [Check Application status link](#) on the Enrollment Page.

[exit](#)

### Tasks for this panel

To **complete** the enrollment:

1. Be sure to record the **Application Tracking Number** shown in bold on the second line of the panel.
2. Note the document(s) listed under **Please remember to submit the following required documents:** that must be submitted.
3. Follow the **WHAT'S NEXT?** instructions:
  - a. If electronically attaching supporting documents, click the **Upload required documents** link. (See **Attachment Uploads** for further instructions on attaching supporting documents electronically.)
  - b. Click the **Print Cover Page** link to print the required cover sheet for any documents that will be sent to ODJFS - Provider Enrollment Unit by mail. (See **Attachment Cover** for an image of this document.)
  - c. Click the **Print Application** link to print a copy of the enrollment application.
4. To **exit** the application, select the exit button.

## Field Descriptions – Confirmation of Receipt – Group Practice

Field	Description	Field Type	Data Type	Length
exit	Exit to the provider enrollment landing page.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Agreement	Link to the provider enrollment agreement.	Hyperlink	N/A	0
MCP Addendum Terms	Link to MCP Addendum Terms	Hyperlink	N/A	0
Summary	Link to view summary of the provider enrollment application.	Hyperlink	N/A	0
Submit Information	Application tracking number that is assigned when the application is submitted.	Label	N/A	0

## Field Edits – Confirmation of Receipt – Group Practice

None.

## Attachment Upload – Group Practice

The Attachment Upload panel enables the user to upload files for claims, prior authorizations, and provider enrollments.

Attachment Upload		
Type of Document	Reference	Received
EXPLANATION OF BENEFITS	2309351050001 017033877000014989101	YES
OPERATIVE NOTE	2309351050001 017033877000014989102	IN PROCESS
PERIODONTAL CHARTS	2309351050001 017033877000014989103	IN PROCESS
RADIOLOGY REPORTS	2309351050001 017033877000014989104	YES
SUPPORT DATA FOR CLAIM	2309351050001 017033877000014989105	NO

Please note the following important parameters when uploading files:

- File size cannot be greater than 50MB (51200KB).
- Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.
- For claim attachments: Select row from the list above and then use the below panel to select the file for upload.

Attachment Upload	
<input type="button" value="upload attachment"/>	
Type of Document	EXPLANATION OF BENEFITS
Reference	2309351050001 017033877000014989101
*File to Upload	<input type="text"/> <input type="button" value="Browse..."/>

### Tasks for this panel

To **upload** an attachment:

- Select a row in **Attachment Upload** list section of the panel.
- Click the **browse** button and select the file to upload.
- Click the **upload attachment** button.

### Field Descriptions – Attachment Uploads – Group Practice

Field	Description	Field Type	Data Type	Length
Browse	Allows the user to navigate and select a local file to upload.	Button	N/A	0
upload attachment	Initiate the file upload.	Button	N/A	0
File to Upload	The navigational path of the file to be uploaded including the file name. Is a required field.	Field	Character	256
Upload	Bound file input - for direction on which file to upload.	Field	Character	0
Reference	Control number assigned to the attachment for identification purposes.	Label	N/A	0
Type of Document	Description of the uploaded file.	Label	N/A	0
Received	Indicates if the attachment has been received (This field will visible only for Claims attachment).	Listview	Character	10
Reference	Control number assigned to the attachment for identification purposes.	Listview	Character	35
Type of Document	Description of the uploaded file.	Listview	Character	75

### Field Edits – Attachment Uploads – Group Practice

Field	Field Type	Error Code	Error Message	To Correct
upload attachment	Button	0	File format must be one of the following: bmp, doc, gif, jpg, mdi, pdf, ppt, tiff, txt, xls.	Select a file of the proper format to be uploaded.
File to Upload	Field	0	Please select a file to upload.	Click the Browse button to select a file to upload into the Web Portal.

### Attachment Cover – Group Practice

The Attachment Cover panel displays the provider enrollment attachment cover page. Providers print this page and include it when mailing or faxing required documents to the fiscal agent.



### Field Descriptions – Attachment Cover – Group Practice

Field	Description	Field Type	Data Type	Length
Control Number	Control number assigned to the attachment for identification purposes.	Label	Number	80
Date Submitted	Date the enrollment application was submitted.	Label	Date (MM/DD/CCYY)	8
Name	Name of the provider or business.	Label	Character	30
SSN/FEIN	Social Security number or Federal Employer Identification number of the provider or business.	Label	Character	10

This is the end of the Group Practice enrollment process.

## 6 WHAT HAPPENS AFTER ENROLLMENT?

When ODJFS has approved each enrollment application, the applicant will be sent a letter with a personal identification number (PIN) and instructions for completing portal registration. When this PIN letter is received, please refer to the “Getting Started” section in Volume 2 of this user manual, *Provider Medicaid Portal User Manual: Introduction*.