Ohio | Medicaid Information Technology System

Provider Medicaid Portal User Manual Volume 3D

Enrollment - Hospitals and Managed Care Providers

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1 PROVIDER ENROLLMENT - HOSPITAL AND MANAGED CARE PROVIDERS

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

- Enrollment for hospitals.
- Enrollment for managed care providers.

Hospital and managed care providers 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 who need assistance 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. **Note:** 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.

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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 as an Internet browser. 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.

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ODJFS Medicaid Welcome Page

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

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.

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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.

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.

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Provider Enrollment Page

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

Ohio.gov | Department of Job and Family Services

Search >

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Job & Family Services Ohio Medicaid

Medicaid Home
MITS
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Provider Info
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Provider Enrollment

New! **Important Enrollment Updates:** CLICK HERE TO ENROLL

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

New! Enroll as a New Provider
New! Check Provider Enrollment Status
New! Update Demographic Information

Contact Enrollment

Please listen to the entire message before making your selection

New! 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.

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2 ENROLLMENT TASKS

Panels for enrollment presented in this section of the Provider Medicaid Portal User Manual show the following categories of new enrollment:

- Enrollment for hospitals.
- Enrollment for managed care provider reporting numbers

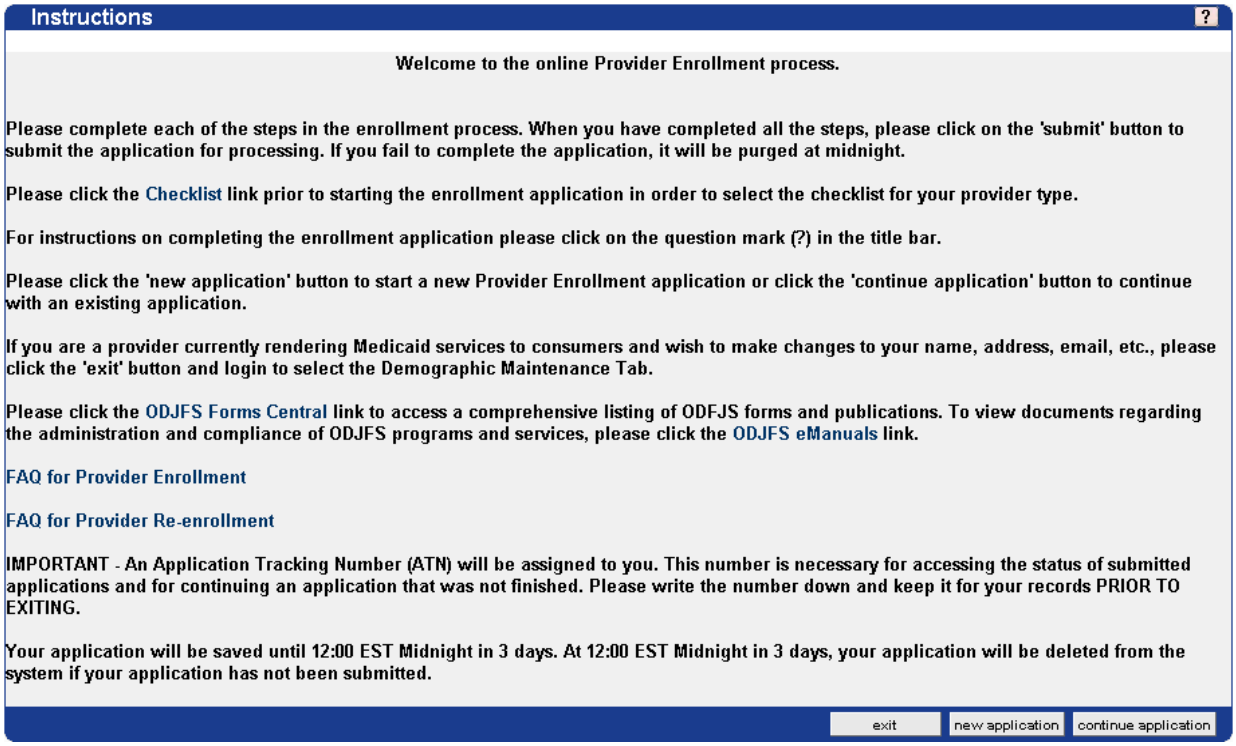
General Enrollment Instructions

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 one.
5. To exit the Provider Enrollment application and return to the **Instructions** panel, select the **exit** button.

Instructions Panel

The Instructions panel provides detailed information regarding how to proceed with the enrollment process.


Instructions

Welcome to the online Provider Enrollment process.

Please complete each of the steps in the enrollment process. When you have completed all the steps, please click on the 'submit' button to submit the application for processing. If you fail to complete the application, it will be purged at midnight.

Please click the Checklist link prior to starting the enrollment application in order to select the checklist for your provider type.

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

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

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

Please click the ODJFS Forms Central link to access a comprehensive listing of ODFJS forms and publications. To view documents regarding the administration and compliance of ODJFS programs and services, please click the ODJFS eManuals link.

FAQ for Provider Enrollment

FAQ for Provider Re-enrollment

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

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

exit | new application | continue application

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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 to display the Request Type panel.
7. To continue with an existing enrollment, select the **continue application** button to display the Search panel.
8. To exit the application, select the **exit** button.

Field Descriptions – Instructions

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 that lists frequently asked questions about the provider enrollment process.	Hyperlink	N/A	0
FAQ for Provider Re-enrollment	Link to an ODJFS pdf that lists frequently asked questions about the re-enrollment process.	Hyperlink	N/A	0
JFS Provider Forms Central	Links to the ODJFS Provider Forms Central website (http://www.odjfs.state.oh.us/forms/inter.asp).	Hyperlink	N/A	0
ODJFS Provider e-Manuals	Links to the ODJFS Provider e-Manuals website (http://emanuals.odjfs.state.oh.us/emanuals/).	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Instructions	Instructions for the online provider enrollment wizard.	Label	N/A	0

Field Edits – Instructions

None.

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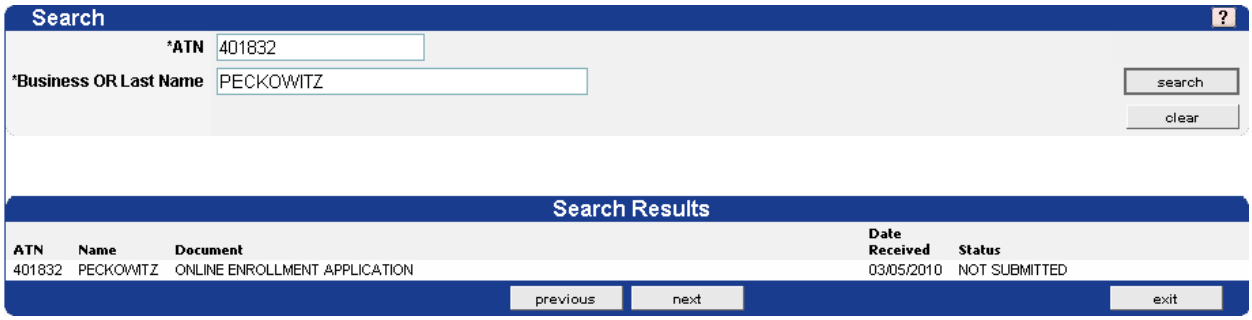
Continue Application Panel

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.



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 criteria entered on the search panel.	Button	N/A	0
ATN	Unique code assigned to	Field	Number	9

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Field	Description	Field Type	Data Type	Length
	the application for identification purposes.			
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.

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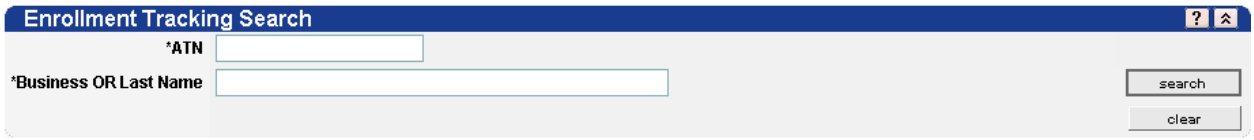
Enrollment Tracking

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.

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Enrollment Tracking Search Results Panel

The 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
400091	HOSPITAL	ENROLLMENT APPLICATION	08/14/2007	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.

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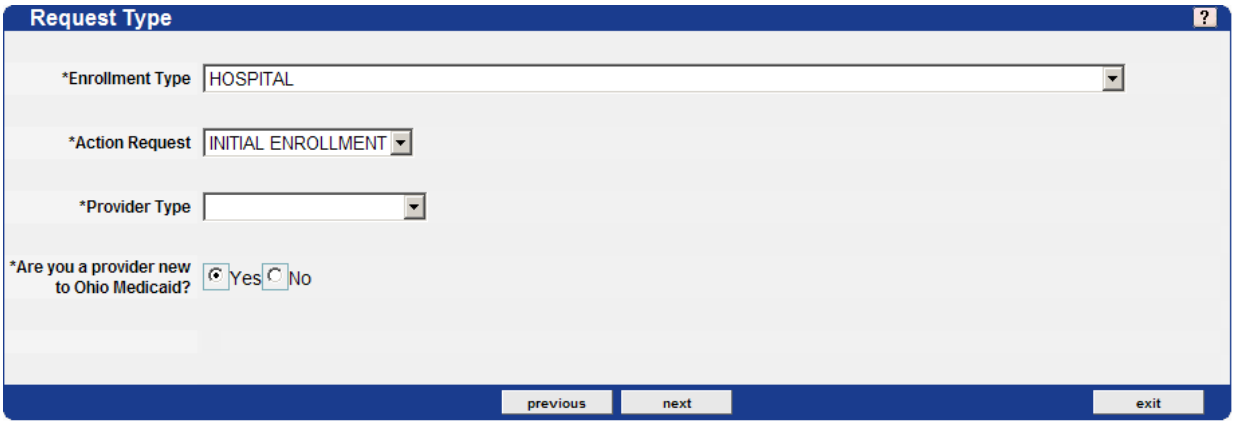
Enrollment Request Type

The enrollment type selected by the enrolling provider 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 enrollment type are as follows:

- Initial Enrollment
- Change of Operator/Provider (CHOP)
- Facility New to Ohio Medicaid
- Facility Re-entering Medicaid Program
- Out of State Provider
- Replacement Facility

Request Type Panel

The Request Type panel is used by an enrolling provider applicant to select the type of enrollment and provider type for the application.



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.
2. Select a value from the **Action Request** drop down list box.
   a. If the enrolling provider is an individual practitioner, a group practice, an organization, a hospital, or a managed care provider, select **INITIAL ENROLLMENT**.
   b. If the enrolling provider is a long term care facility or an intermediate care facility for the mentally retarded, select **FACILITY NEW TO OHIO MEDICAID**.
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 **previous** button to review information entered in previous panels, if desired.

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6. Select the **next** button to proceed to the next enrollment panel.
7. To exit the application, select the **exit** button.

Field Descriptions – Request Type

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
Are you a provider new to Ohio Medicaid?	Indicates if the provider has been previously registered with Ohio Medicaid.	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

Field	Message			
Provider Type	A valid Provider Type is required.			

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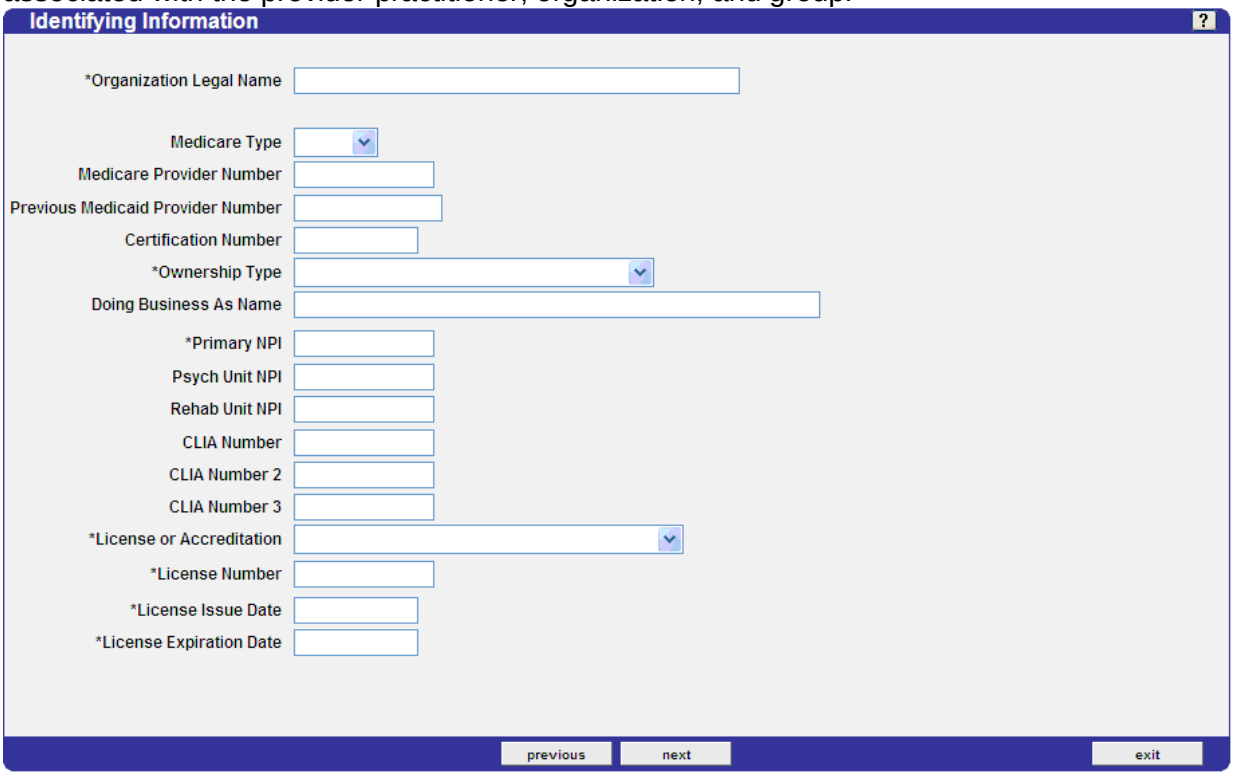
3 ENROLLMENT BY PROVIDER TYPE – HOSPITAL

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

Identifying Information – Hospital

The Identifying Information panel allows a provider applicant to enter identifying information associated with the provider practitioner, organization, and group.



Tasks for this panel

To **enter** identifying information:

1. Select values from the **Ownership Type**, **Type**, **County**, and **State** drop down list boxes.
2. Enter valid values in the **SSN/FEIN**, **Address 1**, **City**, and **Zip** fields.
3. Select a **Yes** or **No** response to the question **Primary Care Provider?**
4. Enter values in the **Legal Entity Name**, **Individual Last Name**, **First Name**, **MI**, **Doing Business as Name**, **NPI**, **Address 2**, and **4-digit Zip** extension fields, 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 panel.
7. To exit the application, select the **exit** button.

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Field Descriptions – Identifying Information – Hospital

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
County	Code for the County.	Combo Box	Drop Down List Box	0
Ownership Type	Ownership Type.	Combo Box	Character	1
Accreditation?	If accredited, enter your accreditation granting agency name and type here e.g. JC, CARF, etc.	Field	Alphanumeric	100
Address 1	Address of the business.	Field	Character	60
Address 2	Extra Address of the business.	Field	Character	60
Business Name	Name of the business.	Field	Character	50
Business Structure	Business Structure Type.	Field	Drop Down List Box	1
CLIA Number	Clinical Laboratory Improvement Act (CLIA) number assigned to the provider.	Field	Alphanumeric	10
CLIA Number 2	The second hospital CLIA number.	Field	Alphanumeric	10
CLIA Number 3	The third hospital CLIA number.	Field	Alphanumeric	10
Certification Number	Certification Number.	Field	Number	7
City	City.	Field	Character	30
DEA Number	DEA Number.	Field	Character	9
Date of Birth	Date of Birth.	Field	Date (MM/DD/CCYY)	8
Doing Business As Name	Name for individual or entity applicants doing business under a trade or company name.	Field	Character	50
Facility Care Setting	Code for Facility Care Setting.	Field	Drop Down List	0

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Field	Description	Field Type	Data Type	Length
			Box	
Facility Care Setting (if 'Other' selected)	Description for Facility Care Setting if Other is selected.	Field	Character	60
First, MI	First name and middle initial of the individual.	Field	Character	13
Gender	Code to describe Gender.	Field	Drop Down List Box	0
Group Legal Name	Legal Name of the Group.	Field	Character	50
ICF-MR License Date of Expiration	ICF-MR License Date of Expiration.	Field	Date (MM/DD/CCYY)	8
Individual Last Name	If not using a business name, enter the last name for the record.	Field	Alphanumeric	25
Legal Entity Name	Legal Name of the Entity.	Field	Character	50
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
Licensed by/to be Licensed by?	Licensed by/to be Licensed by?	Field	Drop Down List Box	0
MI	Middle initial of the individual.	Field	Character	1
MR/DD Facility Number	MR/DD Facility Number.	Field	Number	15
Medicaid Provider Number	Medicaid Provider Number.	Field	Number	10
Medicare Certification Number (CCN)	Medicare Certification Number (CCN).	Field	Number	15
Medicare Certification Status	Status of Medicare Certification.	Field	Drop Down List Box	1
Medicare Provider Number	Medicare Provider Number.	Field	Number	10
Medicare Type	Medicare Type PTAN/CCN.	Field	Drop Down List Box	4
NAPB ID (Pharmacy)	Pharmacy ID Number.	Field	Alphanumeric	0

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Field	Description	Field Type	Data Type	Length
NPI	National Provider Identifier number. If an individual, enter NPI associated with SSN.	Field	Number	10
NPI Associated with SSN	NPI associated with SSN.	Field	Alphanumeric	0
NPI Verified	NPI Verified Yes/No.	Field	Radio Button	0
Nursing Home License Date of Issue	Nursing Home License Date of Issue.	Field	Date (MM/DD/CCYY)	8
ODDD Facility Number	ODDD Facility Number.	Field	Number	15
ODH Facility ID Number if applicable	Enter the ODH Facility ID Number if Applicable.	Field	Character	5
ODH Home Number	ODH Home Number	Field	Alphanumeric	0
Operator License Number	License Number of the Operator.	Field	Character	15
Organization Legal Name	Legal Name of the Organization.	Field	Character	50
Organization Name	Name of organization of the associated Managed Care Plan.	Field	Alphanumeric	0
Other Business Structure Type?	Type of Business Structure for "Other" category.	Field	Alphanumeric	50
Ownership Type	Type of Ownership.	Field	Drop Down List Box	1
Previous Medicaid Provider Number	Previous Medicaid Provider Number.	Field	Number	7
Primary Care Provider	Primary Care Provider Yes/No.	Field	Radio Button	0
Primary NPI	The hospital's Primary NPI number.	Field	Number	10
Proprietor Social Security Number	Social Security Number of the Proprietor.	Field	Number	9
Psych Unit NPI	The Psychiatric Unit's NPI number for the hospital.	Field	Number	10
Publicly Owned	Publicly Owned Yes/No.	Field	Radio Button	0
Rehab Unit NPI	The Rehabilitation Unit's NPI number for the hospital.	Field	Number	10

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Field	Description	Field Type	Data Type	Length
Residential Facility License Date of Expiration	Enter Residential Facility License Date of Expiration.	Field	Date (MM/DD/CCYY)	8
Residential Facility License Date of Issue	Enter Residential Facility License Date of Issue.	Field	Date (MM/DD/CCYY)	8
SSN/ FEIN	SSN Number or Federal Employer Identification Number.	Field	Number	9
State	Code for the State.	Field	Drop Down List Box	0
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	Character	4
Zip	Zip Code.	Field	Character	5
Zip+4	Zip+4.	Field	Character	4

Field Edits – Identifying Information – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Ownership Type	Combo Box	1	A Valid Ownership Type is required	This field must be completed.
Accreditation?	Field	1	Ownership Code is required.	This field must be completed.
Address 1	Field	1	Address 1 is required.	This field must be completed.
Business Name	Field	1	Business Name or Individual Last Name is required.	Either Business Name or Individual Last Name must be completed.
CLIA Number	Field	1	CLIA Number is required.	This field must be completed when provider type is Independent Laboratory.
City	Field	1	City is required.	This field must be completed.
Doing Business	Field	0	Doing Business As Name is	This field must be

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Field	Field Type	Error Code	Error Message	To Correct
As Name			required.	completed.
First, MI	Field	1	First Name is required.	Enter a first name.
First, MI	Field	2	First, MI must be blank when Business Name is entered.	Delete the First Name, MI or the Business Name.
First, MI	Field	3	First, MI is required when Individual Last Name is entered.	Enter a first name.
Gender	Field	1	Gender is required.	This field must be completed.
Group Legal Name	Field	1	Legal Entity Name or Individual Last Name is required.	This field must be completed.
Individual Last Name	Field	1	Individual Last Name is required.	Enter a Last Name.
Individual Last Name	Field	2	Either Business Name or Individual Last Name is required.	Delete either Individual Last Name or Business Name.
Legal Entity Name	Field	1	Legal Entity Name or Individual Last Name is required.	This field must be completed.
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.
License Issue Date	Field	2	License Issue Date[1/1/2010 12:00:00 AM] must be less than or equal to License Expiration Date[10/10/2009 12:00:00 AM]	Enter a date less than or equal to the Expiration Date
License Number	Field	1	License Number is required.	This field must be completed.
Licensed by/to be Licensed by?	Field	1	Licensed By 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.

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Field	Field Type	Error Code	Error Message	To Correct
NPI Verified	Field	1	This field must be completed.	This field must be completed.
Nursing Home License Date of Issue	Field	1	Operator License Issue Date[10/1/2009 12:00:00 AM] must be less than or equal to Operator License Expiration Date[10/10/2000 12:00:00 AM]	Enter a date less than or equal to the Expiration Date
Organization Legal Name	Field	1	Legal Entity Name or Individual Last Name is required.	This field must be completed.
Organization Legal Name	Field	2	Organization Legal Name is required.	This field must be completed.
Primary Care Provider	Field	1	Primary Care Provider is required.	This field must be completed.
Primary NPI	Field	1	Primary NPI is required.	This field must be completed.
Proprietor Social Security Number	Field	1	Employer Identification Number or Proprietor Social Security Number is required.	This field must be completed, if Employer Identification Number is not entered
Proprietor Social Security Number	Field	2	Either Employer Identification Number or Proprietor Social Security Number is required, Not Both.	Enter in just one not both
SSN/ FEIN	Field	1	SSN/FEIN is required.	This field must be completed.
SSN/ FEIN	Field	2	SSN/FEIN is invalid	Please enter a valid SSN/FEIN
State	Field	1	A Valid State 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.
Zip	Field	1	Zip is required.	This field must be completed.

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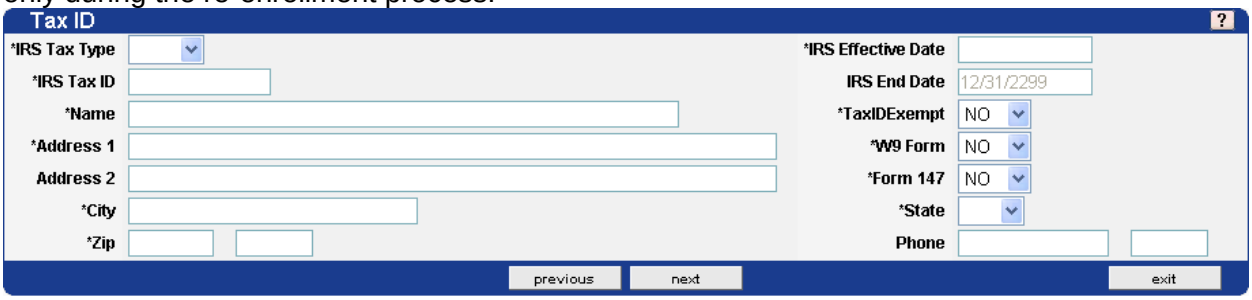
Tax ID – Hospital

The Tax ID panel captures tax information during the enrollment process. This panel is read-only during the re-enrollment process.



Tasks for this panel

To **enter** tax information:

1. Select valid 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**, **and 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 – Hospital

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	30
Ext	Provider's phone number extension.	Field	Number	4

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Field	Description	Field Type	Data Type	Length
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)	10
IRS End Date	End date of IRS tax ID.	Field	Date (MM/DD/CCYY)	10
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 – Hospital

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.
	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for either Tax ID Exempt, W9 Form, or Form 147 fields.
IRS Effective Date	Field	1	IRS Effective Date is required.	Enter an IRS Effective Date.
	Field	2	IRS Effective Date [<Date>] must be less than or equal to IRS End Date [<Date>].	IRS Effective Date [<Date>] must be less than or equal to IRS End Date [<Date>].

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Field	Field Type	Error Code	Error Message	To Correct
IRS End Date	Field	1	IRS End Date is required.	Enter an IRS End Date.
	Field	2	IRS Effective Date [<Date>] must be less than or equal to IRS End Date [<Date>].	IRS Effective Date [<Date>] must be less than or equal to IRS End Date [<Date>].
IRS Tax ID	Field	1	IRS Tax ID is required.	Enter a valid 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.
	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for either Tax ID Exempt, W9 Form, or Form 147 fields.
W9 Form	Field	1	W9 Form is required.	Select Yes or No.
	Field	2	You must answer 'YES' to one of the following fields: Tax ID Exempt, W9 Form, or Form 147.	Select 'YES' for either Tax ID Exempt, W9 Form, or Form 147 fields.
Zip	Field	1	Zip is required.	Enter a 5 digit 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.

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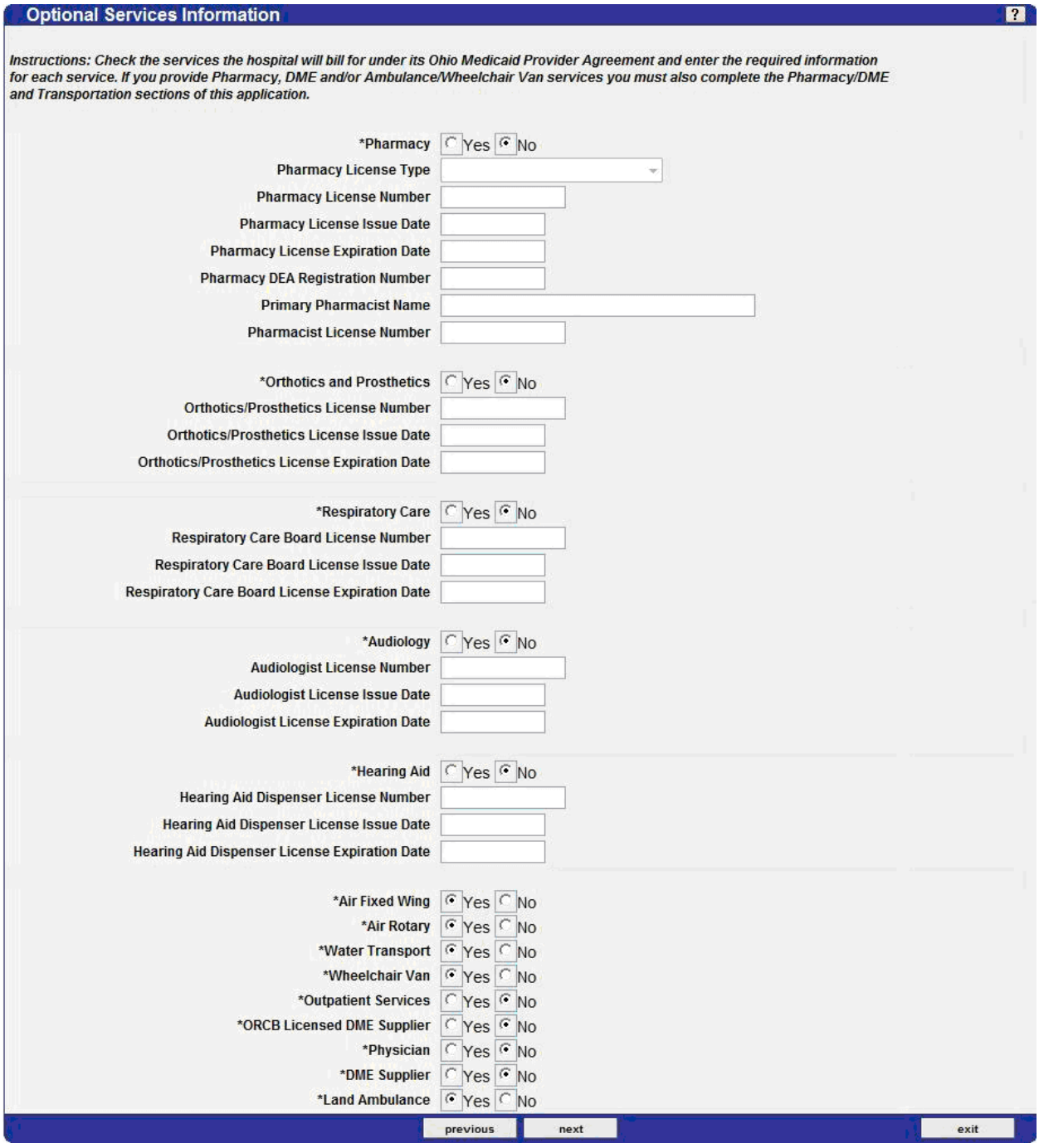
Optional Services – Hospital

The Optional Services panel displays for all enrolling Hospital providers using the Hospital Wizard.



Tasks for this panel

To **enter** information on optional services:

1. Select **Yes** or **No** for **Pharmacy** service.

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a. If **Yes** is selected, enter valid values in the **Pharmacy License Type**, **Pharmacy License Number**, **Pharmacy License Issue Date**, **Pharmacy License Expiration Date**, **Pharmacy DEA Registration Number**, **Primary Pharmacist Name**, and **Pharmacist License Number** fields.

2. Select **Yes** or **No** for **Orthotics** and **Prosthetics** service.
   a. If **Yes** is selected, enter valid values in the **Orthotics/Prosthetics License Number**, **Orthotics/Prosthetics License Issue Date**, and **Orthotics/Prosthetics License Expiration Date** fields.
3. Select **Yes** or **No** for **Respiratory Care** service.
   a. If **Yes** is selected, enter valid values in the **Respiratory Care Board License Number**, **Respiratory Care Board License Issue Date**, and **Respiratory Care Board License Expiration Date** fields.
4. Select **Yes** or **No** for **Audiology** service.
   a. If **Yes** is selected, enter valid values in the **Audiologist License Number**, **Audiologist License Issue Date**, and **Audiologist License Expiration Date** fields.
5. Select **Yes** or **No** for **Hearing Aid** service.
   a. If **Yes** is selected, enter valid values in the **Hearing Aid Dispenser License Number**, **Hearing Aid Dispenser License Issue Date**, and **Hearing Aid Dispenser License Expiration Date** fields.
6. Select **Yes** or **No** for the following services: **Air Fixed Wing, Air Rotary, Water Transport, Wheelchair Van, Outpatient Services, ORCB Licensed DME Supplier, Physician, DME Supplier,** and **Land Ambulance**.
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 – Optional Services – Hospital

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
Air Fixed Wing	Question stating if it is for Air Fixed Wing.	Field	Radio Button	1
Air Rotary	Question stating if it is for Air Rotary.	Field	Radio Button	1
Audiologist License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Audiologist License Issue Date	The date for which the license begins.	Field	Date (MM/DD/CCYY)	8
Audiologist License Number	The license number assigned.	Field	Alphanumeric	11
Audiology	Question stating if is for Audiology. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
DME Supplier	Question stating if it is for DME Supplier.	Field	Radio Button	1
Hearing Aid Dispenser	Question stating if is for Hearing Aid Dispenser. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
Hearing Aid Dispenser License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8
Hearing Aid Dispenser License Issue Date	The date for which the license begins.	Field	Date (MM/DD/CCYY)	8
Hearing Aid Dispenser License Number	The license number assigned.	Field	Alphanumeric	11
Land Ambulance	Question stating if it is for Land Ambulance.	Field	Radio Button	1
ORCB Licensed DME Supplier	Question stating if it is for ORCB Licensed DME Supplier.	Field	Radio Button	1
Orthotics and Prosthetics	Question stating if is for Orthotics and Prosthetics. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
Orthotics/Prosthetics License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8
Orthotics/Prosthetics License Issue Date	The date for which the license begins.	Field	Date (MM/DD/CCYY)	8
Orthotics/Prosthetics License Number	The license number assigned.	Field	Alphanumeric	11
Outpatient Services	Question stating if it is for Outpatient Services.	Field	Radio Button	1
Pharmacist License Number	The license number assigned to the Primary Pharmacist.	Field	Alphanumeric	11
Pharmacy	Question stating if is for Pharmacy. Other fields are	Field	Radio Button	1

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Field	Description	Field Type	Data Type	Length
	required if 'Yes' is selected.			
Pharmacy DEA Registration Number	The assigned DEA number.	Field	Alphanumeric	11
Pharmacy License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8
Pharmacy License Issue Date	The date for which the license was issued.	Field	Date (MM/DD/CCYY)	8
Pharmacy License Number	The license number assigned.	Field	Number	11
Pharmacy License Type	Dropdown containing a list of possible Pharmacy license type to choose from.	Field	Drop Down List Box	0
Physician	Question stating if it is for Physician.	Field	Radio Button	1
Primary Pharmacist Name	Name of the primary Pharmacist.	Field	Alphanumeric	30
Respiratory Care	Question stating if is for Respiratory Care. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
Respiratory Care Board License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8
Respiratory Care Board License Issue Date	The date for which the license was issued.	Field	Date (MM/DD/CCYY)	8
Respiratory Care Board License Number	The license number assigned.	Field	Alphanumeric	11
Water Transport	Question stating if it is for Water Transport.	Field	Radio Button	1
Wheelchair Van	Question stating if it is for Wheelchair Van.	Field	Radio Button	1

Field Edits – Optional Services – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Air Fixed Wing	Field	1	YES/NO response to Air Fixed Wing question is required.	Enter YES/NO to Air Fixed Wing question.
Air Rotary	Field	1	YES/NO response to Air Rotary question is required.	Enter YES/NO to Air Rotary.
Audiologist License	Field	1	Audiologist License	Enter Audiologist

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Field	Field Type	Error Code	Error Message	To Correct
Expiration Date			Expiration Date is required.	License Expiration Date.
	Field	2	Audiologist License Expiration Date must be greater than Audiologist License Issue Date.	Enter Audiologist License Expiration Date greater than Audiologist License Issue Date.
Audiologist License Issue Date	Field	1	Audiologist License Issue Date is required.	Enter Audiologist License Issue Date.
	Field	2	Audiologist License Issue Date must be earlier than or equal to today.	Enter Audiologist License Issue Date earlier than or equal to today.
Audiologist License Number	Field	1	Audiologist License Number is required.	Enter Audiologist License Number.
Audiology	Field	1	YES/NO response to Audiology question is required.	Enter YES/NO to Audiology question.
DME Supplier	Field	1	YES/NO response to DME Supplier question is required.	Enter YES/NO to DME Supplier question.
Hearing Aid Dispenser	Field	1	YES/NO response to Hearing Aid Dispenser question is required.	Enter YES/NO to Hearing Aid Dispenser question.
Hearing Aid Dispenser License Expiration Date	Field	1	Hearing Aid License Expiration Date is required.	Enter Hearing Aid License Expiration Date.
	Field	2	Hearing Aid License Expiration Date must be greater than Hearing Aid License Issue Date.	Enter Hearing Aid License Expiration Date greater than Hearing Aid License Issue Date.
Hearing Aid Dispenser License Issue Date	Field	1	Hearing Aid License Issue Date is required.	Enter Hearing Aid License Issue Date.
	Field	2	Hearing Aid License Issue Date must be earlier than or equal to today.	Enter Hearing Aid License Issue Date earlier than or equal to today.
Hearing Aid Dispenser License Number	Field	1	Hearing Aid License Number is required.	Enter Hearing Aid License Number.
Land Ambulance	Field	1	YES/NO response to Land Ambulance	Enter YES/NO to Land Ambulance

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Field	Field Type	Error Code	Error Message	To Correct
			question is required.	question.
ORCB Licensed DME Supplier	Field	1	YES/NO response to ORCB Licensed DME Supplier question is required.	Enter YES/NO to ORCB Licensed DME Supplier question.
Orthotics and Prosthetics	Field	1	YES/NO response to Orthotics and Prosthetics question is required.	Enter YES/NO to Orthotics and Prosthetics question.
Orthotics/Prosthetics License Expiration Date	Field	1	Orthotics and Prosthetics License Expiration Date is required.	Enter Orthotics and Prosthetics License Expiration Date.
	Field	2	Orthotics and Prosthetics License Expiration Date must be greater than Orthotics and Prosthetics License Issue Date.	Enter Orthotics and Prosthetics License Expiration Date greater than Orthotics and Prosthetics License Issue Date.
Orthotics/Prosthetics License Issue Date	Field	1	Orthotics and Prosthetics License Issue Date is required.	Enter Orthotics and Prosthetics License Issue Date.
	Field	2	Orthotics and Prosthetics License Issue Date must be earlier than or equal to today.	Enter Orthotics and Prosthetics License Issue Date earlier than or equal to today.
Orthotics/Prosthetics License Number	Field	1	Orthotics and Prosthetics License Number is required.	Enter Orthotics and Prosthetics License Number.
Pharmacist License Number	Field	1	Pharmacist License Number is required.	Enter Pharmacist License Number.
Pharmacy	Field	1	YES/NO response to Pharmacy question is required.	Enter YES/NO to Pharmacy question.
Pharmacy DEA Registration Number	Field	1	Pharmacy DEA Registration Number is required.	Enter Pharmacy DEA Registration Number.
Pharmacy License Expiration Date	Field	1	Pharmacy License Expiration Date is required.	Enter Pharmacy License Expiration Date.
	Field	2	Pharmacy License Expiration Date must	Enter Pharmacy License Expiration

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Field	Field Type	Error Code	Error Message	To Correct
			be greater than Pharmacy License Issue Date.	Date greater than Pharmacy License Issue Date.
Pharmacy License Issue Date	Field	1	Pharmacy License Issue Date is required.	Enter Pharmacy License Issue Date.
	Field	2	Pharmacy License Issue Date must be earlier than or equal to today.	Enter Pharmacy License Issue Date earlier than or equal to today.
Pharmacy License Number	Field	1	Pharmacy License Number is required.	Enter Pharmacy License Number.
Pharmacy License Type	Field	1	Pharmacy License Type is required.	Enter Pharmacy License Type.
Physician	Field	1	YES/NO response to Physician question is required.	Enter YES/NO to Physician question.
Respiratory Care	Field	1	YES/NO response to Respiratory Care question is required.	Enter YES/NO to Respiratory Care question.
Respiratory Care Board License Expiration Date	Field	1	Respiratory Care Board License Expiration Date is required.	Enter Respiratory Care Board License Expiration Date.
	Field	2	Respiratory Care Board License Expiration Date must be greater than Respiratory Care Board License Issue Date.	Enter Respiratory Care Board License Expiration 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 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 Respiratory Care Board License Number.
Water Transport	Field	1	YES/NO response to Water Transport question is required.	Enter YES/NO to Water Transport question.

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Field	Field Type	Error Code	Error Message	To Correct
Wheelchair Van	Field	1	YES/NO response to Wheelchair Van question is required.	Enter YES/NO to Wheelchair Van question.

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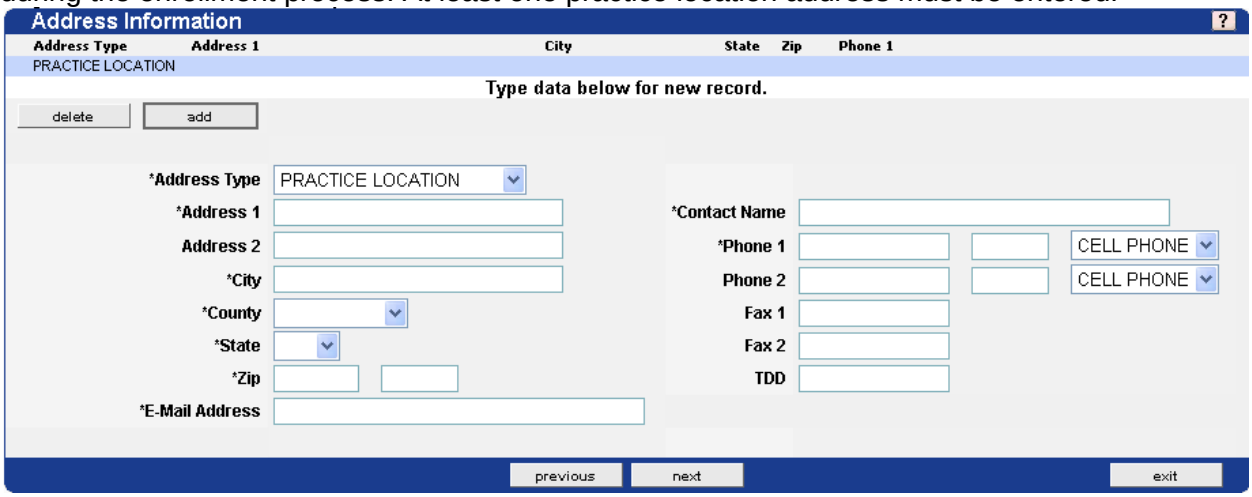
Address Information – Hospital

The Address Information panel is used by a provider applicant to provide address information during the enrollment process. At least one practice location address must be entered.



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 – Hospital

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

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Field	Description	Length	Data Type	Field Type
next	Navigates to the next panel in the provider enrollment wizard.	0	N/A	Button
previous	Navigates to the previous panel in the provider enrollment wizard.	0	N/A	Button
Address 1	First line of the address specified by Address Type.	60	Character	Field
Address 2	Second line of the address specified by Address Type.	60	Character	Field
Address Type	Type of address.	0	Drop Down List Box	Field
City	City of the address specified by Address Type.	30	Character	Field
Contact Name	Name of the contact at the specified address.	40	Character	Field
County	County of the address specified by Address Type.	0	Drop Down List Box	Field
E-Mail Address	Email address for the business.	50	Character	Field
Fax 1	First fax number for provider at the specified Address Type.	10	Number	Field
Fax 2	Second fax number for provider at the specified Address Type.	10	Number	Field
Phone 1	First phone number for the provider at the address specified by Address Type.	10	Number	Field
Phone 2	Second phone number for the provider at the address specified by Address Type.	10	Number	Field
Phone Ext 1	First phone extension for the provider (no label on panel).	4	Number	Field
Phone Ext 2	Second phone extension for the provider (no label on panel).	4	Number	Field
Phone Type 1	First phone type (no label on panel).	0	Drop Down List Box	Field
Phone Type 2	Second phone type (no label on panel).	0	Drop Down List Box	Field
State	State of the address specified by Address Type.	0	Drop Down List Box	Field
TDD	Telecommunications Device for the Deaf number of the address specified by Address	10	Number	Field

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

Field Edits – Address Information – Hospital

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	One Address Type of Practice Location must be added.	There must be one address with Address Type "Practice Location" added.
Address Type	Field	1	Only 1 of each Address Type is allowed. Please verify and try again.	There can only be one address of each address type entered.
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	Field	1	Contact Name is	Enter a name in the field.

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Field	Field Type	Error Code	Error Message	To Correct
Name			required.	
County	Field	0	County is required.	This field must be completed.
County	Field	1	Invalid County for Zip Code entered.	Choose a valid county.
County	Field	2	County must be OTHER when state is not Ohio.	Choose OTHER from county dropdown if State is not Ohio.
County	Field	3	County cannot be OTHER when state is Ohio.	Please enter a valid zip code or choose state other than Ohio.
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.

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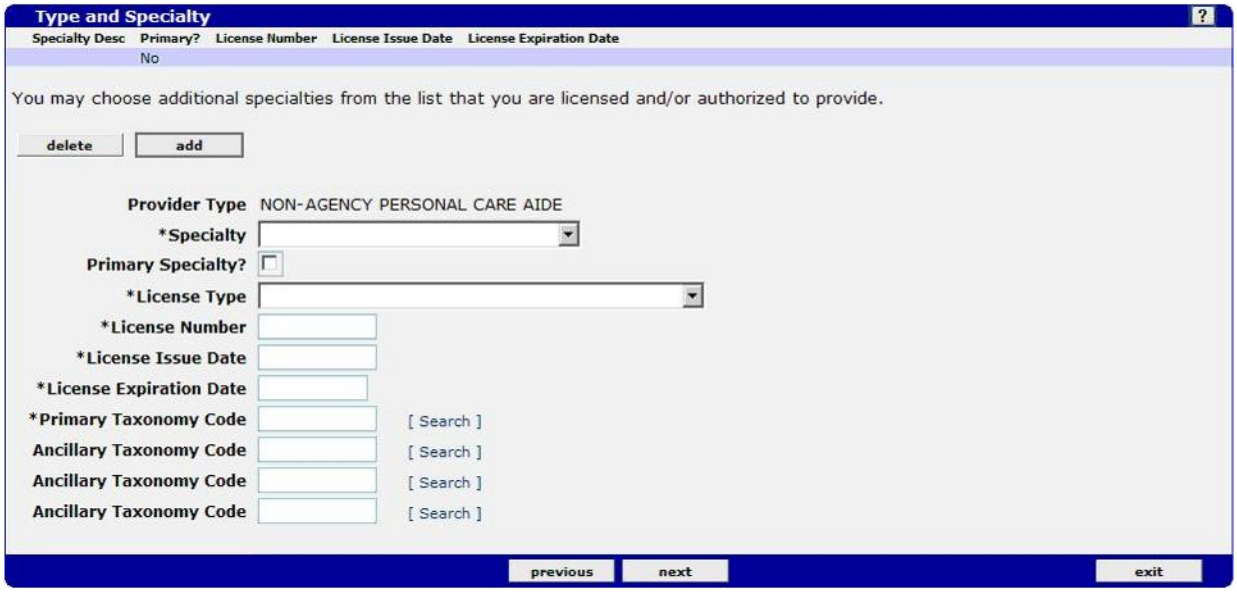
Type and Specialty – Hospital

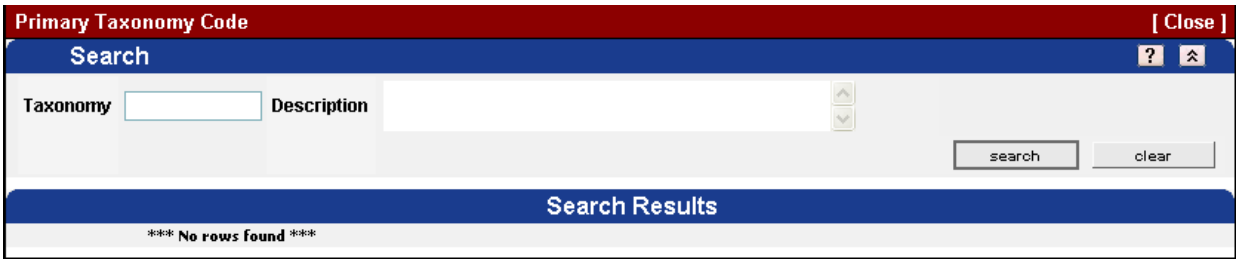
The Type and Specialty panel is used by an applicant to specify the applicant's primary specialty and any additional specialties. If the option is available to choose a primary specialty, the applicant must select one before continuing the enrollment.



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?** checkbox may or may not display.
2. Select the **Primary Specialty?** check box, if applicable.
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.

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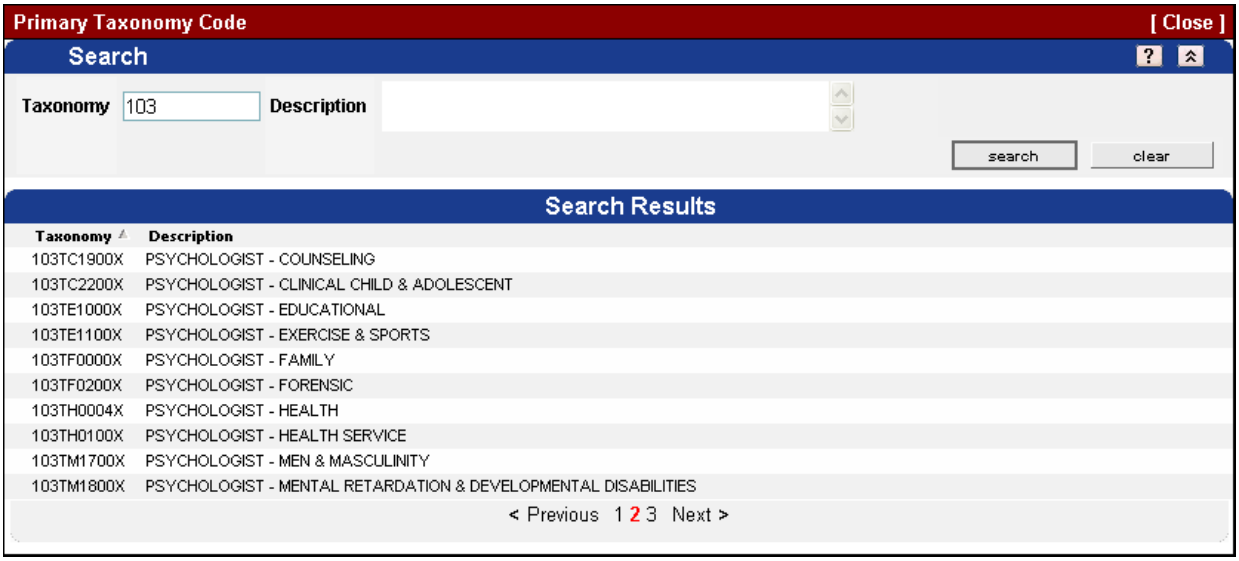
b. Select the **search** button. Taxonomy information that matches the search criteria displays in the **Search Results** area.



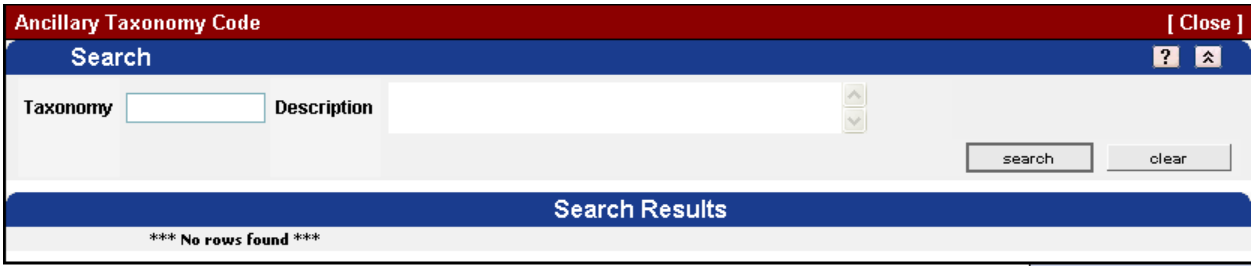
c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.

d. Select the line with the taxonomy code that is appropriate for the enrolling provider.

e. The selected code displays in the **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.

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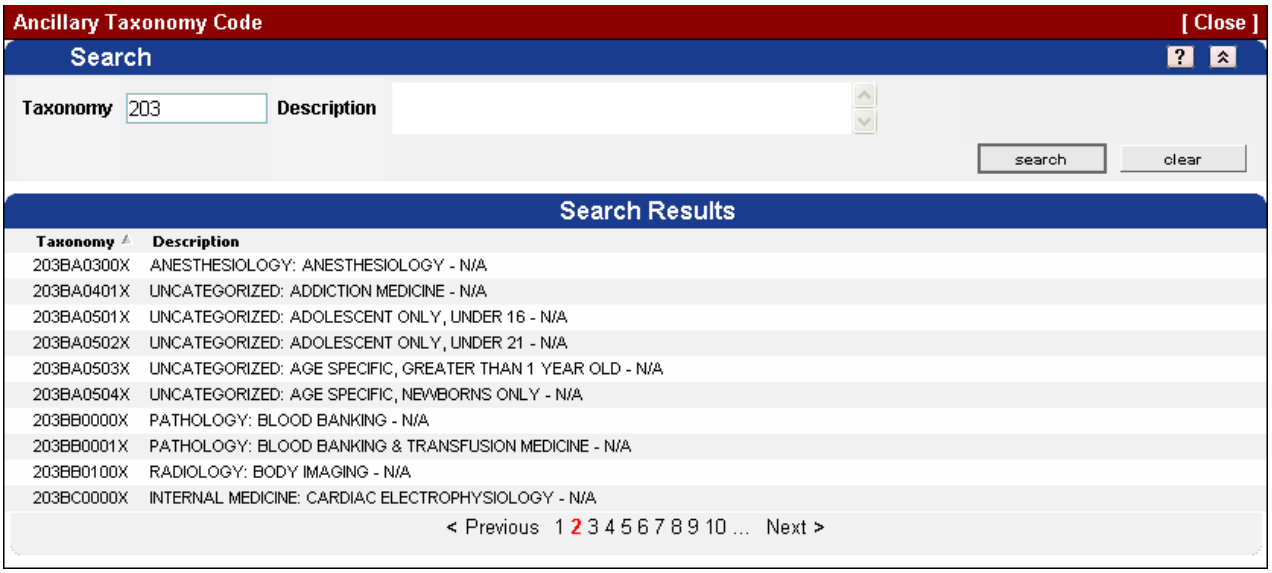

c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.

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 – Hospital

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
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
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
Effective Date [List]	Effective date of the specified specialty.	Listview	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
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 – Hospital

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 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.

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Field	Field Type	Error Code	Error Message	To Correct
	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 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.

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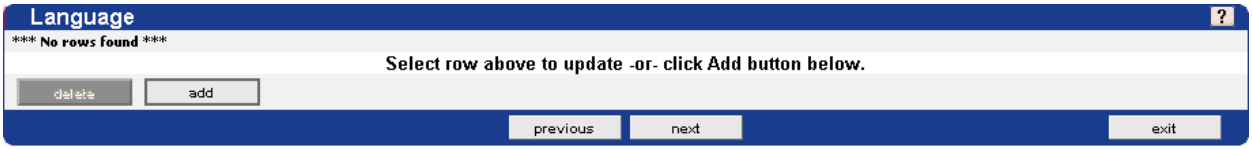
Language – Hospital

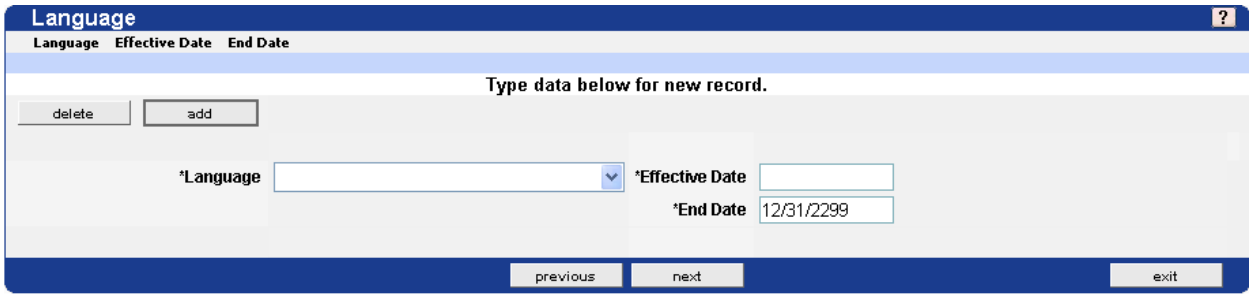
The Language panel allows an enrolling organization to specify language information.



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 redisplays 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 – Hospital

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 -	Button	N/A	0

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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
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 [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 – Hospital

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.

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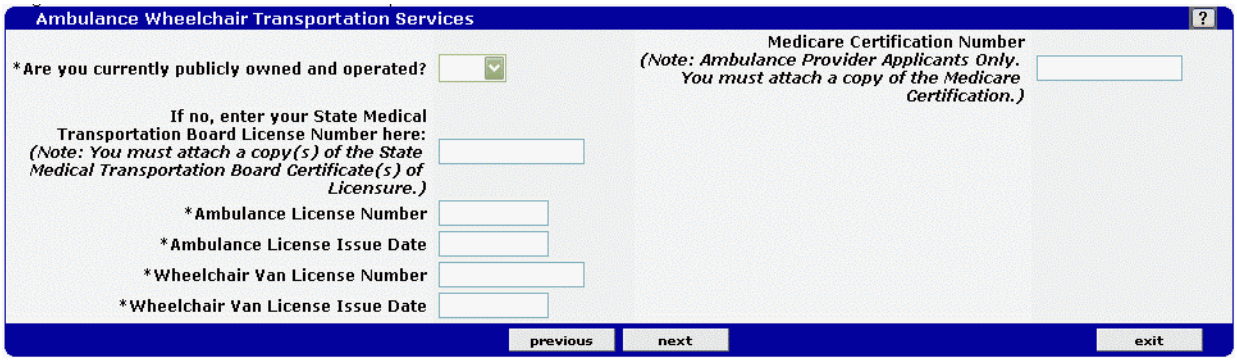
Ambulance Wheelchair Transportation Services – Hospital

The Ambulance Wheelchair Transportation Services panel displays for all enrolling Hospital providers using the Hospital Wizard that select transportation options of Air Fixed Wing, Air Fixed Rotary, Water Transport, Wheelchair Van, and Van Ambulance and Organization providers using the Organization Wizard that select transportation options of Air Fixed Wing, Air Fixed Rotary, Water Transport, Wheelchair Van, and Van Ambulance.



Tasks for this panel

To **provide** information about ambulance wheelchair transportation services:

1. Select a value from the **Are you currently publicly owned and operated?** drop down list box.
2. Enter valid values in the **Ambulance License Number**, **Ambulance License Issue Date**, **Wheelchair Van License Number**, and **Wheelchair Van License Issue Date** fields.
3. Enter values in the **If no, enter your State Medical Transportation Board License Number here:** and **Medicare Certification Number** 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 – Ambulance Wheelchair Transportation Services – Hospital

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
Ambulance License Issue	Date that the Ambulance License was issued.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Date				
Ambulance License Number	A number issued to the medical service organization indicating that specified vehicles are authorized to provide ambulance services.	Field	Alphanumeric	6
Are you currently publicly owned and operated?	Are you currently publicly owned and operated?	Field	Drop Down List Box	1
Medicare Certification Number	A number issued to the medical service organization indicating they are certified by Medicare to perform transportation services.	Field	Alphanumeric	11
State Medical Transportation Board License Number	A number issued to the medical service organization indicating they are certified to perform one or more type of transportation service.	Field	Alphanumeric	11
Wheelchair Van License Issue Date	Date that the Wheelchair Van License was issued.	Field	Date (MM/DD/CCYY)	8
Wheelchair Van License Number	A number issued to the medical service organization indicating that specified vehicles are authorized to provide wheelchair van services.	Field	Alphanumeric	11

Field Edits – Ambulance Wheelchair Transportation Services – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Ambulance License Issue Date	Field	1	Ambulance License Issue Date is required.	Enter Ambulance License Issue Date.
	Field	2	Ambulance License Issue Date must be earlier than or equal to today.	Enter Ambulance License Issue Date earlier than or equal to today.
Ambulance License Number	Field	1	Ambulance License Number is required.	Enter Ambulance License Number.
Are you currently publicly owned and operated?	Field	1	YES/No response to currently publicly owned and operated question is required.	Choose YES/No to currently publicly owned and operated question.

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Field	Field Type	Error Code	Error Message	To Correct
Medicare Certification Number	Field	1	Medicare Certification Number is required.	Enter Medicare Certification Number.
State Medical Transportation Board License Number	Field	1	State Medical Transportation Board License Number is required.	Enter State Medical Transportation Board License Number.
Wheelchair Van License Issue Date	Field	1	Wheelchair Van License Issue Date is required.	Enter Wheelchair Van License Issue Date.
	Field	2	Wheelchair Van License Issue Date must be earlier than or equal to today.	Enter Wheelchair Van License Issue Date earlier than or equal to today.
Wheelchair Van License Number	Field	1	Wheelchair Van License Number is required.	Enter Wheelchair Van License Number.

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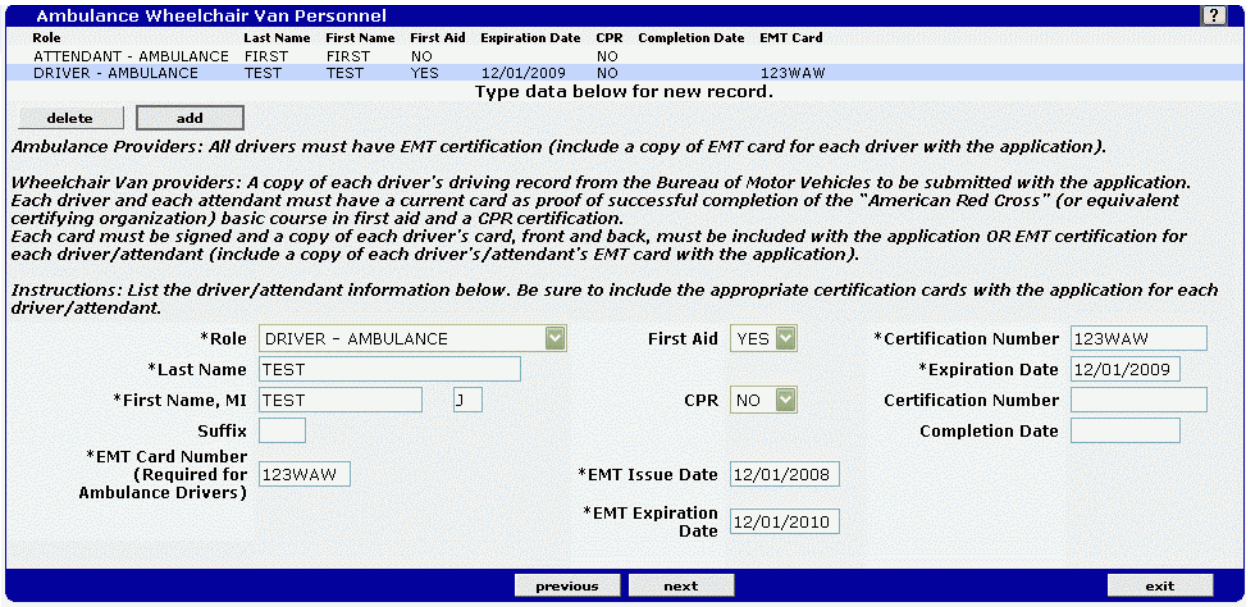
Ambulance Wheelchair Van Personnel – Hospital

The Ambulance Wheelchair Van Personnel panel displays for all enrolling Hospital providers using the Hospital Wizard that select transportation options of Air Fixed Wing, Air Fixed Rotary, Water Transport, Wheelchair Van, and Van Ambulance and Organization providers using the Organization Wizard that select transportation options of Air Fixed Wing, Air Fixed Rotary, Water Transport, Wheelchair Van, and Van Ambulance.



Tasks for this panel

To **enter** information about ambulance wheelchair van personnel:

1. Select a value from the **Role** drop down list box.
2. Enter valid values in the **Last Name**, **First Name, MI**, **EMT Card Number**, **EMT Issue Date**, **EMT Expiration Date**, **Certification Number**, and **Expiration Date** fields.
3. Select a **Yes** or **No** response from the **First Aid** drop down list box.
4. If **Yes** is selected, enter valid values in the first aid **Certification Number** and **Expiration Date** fields.
5. Select a **Yes** or **No** response from the **CPR** drop down list box.
6. If Yes is selected, enter valid values in the CPR **Certification Number** and **Completion Date** fields.
7. Enter a value in the **Suffix** field, if applicable.
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.

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Field Descriptions – Ambulance Wheelchair Van Personnel – Hospital

Field	Description	Field Type	Data Type	Length
add	Adds a new record to the data list.	Button	N/A	0
delete	Deletes the currently selected record from the data list.	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
CPR	Indicates whether the ambulance or wheelchair van employee is certified to perform CPR.	Field	Drop Down List Box	2
Certification Number [CPR]	A number issued to the ambulance or wheelchair van employee indicating he/she has passed the mandated CPR exam.	Field	Alphanumeric	11
Completion Date	Date that the CPR certification will expire.	Field	Date (MM/DD/CCYY)	8
EMT Card Number	A number issued to the ambulance or wheelchair van employee indicating he/she has passed the mandated EMT certification exam.	Field	Alphanumeric	6
EMT Expiration Date	Date that the EMT certification will expire.	Field	Date (MM/DD/CCYY)	8
EMT Issue Date	Date that the EMT Card was issued.	Field	Date (MM/DD/CCYY)	8
Expiration Date	Date that the First Aid certification will expire.	Field	Date (MM/DD/CCYY)	8
First Aid	Indicates whether the ambulance or wheelchair van employee is certified to perform first aid.	Field	Drop Down List Box	2
First Aid Certification Number	A number issued to the ambulance or wheelchair van employee indicating he/she	Field	Alphanumeric	11

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Field	Description	Field Type	Data Type	Length
	has passed the mandated First Aid exam.			
First Name, MI	First name and middle initial of the ambulance or wheelchair van employee.	Field	Character	14
Last Name	Last name of the ambulance or wheelchair van employee.	Field	Character	25
Role	Role of the ambulance or wheelchair van employee.	Field	Drop Down List Box	0
Suffix	Suffix of the ambulance or wheelchair van employee.	Field	Character	3

Field Edits – Ambulance Wheelchair Van Personnel – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Certification Number [CPR]	Field	1	CPR Certification Number is required.	Enter CPR Certification Number.
Completion Date	Field	1	CPR Expiration Date is required.	Enter CPR Expiration Date.
	Field	2	CPR Expiration Date must be greater than today.	Enter CPR Expiration Date greater than today.
EMT Card Number	Field	1	EMT Card Number is required.	Enter EMT Card Number.
EMT Expiration Date	Field	1	EMT Expiration Date is required.	Enter EMT Expiration Date.
	Field	2	EMT Expiration Date must be greater than EMT Issue Date.	Enter EMT Expiration Date greater than EMT Issue Date.
EMT Issue Date	Field	1	EMT Issue Date is required.	Enter EMT Issue Date.
	Field	2	EMT Issue Date must be earlier than or equal to today.	Enter EMT Issue Date earlier than or equal to today.
Expiration Date	Field	1	First Aid Expiration Date is required.	Enter First Aid Expiration Date.
	Field	2	First Aid Expiration Date must be greater than today.	Enter First Aid Expiration Date greater than today

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Field	Field Type	Error Code	Error Message	To Correct
First Aid Certification Number	Field	1	First Aid Certification Number is required.	Enter First Aid Certification Number.
First Name, MI	Field	1	First Name and MI is required.	Enter First Name and MI.
Last Name	Field	1	Last Name is required.	Enter Last Name.
Role	Field	1	Role is required.	Choose a valid Role.

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Requirements for Wheelchair Vehicle Providers – Hospital

The Requirements for Wheelchair Vehicle Providers panel allows the enrolling provider to certify that it meets requirements for wheelchair van vehicle providers.

Requirements for Wheelchair Vehicle Providers ?

Requirements for Wheelchair Van Vehicle Providers Documents to be included with the application

You must include, with your application, copies of documents for each item listed on this page. In addition, all wheelchair van vehicle providers must have documented proof on file of compliance with the following requirements, to be available upon request from the Department of Job and Family Services.

Check each question to certify compliance and include required documentation.

*1a. The number of vehicles the wheelchair van service is operating.	3
* b. The provider maintains a valid current vehicle license registration with the Ohio Bureau of Motor Vehicles for each vehicle. Include a copy of the vehicle registration for each vehicle.	(•) Yes ( ) No
*2. Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle. Include photos of each vehicle for verification.	(•) Yes ( ) No
*3. The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable. Include proof of insurance.	(•) Yes ( ) No
*4. The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any wheelchair van vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident. Include proof of insurance.	(•) Yes ( ) No
*5. Each driver and attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the revised code shall not provide services to medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply. Include a copy of the BCI criminal background check results.	(•) Yes ( ) No
*6. Each driver and each attendant has current cards issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid and CPR. Each card must be signed on the back by the driver or attendant who completed the course. Include a copy of each card for each driver and attendant with the application.	(•) Yes ( ) No
*7. Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen days prior to the date of application for employment. Persons with six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an wheelchair van driver. Include a copy of each driver's driving record with the application.	(•) Yes ( ) No
*8. The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver's license and be eighteen years or older. Include a copy of a valid driver's license for each driver.	(•) Yes ( ) No
*9. Each vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.	(•) Yes ( ) No
*10. Each vehicle has a minimum ceiling to floor height of fifty-six inches.	(•) Yes ( ) No
*11. Each vehicle is equipped with a communication system capable of two-way communication.	(•) Yes ( ) No
*12. Each vehicle is equipped with a stable access ramp or hydraulic lift.	(•) Yes ( ) No
*13. The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.	(•) Yes ( ) No
*14. Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.	(•) Yes ( ) No
*15. Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.	(•) Yes ( ) No
*16. The provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.	(•) Yes ( ) No
*17. The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.	(•) Yes ( ) No
*18. Each wheelchair van driver and each attendant has an identification card available to the patient identifyinghis or her complete name and company affiliation.	(•) Yes ( ) No
*19. The provider maintains on file a signed statement from a licensed physician for each driver and attendant declaring that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.	(•) Yes ( ) No
*20. Each wheelchair van driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.	(•) Yes ( ) No
*21. Each wheelchair van and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.	(•) Yes ( ) No

previous next exit

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Tasks for this panel

To **enter** information on wheelchair vehicle providers:

1. Enter a numerical value in the question **1a.** field.
2. Select either **Yes** or **No** for the remaining question fields **1b.** through **21.**
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 – Requirements for Wheelchair Vehicle Providers – Hospital

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
Question 10	Each vehicle has a minimum ceiling to floor height of fifty-six (56) inches.	Field	Radio Button	1
Question 11	Each vehicle is equipped with a communication system capable of two-way communication.	Field	Radio Button	1
Question 12	Each vehicle is equipped with a stable access ramp or hydraulic lift.	Field	Radio Button	1
Question 13	The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.	Field	Radio Button	1
Question 14	Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.	Field	Radio Button	1
Question 15	Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.	Field	Radio Button	1
Question 16	The provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.	Field	Number	1
Question 17	The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.	Field	Radio Button	1

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Field	Description	Field Type	Data Type	Length
Question 18	Each Wheelchair Van driver and each attendant has an identification card available to the patient identifying his or her complete name and company affiliation.	Field	Radio Button	1
Question 19	The provider maintains on file a signed statement from a licensed physician for each driver and each attendant that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.	Field	Radio Button	1
Question 1a	The number of vehicles Wheelchair Van service is operating.	Field	Number	4
Question 1b	The provider maintains a valid current vehicle license registration with the Ohio Bureau of Motor Vehicles for each vehicle.	Field	Radio Button	1
Question 2	Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle. (Include photos of each vehicle for verification.)	Field	Radio Button	1
Question 20	Each Wheelchair Van driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.	Field	Radio Button	1
Question 21	Each Wheelchair Van driver and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.	Field	Radio Button	1
Question 3	The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars ($500,000.00) in the aggregate, for any cause for which the provider would be liable. (Include proof of insurance.)	Field	Radio Button	1
Question 4	The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation of any Wheelchair Vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars ($100,000.00) for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars ($50,000.00) for damage to property arising from any one accident. (Include proof of insurance.)	Field	Radio Button	1

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Field	Description	Field Type	Data Type	Length
Question 5	Each driver and each attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the Revised Code shall not provide services to Medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of Rule 3701-13-06 of the Administrative Code apply. (Include a copy of the BCI criminal background check results.)	Field	Radio Button	1
Question 6	Each driver and each attendant has current cards issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid and CPR. Each card must be signed on the back by the driver or attendant who completed the course. (Include a copy of each card for each driver and each attendant with the application.)	Field	Radio Button	1
Question 7	Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen (14) days prior to the date of application for employment. Persons with six (6) or more points on their driving record in accordance with Section 4507.02 of the Revised Code cannot be a Wheelchair Van driver. (Include a copy of each driver's driving record with the application.)	Field	Radio Button	1
Question 8	The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver's license and be eighteen (18) years or older. (Include a copy of a valid driver's license for each driver.)	Field	Radio Button	1
Question 9	Each vehicle is specifically designed to transport one (1) or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.	Field	Radio Button	1

Field Edits – Requirements for Wheelchair Vehicle Providers – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Question 10	Field	0	Question 10 is required	Select yes or no.

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Field	Field Type	Error Code	Error Message	To Correct
Question 11	Field	0	Question 11 is required.	Select yes or no.
Question 12	Field	0	Question 12 is required.	Select yes or no.
Question 13	Field	0	Question 13 is required.	Select yes or no.
Question 14	Field	0	Question 14 is required.	Select yes or no.
Question 15	Field	0	Question 15 is required.	Select yes or no.
Question 16	Field	0	Question 16 is required.	Select yes or no.
Question 17	Field	0	Question 17 is required.	Select yes or no.
Question 18	Field	0	Question 18 is required.	Select yes or no.
Question 19	Field	0	Question 19 is required.	Select yes or no.
Question 1a	Field	0	Question 1a is required.	Enter the number of vehicles.
Question 1a	Field	1	The number of vehicles operating must be greater than zero.	Enter number of vehicles greater than zero.
Question 1b	Field	0	Question 1b is required.	Select yes or no.
Question 2	Field	0	Question 2 is required.	Select yes or no.
Question 20	Field	0	Question 20 is required.	Select yes or no.
Question 21	Field	0	Question 21 is required.	Select yes or no.
Question 3	Field	0	Question 3 is required.	Select yes or no.
Question 4	Field	0	Question 4 is required.	Select yes or no.
Question 5	Field	0	Question 5 is required.	Select yes or no.

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Field	Field Type	Error Code	Error Message	To Correct
Question 6	Field	0	Question 6 is required.	Select yes or no.
Question 7	Field	0	Question 7 is required.	Select yes or no.
Question 9	Field	0	Question 9 is required.	Select yes or no.

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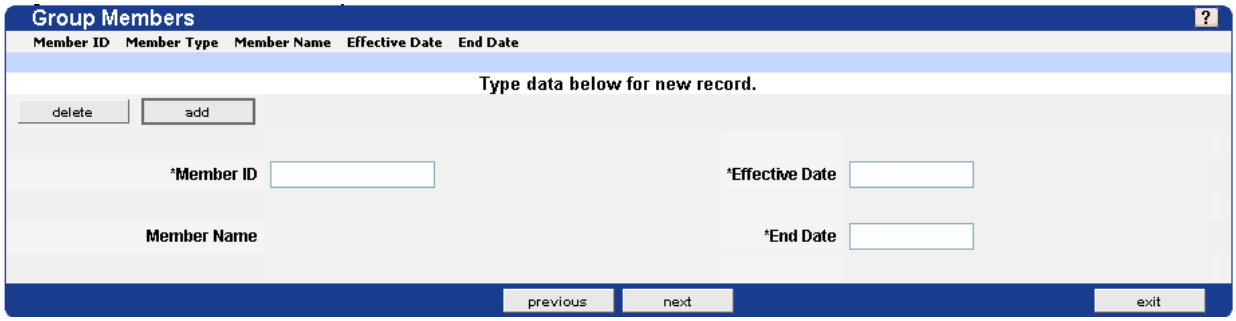
Group Members – Hospital

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.



Tasks for this panel

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

1. Select the **add** button. The **Group Members** panel redisplays 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 – Hospital

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	Effective date of the group.	Field	Date	8

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Field	Description	Field Type	Data Type	Length
[Panel]			(MM/DD/CCYY)	
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 the group.	Listview	Character	15
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 – Hospital

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.

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Field	Field Type	Error Code	Error Message	To Correct
	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

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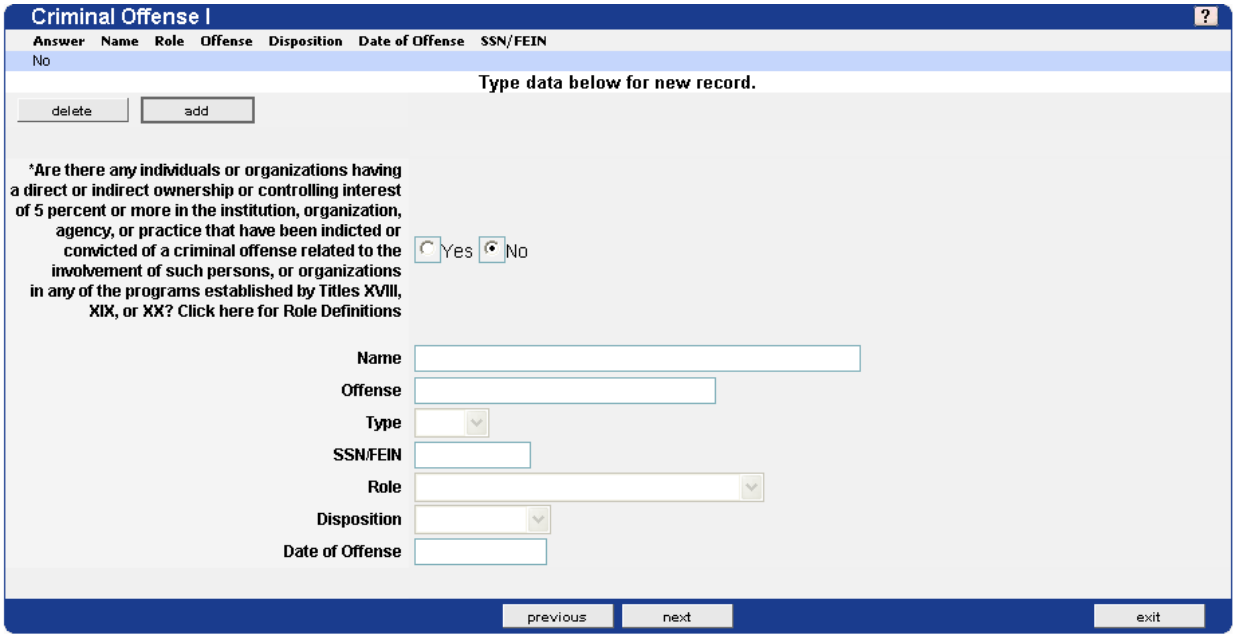
Criminal Offense I – Hospital

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 no owner or controlling interest has ever been indicted or convicted, select the **No** option, then the **next** button.
2. If any 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 – Hospital

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

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Field	Description	Field Type	Data Type	Length
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 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

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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

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Field Edits – Criminal Offense I – Hospital

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.

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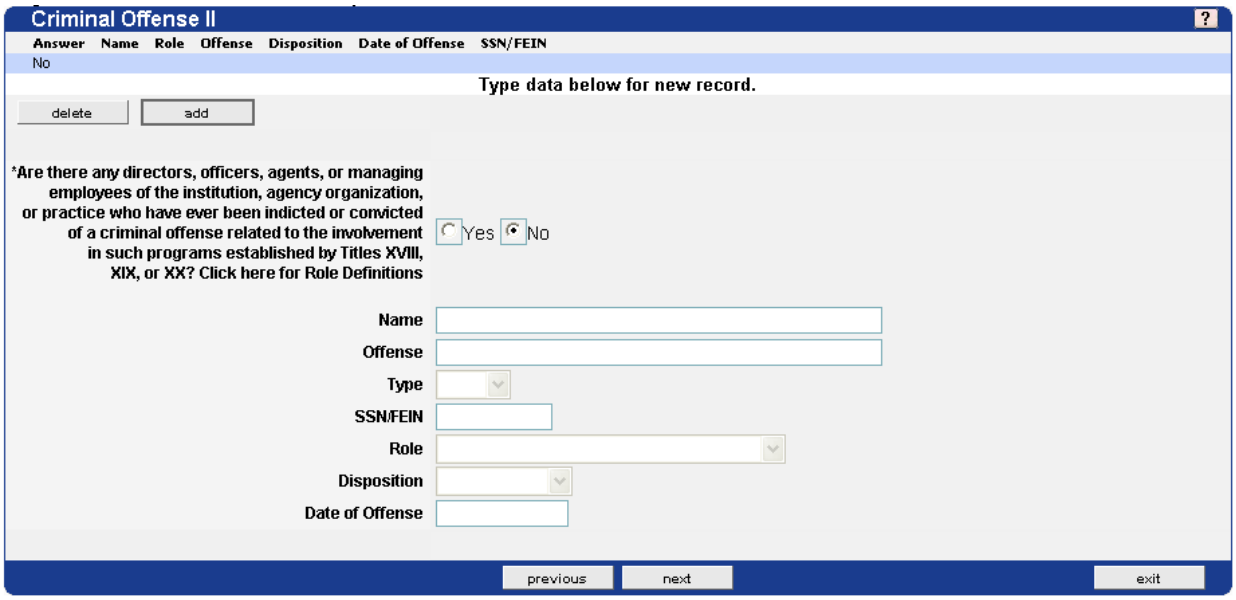
Criminal Offense II – Hospital

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 no executives or agents of the organization have ever been indicted or convicted, select the **No** option, then the **next** button.
2. If any executives or agents of the organization 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 – Hospital

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

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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 (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
[List]				
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 – Hospital

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 Identification number.

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

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Type of Entity or Practice – Hospital

The Type of Entity or Practice panel captures the type of business that is represented in the application.

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 – Hospital

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 – Hospital

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.

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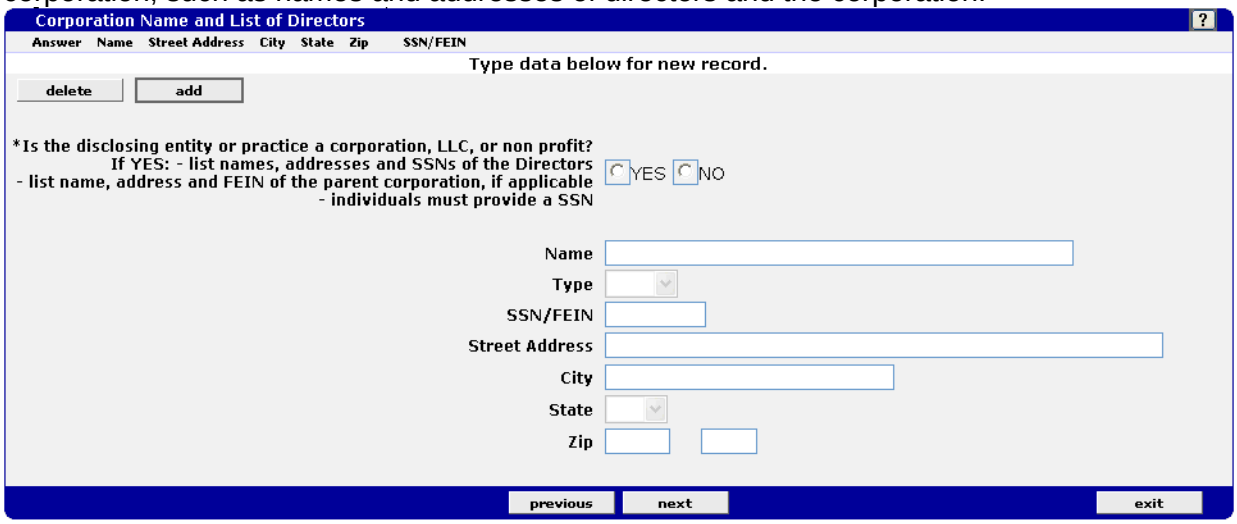
Corporation Name and List of Directors – Hospital

The Corporation Name and List of Directors panel captures information pertaining to a corporation, such as names and addresses of directors and the corporation.



Tasks for this panel

To **enter** information pertaining to a corporation:

1. Select a **Yes** or **No** response to the question **Is the disclosing entity or practice a corporation, LLC, or non profit?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Name**, **Type**, **SSN/FEIN**, **Street Address**, **City**, **State**, and **Zip** fields becomes active.
4. Enter valid values in the **Name**, **SSN/FEIN**, **Street Address**, **City**, and **Zip** fields.
5. Select values from the **Type** and **State** drop down list boxes.
6. Enter a value in the 4-digit **Zip** extension field, if applicable.
7. Select the **add** button to add another corporation name record.
8. Select the **delete** button to delete a selected corporation name record.
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 – Corporation Name and List of Directors – Hospital

Field	Description	Field Type	Data Type	Length
Question (Detail)	"Is the disclosing entity or practice a corporation, LLC, or non profit?" If YES: - list names, addresses and SSNs of the Directors - list name, address and FEIN of the parent corporation, if	Button	Radio Button	0

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Field	Description	Field Type	Data Type	Length
	applicable - individuals must provide a SSN "			
Answer (List)	Represents the "Yes" or "No" answer to the question: "Is the disclosing entity or practice a corporation, LLC, or non profit? If YES: - list names, addresses and SSNs of the Directors - list name, address and FEIN of the parent corporation, if applicable - individuals must provide a SSN "	Field	Character	3
City (Detail)	Represents the city in which a Director, associated with a corporation, is located and the city in which the parent corporation is located, if applicable. For individual entities, this represents the city in which the individual resides.	Field	Character	50
Name (Detail)	Represents the name of a Director associated with a Corporation and the name of the parent corporation, if applicable. For individual entities, this represents the individual's name.	Field	Character	50
Name (List)	Represents the name of a Director associated with a Corporation and the name of the parent corporation, if applicable. For individual entities, this represents the individual's name.	Field	Character	50
SSN/FEIN (Detail)	Represents the SSN of a Director, associated with a corporation and the EIN of the parent corporation, if applicable. For Individual entities, this represents the SSN of the Individual.	Field	Number	9
State (Detail)	Represents the state in which a Director, associated with a corporation, is located and the city in which the parent corporation is located, if applicable. For individual entities, this represents the state in which the individual resides.	Field	Drop Down List Box	0
Street Address (Detail)	Represents the address of the Director associated with a corporation and the address of the parent corporation if applicable. For individual entities, this represents the address of the individual.	Field	Alphanumeric	60
Type (Detail)	Represents the type of identifier number (SSN) of a Director, associated with a corporation and the type of identifier (EIN) of the parent corporation, if applicable. For Individual entities, this represents the type of identifier number (SSN) of the Individual.	Field	Drop Down List Box	0
Zip (Detail)	Represents the five digit zip code plus the	Field	Number	9

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Field	Description	Field Type	Data Type	Length
	additional 4 digits of the zip code in which the Director, associated with a corporation, is located and the zip code of the parent corporation if applicable. For individual entities, this represents the zip code in which the individual is located.			
Zip (List)	Represents the five digit zip code plus the additional 4 digits of the zip code in which the Director, associated with a corporation, is located and the zip code of the parent corporation if applicable. For individual entities, this represents the zip code in which the individual is located.	Field	Number	9
City (List)	Represents the city in which a Director, associated with a corporation, is located and the city in which the parent corporation is located, if applicable. For individual entities, this represents the city in which the individual resides.	Listview	Character	50
State (List)	Represents the state in which a Director, associated with a corporation, is located and the city in which the parent corporation is located, if applicable. For individual entities, this represents the state in which the individual resides.	Listview	Character	2
Street Address (List)	Represents the address of the Director associated with a corporation and the address of the parent corporation if applicable. For individual entities, this represents the address of the individual.	Listview	Alphanumeric	60

Field Edits – Corporation Name and List of Directors – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Question (Detail)	Button	1	Can not have a "YES" and a "NO" response to the Question.	Delete appropriate "YES" or "NO" record.
Question (Detail)	Button	2	Can only answer "NO" to the Question once	Delete duplicate "NO" response
Question (Detail)	Button	5100	A "YES" or "NO" response to the Question is required when click on "Add"	Click "YES" or "NO"

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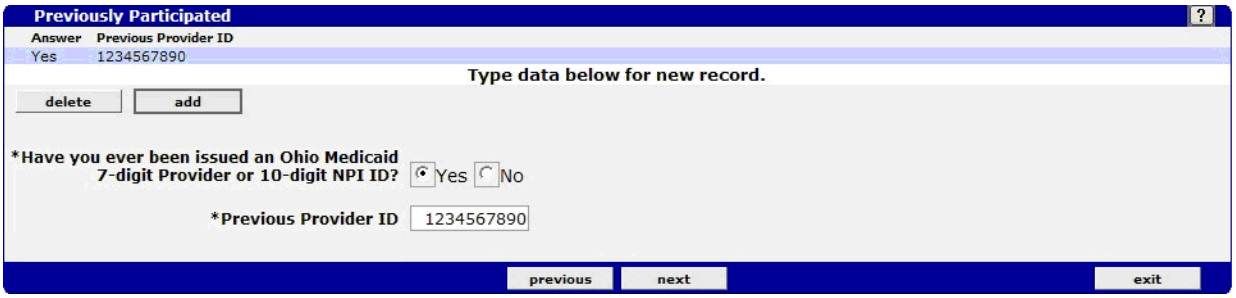
Previously Participated – Hospital

The Previously Participated panel captures 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 – Hospital

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

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Field	Description	Field Type	Data Type	Length
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 – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Previous Provider ID Question	Field	0	YES/NO response to this question is required.	Choose Yes or No.
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.

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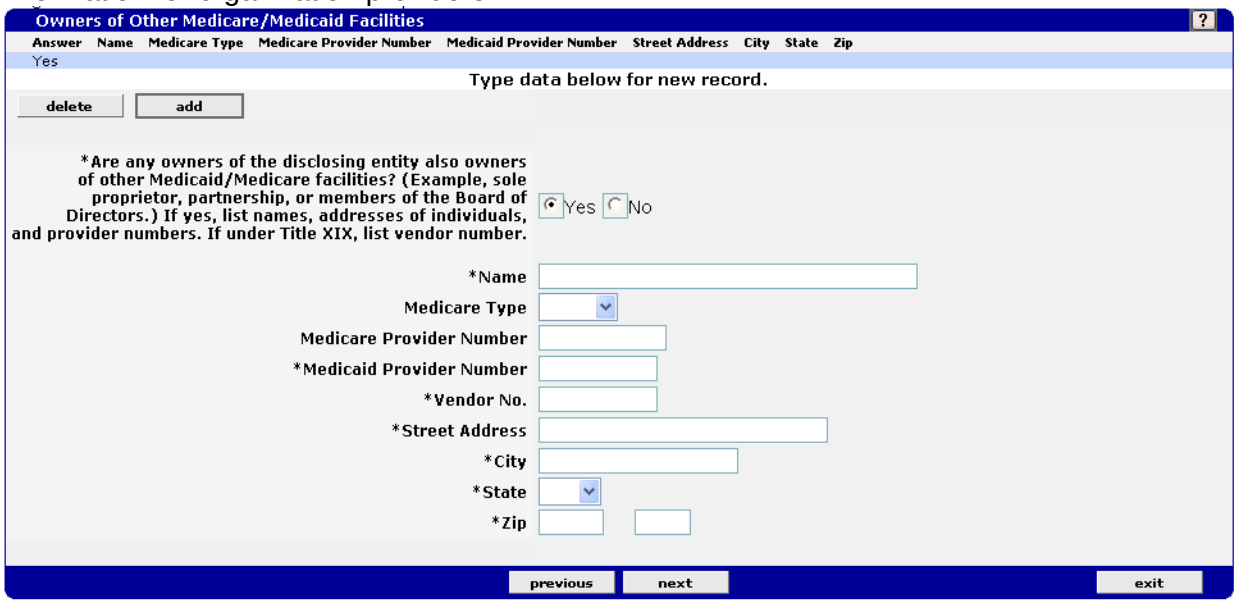
Owners of Other Facilities – Hospital

The Owners of Other Facilities panel captures the owners of other Medicaid/Medicare facilities information for organization providers.



Tasks for this panel

To **enter** information on owners of other Medicaid and/or Medicare facilities:

1. Select a **Yes** or **No** response to the question **Are any owners of the disclosing entity also owners of other Medicaid/Medicare facilities?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Name**, **Medicare Type**, **Medicare Provider Number**, **Medicaid Provider Number**, **Vendor Number**, **Street Address**, **City**, **State**, and **Zip** fields becomes active.
4. Enter valid values in the **Name**, **Medicaid Provider Number**, **Vendor Number**, **Street Address**, **City**, and **Zip** fields.
5. Select values from the **Medicare Type** and **State** drop down list boxes.
6. Enter values in the **Medicare Provider Number** and 4-digit **Zip** extension fields, if applicable.
7. Select the **add** button to add another owners of other facilities record.
8. Select the **delete** button to delete a selected owner of other facilities record.
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.

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Field Descriptions – Owners of Other Medicare/Medicaid Facilities – Hospital

Field	Description	Field Type	Data Type	Length
add	Inserts a new owner 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
City [Detail]	City of the owner.	Field	Character	30
Medicaid Provider Number [Detail]	Provider's identification number.	Field	Number	10
Medicare Provider Number [Detail]	Medicare Provider Number	Field	Number	10
Medicare Type [Detail]	Medicare Type PTAN/CCN	Field	Drop Down List Box	0
Name [Detail]	Name of the individual who is an owner of another Medicaid or Medicare facility.	Field	Character	50
Question	Are any owners of the disclosing entity also owners of other Medicaid/Medicare facilities? Choose yes or No.	Field	Radio Button	1
State [Detail]	State of the owner.	Field	Drop Down List Box	0
Street Address [Detail]	Street address of the owner.	Field	Character	60
Vendor No.	Provider's vendor number.	Field	Alphanumeric	9
ZIP [Detail]	Zip code of the owner.	Field	Number	5
ZIP+4	Zip code extension of the owner.	Field	Number	4
Answer	Response to the other ownership question.	Listview	Character	0
City [List]	City of the owner.	Listview	Character	0

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Field	Description	Field Type	Data Type	Length
Medicaid Provider Number [List]	Provider's identification number.	Listview	Number	10
Medicare Provider Number [List]	Medicare Provider Number.	Listview	Number	10
Medicare Type [List]	Medicare Type PTAN/CCN.	Listview	Character	4
Name [List]	Name of the individual who is an owner of another Medicaid or Medicare facility.	Listview	Character	50
State [List]	State of the owner.	Listview	Character	0
Street Address [List]	Street address of the owner.	Listview	Character	0
ZIP [List]	Zip code of the owner.	Listview	Number	5

Field Edits – Owners of Other Medicare/Medicaid Facilities – Hospital

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.
Medicaid Provider Number [Detail]	Field	0	Medicaid Provider Number is required.	Enter a Medicaid Provider Number.
Medicaid Provider Number [Detail]	Field	1	Medicaid Provider Number must be 7 or 10 digits in length.	Enter a valid Medicaid Provider Number.
Medicare Provider Number [Detail]	Field	1	When Medicare Type is selected Medicare Provider Number is required.	Enter Medicare Provider Number.

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Field	Field Type	Error Code	Error Message	To Correct
Medicare Provider Number [Detail]	Field	2	Medicare Provider Number must be 7 or 10 digits in length.	Enter Medicare Provider Number.
Medicare Type [Detail]	Field	1	When Medicare Type is selected Medicare Provider Number is required.	Enter Medicare Provider Number.
Medicare Type [Detail]	Field	2	When Medicare Provider Number is entered Medicare Type is required	Enter Medicare Type
Name [Detail]	Field	0	Name is required.	Enter a Name.
Question	Field	0	YES/NO response to this question is required.	Choose Yes or No.
Question	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Question	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
Vendor No.	Field	0	Vendor No. is required.	Enter a Vendor No.
Vendor No.	Field	1	Required input must be between 6 and 9.	Enter a 6 to 9 alphanumeric value of Vendor No.
ZIP [Detail]	Field	1	Enter a valid value.	Enter a 5 digits value of Zip.
ZIP+4	Field	0	Enter a valid value.	Enter a 4 digits value of Zip+4.

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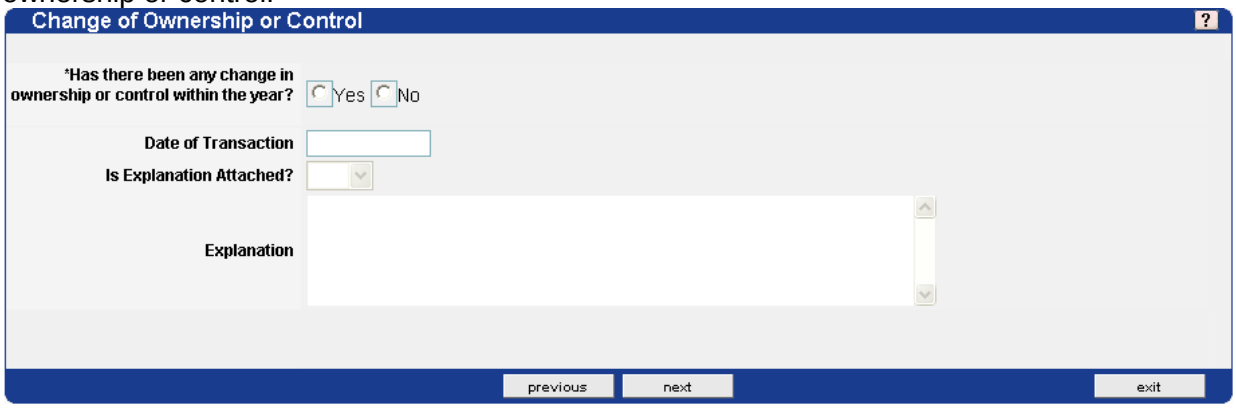
Change of Ownership or Control – Hospital

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 to control or ownership 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 – Hospital

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

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Field	Description	Field Type	Data Type	Length
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 – Hospital

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 Attached?	Field	1	Explanation Attached is required.	Select YES or NO.
Has there been any change in ownership or control within the year?	Field	1	Change of Ownership is required.	Select YES or NO.

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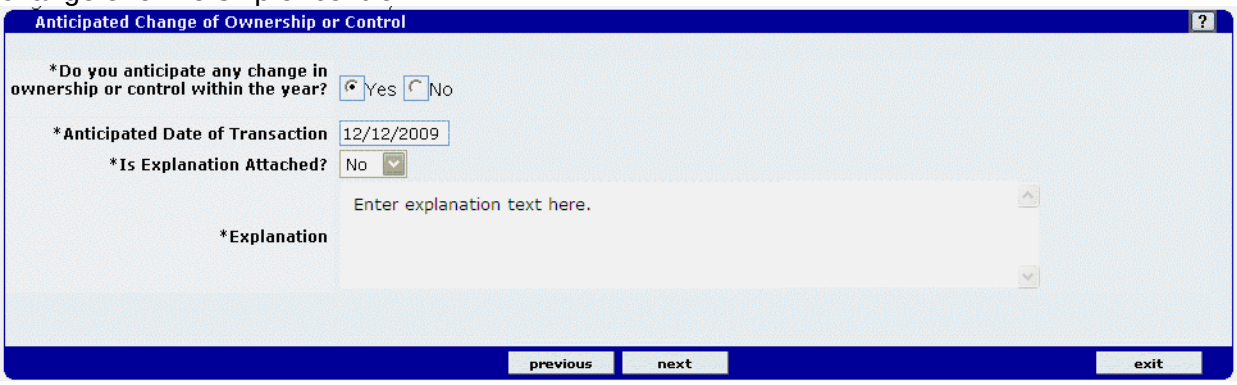
Anticipated Change of Ownership or Control – Hospital

The Anticipated Change of Ownership 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 – Hospital

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

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Field	Description	Field Type	Data Type	Length
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?	Is there an attachment that 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	0
Do you anticipate any change in ownership or control within the year?	Indicates if a change in ownership or control is expected in the coming year. Valid values: Yes or No.	Field	Radio Button	0

Field Edits – Anticipated Change of Ownership or Control – Hospital

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.
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	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.

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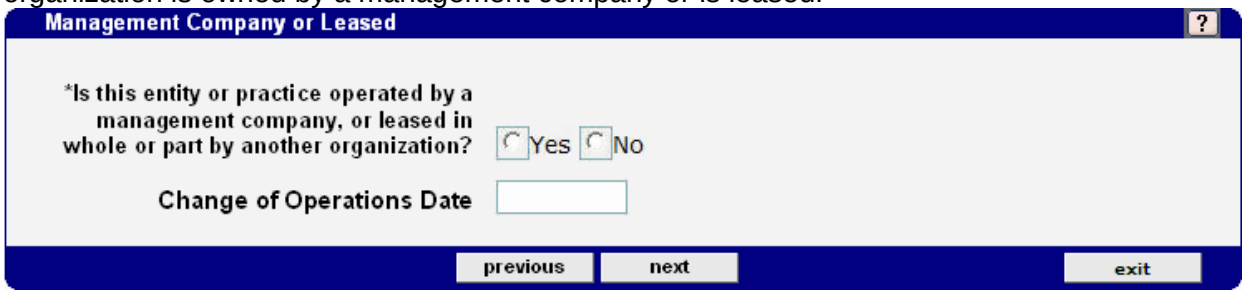
Management Company or Leased – Hospital

The Management Company or Leased panel captures information about whether the organization 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 – Hospital

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 organization is managed or leased by another organization. Valid values: Yes or No.	Field	Radio Button	0

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Field Edits – Management Company or Leased – Hospital

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.
Change of Operations Date	Field	2	Change of Operations Date is invalid.	Enter a valid date.
Change of Operations 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.

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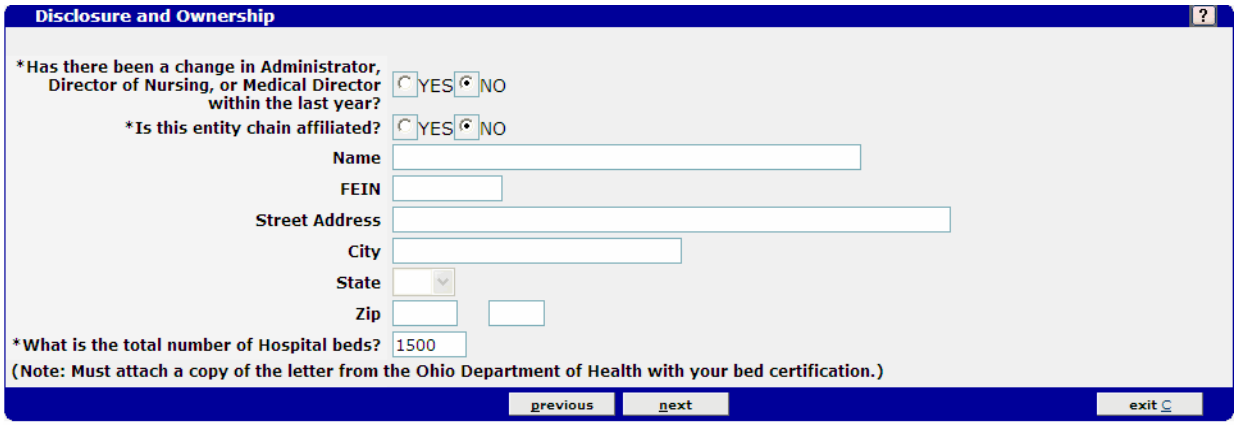
Disclosure and Ownership – Hospital

The Disclosure and Ownership panel allows organization provider applicants to respond to related question information during the enrollment process. This panel provides information on administrative changes, chain affiliations, and hospital bed changes.



Tasks for this panel

To **enter** information on administrative changes, chain affiliations, and hospital bed changes:

1. Select a **Yes** or **No** response to the question **Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?**
2. If **No** is selected, select the **next** button to proceed to the next enrollment panel.
3. If **Yes** is selected, select a **Yes** or **No** response to the question **Is this entity chain affiliated?**
4. If **No** is selected, select the **next** button to proceed to the next enrollment panel.
5. If **Yes** is selected, the **Name**, **FEIN**, **Street Address**, **City**, **State**, **Zip**, and **What is the total number of Hospital beds?** fields become active.
6. Enter valid values in the **Name**, **FEIN**, **Street Address**, **City**, **State**, **Zip**, and **What is the total number of Hospital beds?** fields.
7. Select a value from the **State** drop down list box.
8. Enter a value in the **4-digit Zip** extension, if applicable.
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 – Disclosure and Ownership – Hospital

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

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Field	Description	Field Type	Data Type	Length
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	State of entity chain affiliation.	Combo Box	Character	2
City	City of entity chain affiliation.	Field	Character	30
FEIN	Federal Employer Identification number of entity chain affiliation.	Field	Number	11
Name	Name for the entity chain affiliation.	Field	Character	50
Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?	Indicates any ownership changes in the past year. Valid values: Yes or No.	Field	Radio Button	0
Is this entity chain affiliated?	Indicates if the organization is part of a chain. Valid values: Yes or No.	Field	Radio Button	0
What is the total number of Hospital beds?	Number of hospital beds.	Field	Number	5
Street Address	Address of entity chain affiliation.	Field	Character	60
Zip	Zip code and Zip + 4 for entity chain affiliation.	Field	Number	5
Zip + 4	Zip code extension	Field	Number	4

Field Edits – Disclosure and Ownership – Hospital

Field	Field Type	Error Code	Error Message	To Correct
State	Combo Box	1	State is required.	Enter state for entity chain affiliation.
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

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Field	Field Type	Error Code	Error Message	To Correct
				contain A - Z and 0 - 9.
	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.
City	Field	1	City is required.	Enter a city for entity chain affiliation.
FEIN	Field	1	FEIN is required.	Enter a FEIN for entity chain affiliation.
Name	Field	0	Name is required.	Enter the name for the entity chain affiliation.
Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?	Field	0	YES or NO response to administration change question is required.	YES or NO response to administration change question is required.
Is this entity chain affiliated?	Field	1	YES or NO response to chain affiliation question is required.	YES or NO response to chain affiliation question is required.
What is the total number of Hospital beds?	Field	1	Number of Hospital beds is required.	Enter number of hospital beds.
Street Address	Field	1	Address is required.	Enter an address for entity chain affiliation.
Zip	Field	1	Zip code is required.	Enter zip code for entity chain affiliation.

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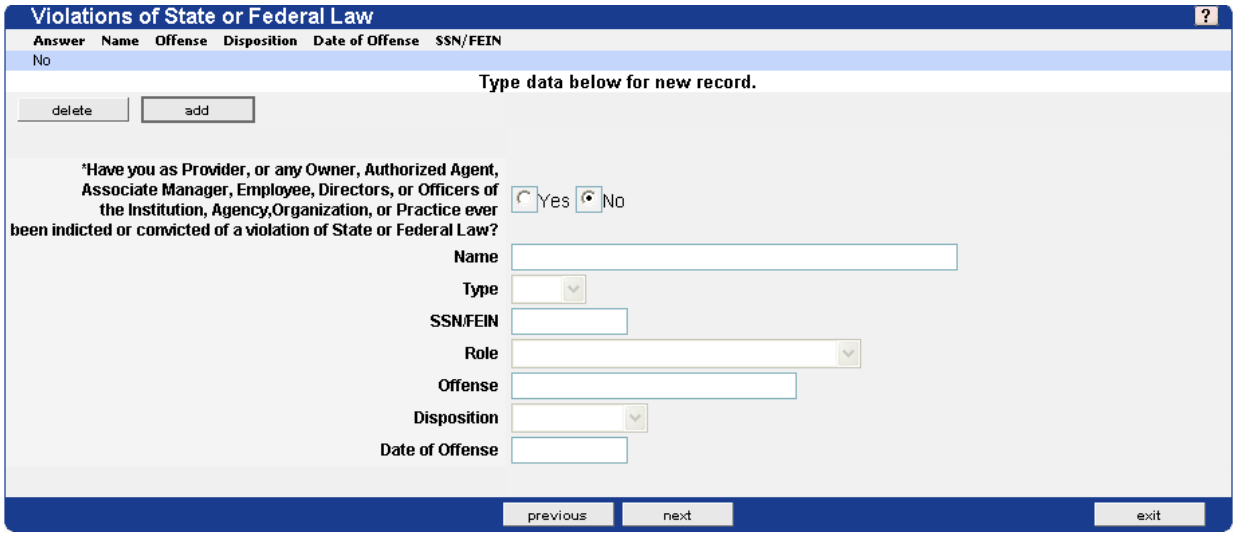
Violations of State or Federal Law – Hospital

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 organization, 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 organization, any of its employees, or any other business associates has ever had a State or Federal violation, select the **Yes** option.
3. The **Name**, **Type**, **SSN/FEIN**, **Role**, **Offense**, **Disposition**, and **Date of Offense** fields become active.
4. Enter valid values for the **Name**, **SSN/FEIN**, **Offense,** and **Date of Offense** fields.
5. Select values for the **Type**, **Role**, and **Disposition** drop down list boxes.
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 – Hospital

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

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Field	Description	Field Type	Data Type	Length
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
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 as Provider or any Owner, Authorized Agent, Associate Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, or Practice ever been indicted or	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

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Field	Description	Field Type	Data Type	Length
convicted of a violation of State or Federal Law?				
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 – Hospital

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.

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Field	Field Type	Error Code	Error Message	To Correct
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 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.
	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.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.

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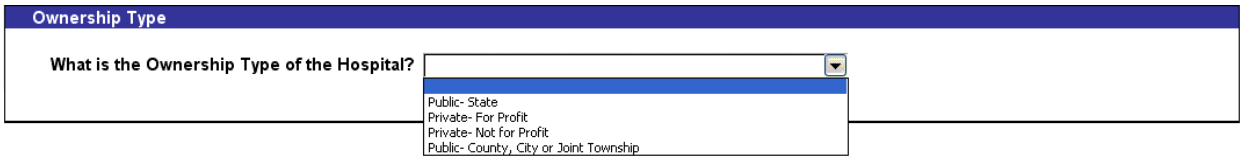
Ownership Type – Hospital

The Ownership Type panel is a question panel for the Hospital Provider Enrollment.



Tasks for this Panel

To **enter** ownership type information:

1. Select a value from the **What is the Ownership Type of the Hospital?** drop down list box.

Field Descriptions – Ownership Type – Hospital

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
Ownership Type of the Hospital	What is the Ownership Type of the Hospital?	Field	Drop Down List Box	0

Field Edits – Ownership Type – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Ownership Type of the Hospital	Field	1	Ownership Type of the Hospital is required.	Choose a value from the dropdown.

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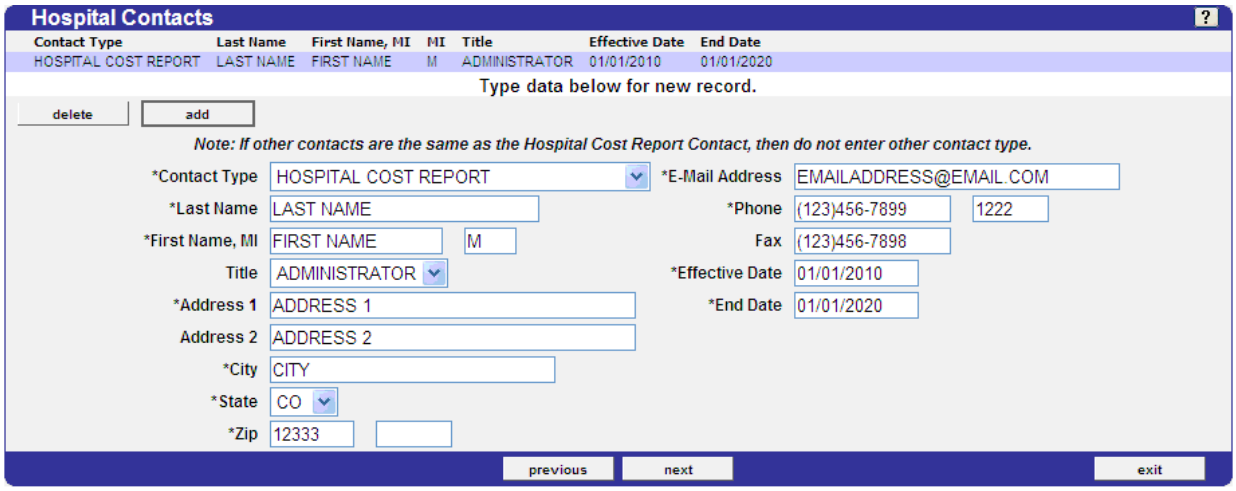
Hospital Contacts – Hospital

The Hospital Contacts panel is a Hospital Enrollment Wizard for entering information related to Hospital contacts.



Tasks for this panel

To **enter** information related to hospital contacts:

1. Select values from the **Contact Type** and **State** drop down list boxes.
2. Enter valid values in the **Last Name**, **First Name**, **Address 1**, **City**, **Zip**, **E-Mail Address**, **Phone**, **Effective Date**, and **End Date** fields.
3. Select a value from the **Title** drop down list box, if applicable.
4. Enter values in the **Address 2**, 4-digit **Zip** extension, **Phone** extension, and **Fax** fields, if applicable.
5. Select the **add** button to add another hospital contacts record.
6. Select the **delete** button to delete a selected hospital contacts 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 – Hospital Contacts – Hospital

Field	Description	Field Type	Data Type	Length
add	Adds a new record to the data list.	Button	N/A	0
delete	Deletes the currently selected record from the data list.	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	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
	Provider Enrollment wizard.			
previous	Navigates to the previous panel in the Provider Enrollment wizard.	Button	N/A	0
Address 1	First line of the address specified by Contact Type.	Field	Alphanumeric	60
Address 2	Second line of the address specified by Contact Type.	Field	Alphanumeric	60
City	City of the address specified by Contact Type.	Field	Character	30
Contact Type	Type of contact.	Field	Drop Down List Box	0
E-Mail Address	E-Mail Address of the person specified by Contact Type.	Field	Alphanumeric	50
Effective Date	Effective Date for the hospital contact.	Field	Date (MM/DD/CCYY)	10
End Date	End Date for the hospital contact.	Field	Date (MM/DD/CCYY)	10
Fax	Fax number for the person specified by Contact Type.	Field	Number	10
First Name, MI	First name and middle initial of the contact person.	Field	Character	14
Last Name	Last name of the contact person.	Field	Character	25
Phone	Phone number and extension for the person specified by Contact Type.	Field	Number	14
State	State of the address specified by Contact Type.	Field	Drop Down List Box	0
Title	Title of the contact person.	Field	Drop Down List Box	0
Zip	Zip code of the address specified by Contact Type.	Field	Number	5
Zip + 4	Zip code extension of the address specified by Contact Type.	Field	Number	4

Field Edits – Hospital Contacts – Hospital

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter Address 1.
City	Field	1	City is required.	Enter City.
Contact Type	Field	1	Contact Type is required.	Choose a Contact Type.

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Field	Field Type	Error Code	Error Message	To Correct
E-Mail Address	Field	1	E-Mail Address is required.	Enter E-Mail address.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Dates for the same contact type cannot overlap.	Enter non overlapping dates.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Dates for the same contact type cannot overlap.	Enter non overlapping dates.
First Name, MI	Field	1	First Name is required.	Enter First Name.
Last Name	Field	1	Last Name is required.	Enter Last Name.
Phone	Field	1	Phone number is required.	Enter Phone number.
State	Field	1	A valid State is required.	Choose a state.
Title	Field	1	Title is required.	Choose a title.
Zip	Field	1	Zip is required.	Enter zip.

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Certification – Hospital

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: SCIENTIST R US

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: INDTEST1

First, MI:

Click this printable Enrollment Checklist link to ensure a complete provider enrollment request.

Legal Provider Primary Practice Address:

*Address 1: ADDRESS1

Address 2: ADDRESS2

*City: CITY

*State: MD

*Zip: 11223

*Type: Tax Identification Number

E-Mail Address: CONTACTMETHOD@EMAIL.COM

*SSN/Tax Identification Number: 112233445

*Preferred Contact Method: E-mail

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

Executive Order 2007-01S Agreement

In accordance with Executive Order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

- ○ I do not accept the terms and conditions
- ◉ I accept the terms and conditions

A copy of the Executive Order can be found on our website at http://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.

- ○ I do not accept the terms and conditions
- ◉ I accept the terms and conditions

Ohio Medicaid Provider Agreement

Broad Street - 31st Floor, Columbus, Ohio 43215".

11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d). This provider agreement may be canceled by either party upon 30 days written notice prior to termination date. I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

- ○ I do not accept the terms and conditions
- ◉ I accept the terms and conditions

Agreement Date: 08/31/2010

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 7 years from the effective date.

*Type Full Name Here: TYPE FULL NAME HERE 08/31/2010

previous next exit

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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 – Hospital

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 the panel.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
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	Field	Check Box	0

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Field	Description	Field Type	Data Type	Length
	service has not been billed to Medicaid in the last 12 months. This checkbox is not visible during the re-enrollment process.			
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 – Hospital

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	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	Field	0	Employer Identification Number is required	This field must be completed

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Field	Field Type	Error Code	Error Message	To Correct
Number				
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

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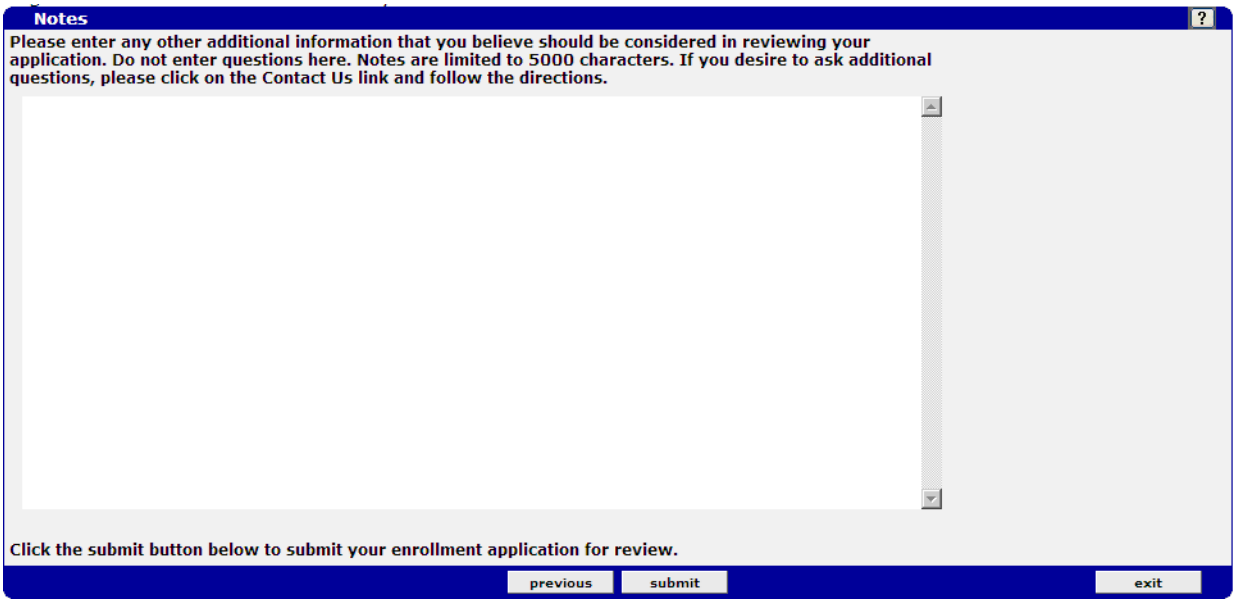
Notes – Hospital

The Notes panel is used to enter additional information or notes associated with the application for the enrolling organization. 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 – Hospital

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 – Notes – Hospital

None.

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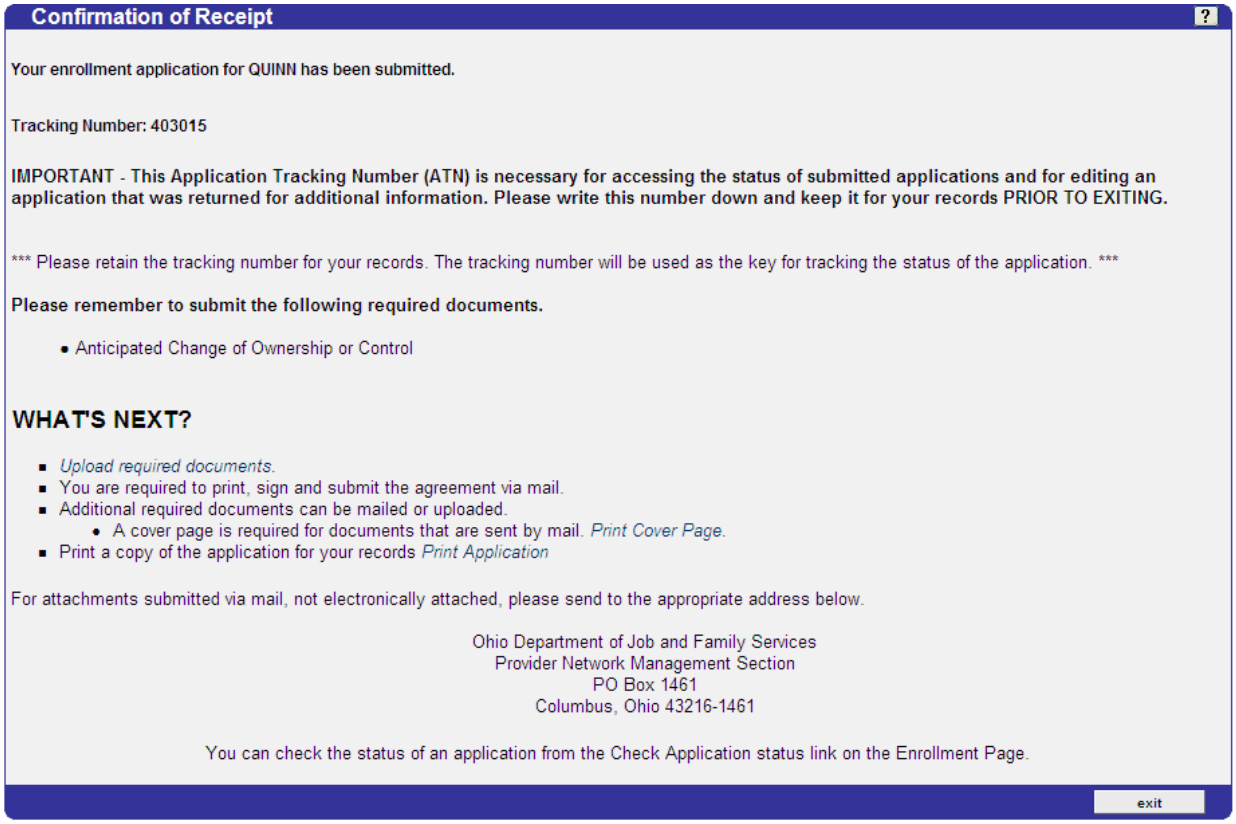
Confirmation of Receipt – Hospital

The Confirmation of Receipt panel displays the Application Tracking Number for the submitted application.

Note: 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.

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

Field Descriptions – Confirmation of Receipt – Hospital

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 – Hospital

None.

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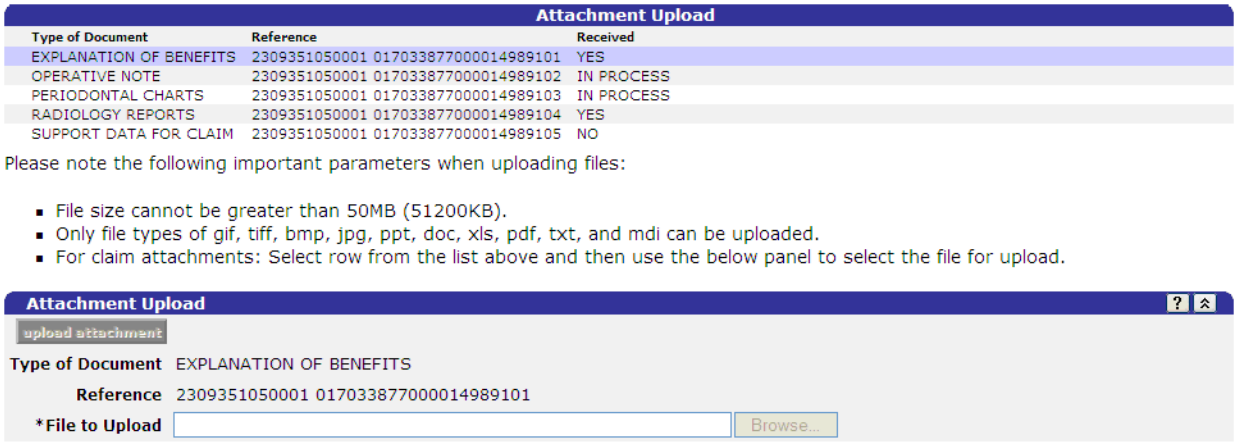
Attachment Uploads – Hospital

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



Tasks for this panel

To **upload** an attachment:

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

Field Descriptions – Attachment Uploads – Hospital

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

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Field	Description	Field Type	Data Type	Length
Type of Document	Description of the uploaded file.	Listview	Character	75

Field Edits – Attachment Uploads – Hospital

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, and 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.

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Attachment Cover – Hospital

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

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: 4 0 2 7 7 9 Recipient ID: Prior Authorization Number:

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

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Tasks for this panel

There are no tasks to perform in this panel.

Field Descriptions – Attachment Cover

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 – Attachment Cover

None.

This is the end of the Hospital enrollment process.

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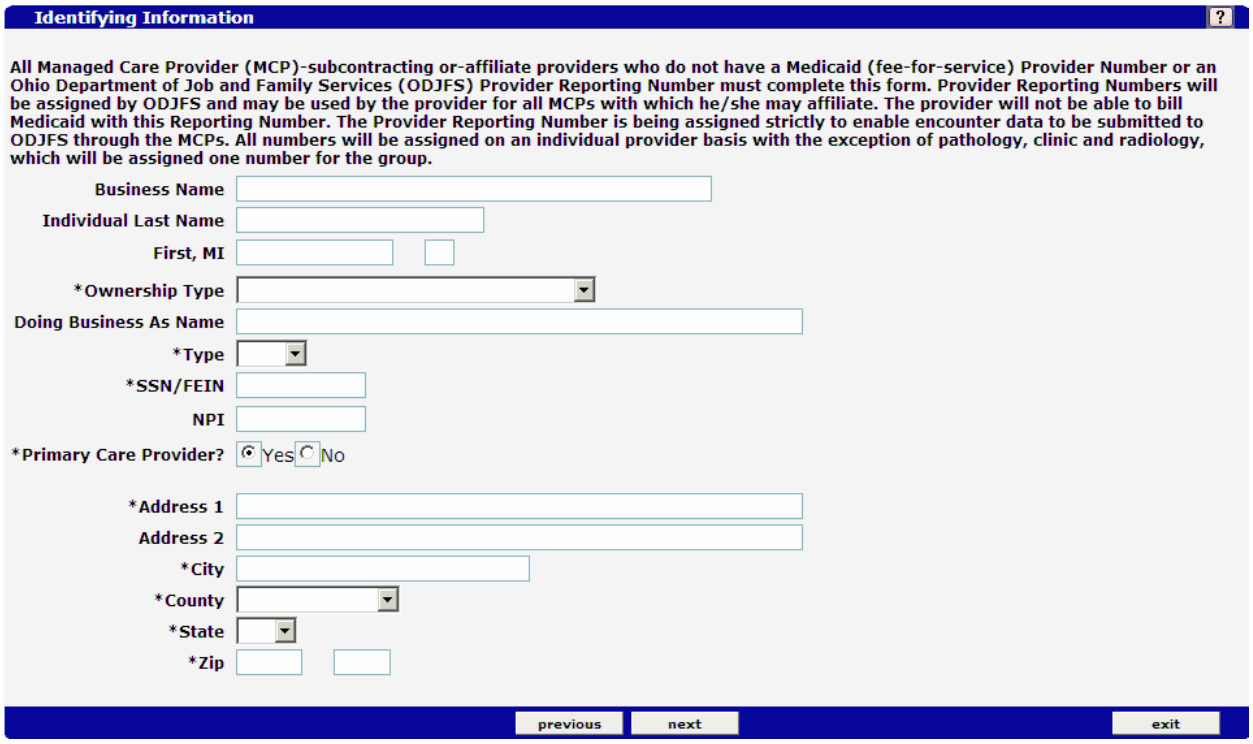
4 ENROLLMENT FOR MANAGED CARE PROVIDERS

Detailed information about the managed care provider must be entered in the **Identifying Information** panel.

Identifying Information – Managed Care Provider

The Identifying Information panel allows a provider applicant to enter identifying information associated with the provider practitioner, organization, and group.



Tasks for this panel

To **enter** managed care provider identifying information:

1. Select values from the **Ownership Type**, **Type**, **County**, and **State** drop down list boxes.
2. Enter valid values in the **SSN/FEIN**, **Address 1**, **City**, and **Zip** fields.
3. Select a **Yes** or **No** response to the question **Primary Care Provider?**
4. Enter values in the **Business Name**, **Individual Last Name**, **First, MI**, **Doing Business As Name**, **NPI**, **Address 2**, and 4-digit **Zip** extension fields, 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.

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Field Descriptions – Identifying Information – Managed Care Provider

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
County	Code for the County.	Combo Box	Drop Down List Box	0
Ownership Type	Ownership Type.	Combo Box	Character	1
Address 1	Address of the business.	Field	Character	60
Address 2	Extra Address of the business.	Field	Character	60
Business Name	Name of the business.	Field	Character	50
City	City.	Field	Character	30
Doing Business As Name	Name for individual or entity applicants doing business under a trade or company name.	Field	Character	50
First, MI	First name and middle initial of the individual.	Field	Character	13
Individual Last Name	If not using a business name, enter the last name for the record.	Field	Alphanumeric	25
MI	Middle initial of the individual.	Field	Character	1
NPI	National Provider Identifier number. If an individual, enter NPI associated with SSN.	Field	Number	10
SSN/ FEIN	SSN Number or Federal Employer Identification Number.	Field	Number	9
State	Code for the State.	Field	Drop Down List Box	0
Type	Type of tax ID. Valid values: SSN or FEIN.	Field	Character	4
Zip	Zip Code.	Field	Character	5
Zip+4	Zip+4.	Field	Character	4

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Field Edits – Identifying Information – Managed Care Provider

Field	Field Type	Error Code	Error Message	To Correct
Ownership Type	Combo Box	1	A Valid Ownership Type is required	This field must be completed.
Address 1	Field	1	Address 1 is required.	This field must be completed.
Business Name	Field	1	Business Name or Individual Last Name is required.	Either Business Name or Individual Last Name must be completed.
City	Field	1	City is required.	This field must be completed.
First, MI	Field	1	First Name is required.	Enter a first name.
	Field	2	First, MI must be blank when Business Name is entered.	Delete the First Name, MI or the Business Name.
	Field	3	First, MI is required when Individual Last Name is entered.	Enter a first name.
Individual Last Name	Field	1	Individual Last Name is required.	Enter a Last Name.
	Field	2	Either Business Name or Individual Last Name is required.	Delete either Individual Last Name or Business Name.
NPI	Field	1	NPI is required.	This field must be completed.
Primary Care Provider	Field	1	Primary Care Provider is required.	This field must be completed.
SSN/ FEIN	Field	1	SSN/FEIN is	This field

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Field	Field Type	Error Code	Error Message	To Correct
			required.	must be completed.
State	Field	1	A Valid State is required	This field must be completed.
Type	Field	1	Type is required	This field must be completed.
Zip	Field	1	Zip is required.	This field must be completed.

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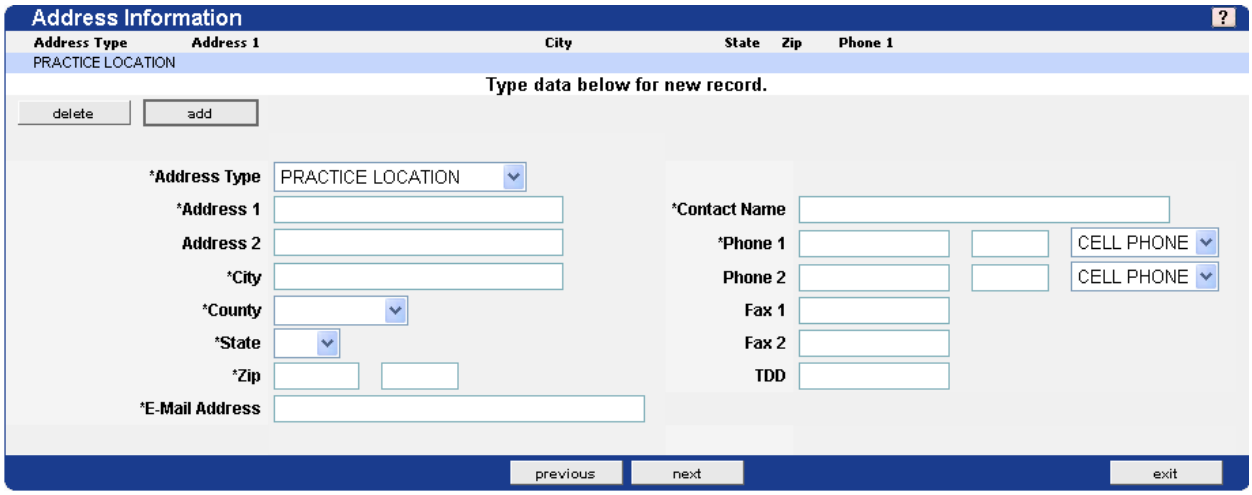
Address Information – Managed Care Provider

The Address Information panel is used by a provider applicant to provide address information during the enrollment process. At least one Practice Location address must be entered.



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 – Managed Care Provider

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	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
	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
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
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

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Field	Description	Field Type	Data Type	Length
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 – Managed Care Provider

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	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.

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Field	Field Type	Error Code	Error Message	To Correct
Zip	Field	0	Zip is required.	This field must be completed

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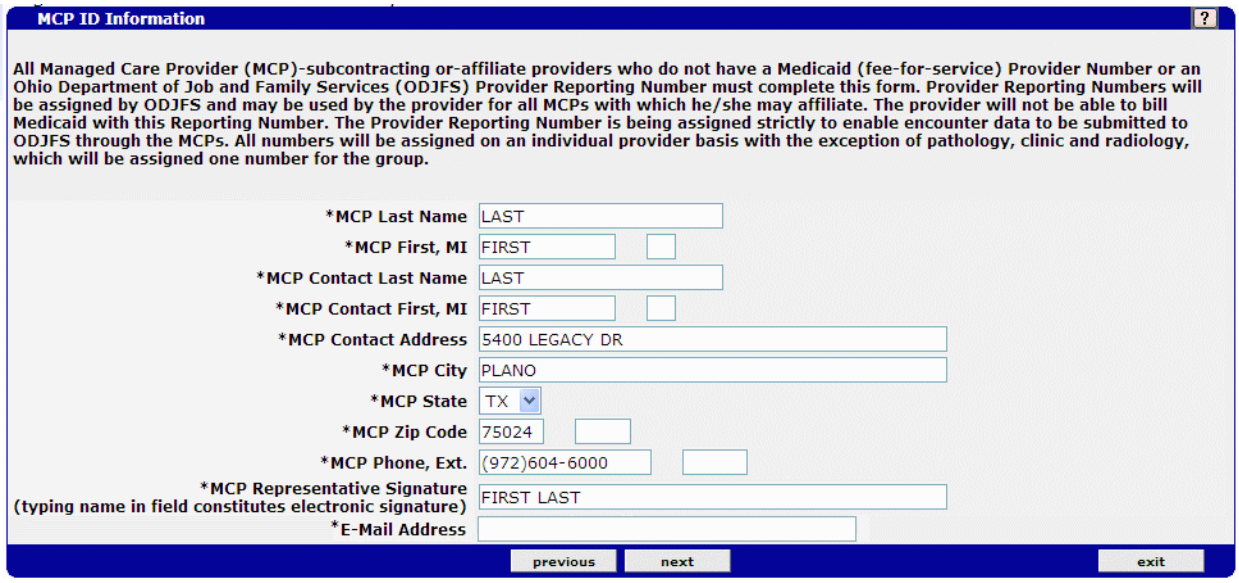
MCP ID Information – Managed Care Provider

The MCP ID Information panel captures the Long Term Care identifying information for Managed Care Providers (MCPs).



Tasks for this panel

To **enter** Long Term Care identifying information for MCPs:

1. Enter valid values in the **MCP Last Name**, **MCP First, MI**, **MCP Contact Last Name**, **MCP Contact First, MI**, **MCP Contact Address**, **MCP City**, **MCP Zip Code**, **MCP Phone, Ext.**, **MCP Representative Signature**, and **E-Mail Address** fields.
2. Select a value from the **MCP State** drop down list box.
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 – MCP ID Information – Managed Care Provider

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
All Fields	All fields.	Field	N/A	0
E-Mail Address	Email address for MCP.	Field	Alphanumeric	50
MCP City	Address city of MCP contact.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
MCP Contact Address	Street address for MCP contact.	Field	Character	50
MCP Contact First, MI	First name and middle initial for MCP contact.	Field	Character	13
MCP Contact Last Name	Last name of MCP contact.	Field	Character	25
MCP Contact Middle Initial	Middle initial of MCP contact (no label on panel).	Field	Character	1
MCP First, MI	First name and middle initial of MCP.	Field	Character	13
MCP Last Name	Last name of MCP.	Field	Character	25
MCP Middle Initial	Middle initial of MCP (no label on panel).	Field	Character	1
MCP Phone Extension	Phone number extension of MCP (no label on panel).	Field	Number	4
MCP Phone Number	Phone number of MCP (no label on panel).	Field	Number	10
MCP Representative Signature	Representative signature for MCP.	Field	Character	50
MCP State	State of MCP address.	Field	Drop Down List Box	0
MCP Zip Code	Zip code of MCP address.	Field	Number	5
MCP Zip Code + 4	Zip code extension of MCP address (no label on panel).	Field	Number	4

Field Edits – MCP ID Information – Managed Care Provider

Field	Field Type	Error Code	Error Message	To Correct
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.

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Field	Field Type	Error Code	Error Message	To Correct
E-Mail Address	Field	0	E-Mail Address is required.	This field must be completed.
MCP City	Field	0	MCP City is required.	This field must be completed.
MCP Contact Address	Field	0	MCP Contact Address is required.	This field must be completed.
MCP Contact First, MI	Field	0	MCP Contact First Name is required.	This field must be completed.
MCP Contact Last Name	Field	0	MCP Contact Last Name is required.	This field must be completed.
MCP First, MI	Field	0	MCP First Name is required.	This field must be completed.
MCP Last Name	Field	0	MCP Last Name is required.	This field must be completed.
MCP Phone Number	Field	0	MCP Phone Number is required.	This field must be completed.
MCP Representative Signature	Field	0	MCP Representative Signature is required.	This field must be completed.
MCP State	Field	0	MCP State is required.	Select a valid state.
MCP Zip Code	Field	0	MCP Zip Code is required.	This field must be completed.

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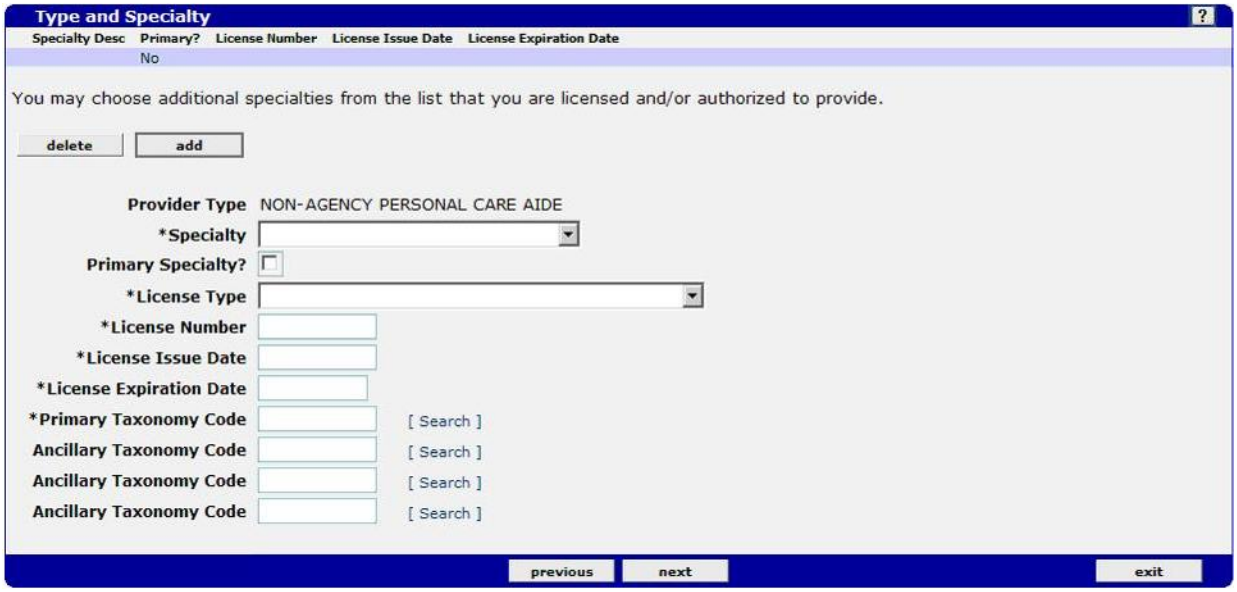
Type and Specialty – Managed Care Provider

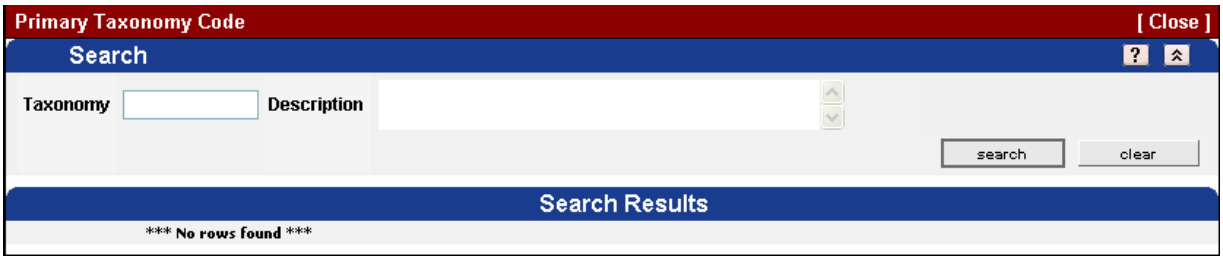
The Type and Specialty panel is used by an enrolling organization to specify the organization's primary specialty and any additional specialties. If the option is available to choose a primary specialty, the applicant must select one before continuing the enrollment.



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?** checkbox may or may not display.
2. Select the **Primary Specialty?** check box, if applicable.
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.

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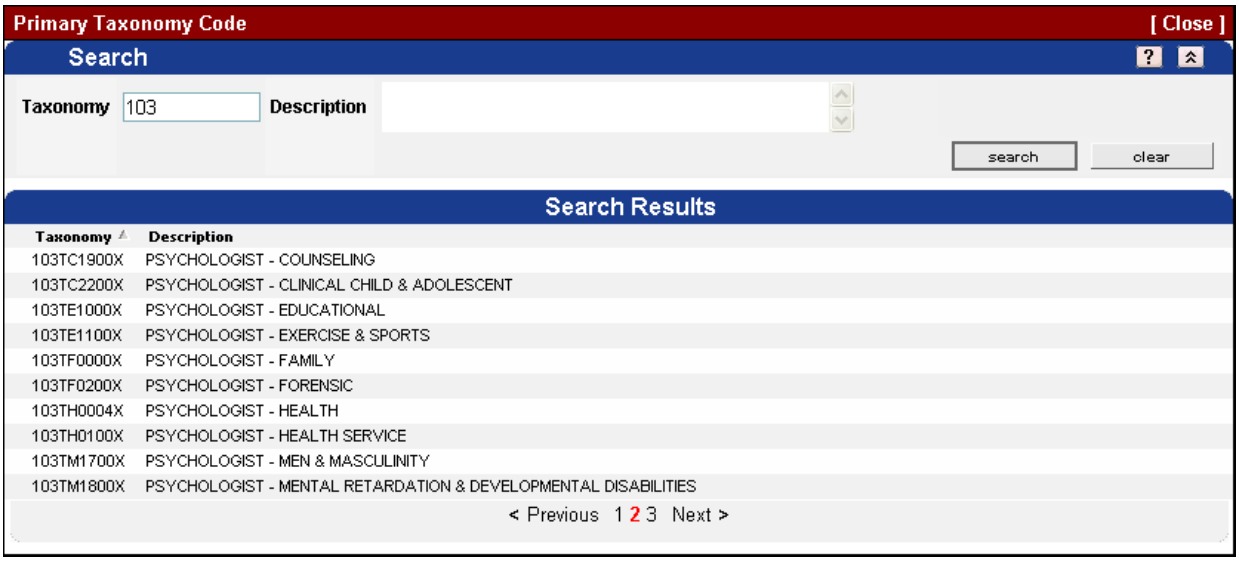


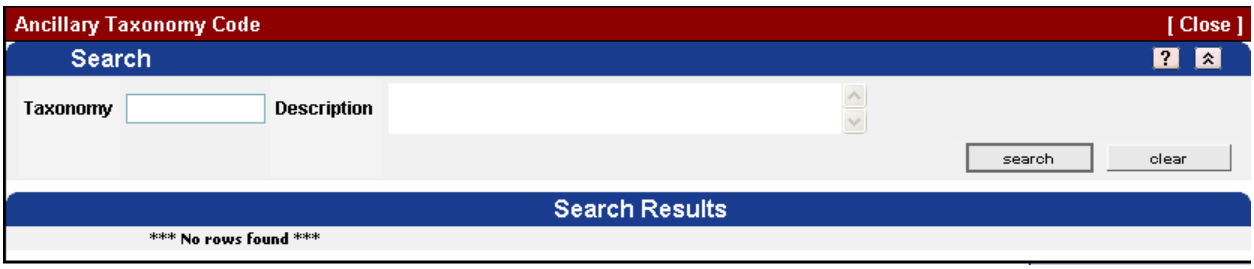
c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.

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.

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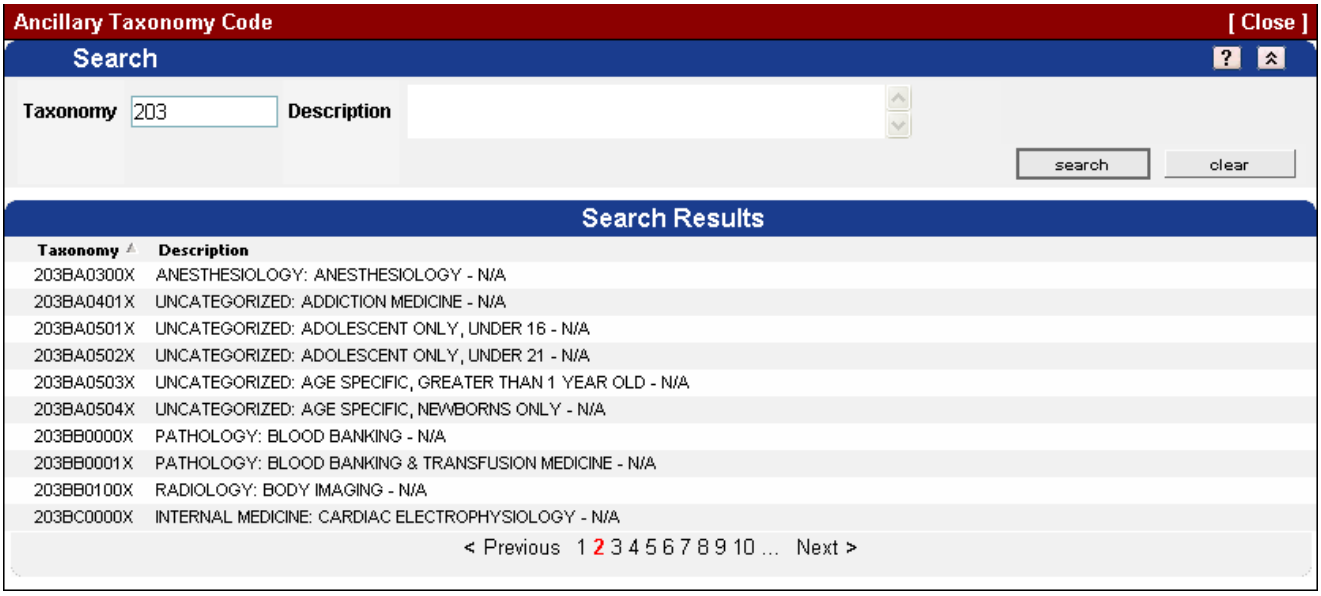

c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.

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 – Managed Care Provider

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
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0

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

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Field Edits – Type and Specialty – Managed Care Provider

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 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	Ensure that Issue Date is on or before Expiration Date.

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Field	Field Type	Error Code	Error Message	To Correct
			MM/DD/CCYY HH:MM AM or PM]	
	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.

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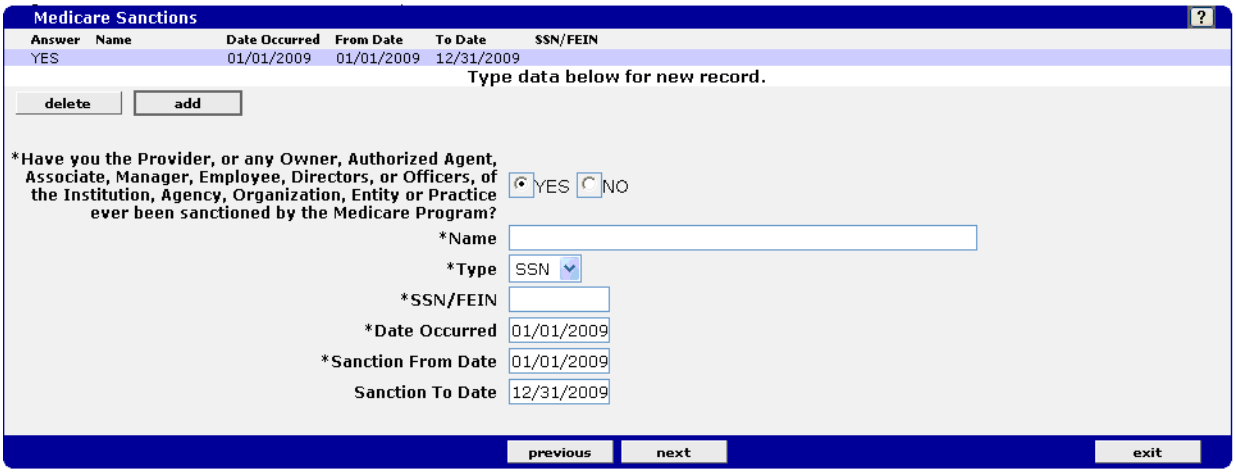
Medicare Sanctions – Managed Care Provider

The Medicare Sanctions panel is used to capture 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?**.
   a. If **No** is selected, select the **next** button to proceed to the next enrollment panel.
   b. If **Yes** is selected, enter values for the **Name**, **Type**, **SSN/FEIN**, **Date Occurred**, **Sanction From Date**, and **Sanction To Date** fields.
3. Select the **add** button to add a new Medicare sanctions record.
4. Select the **delete** button to delete a selected Medicare sanctions record.
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 – Medicare Sanctions – Managed Care Provider

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

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Field	Description	Field Type	Data Type	Length
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)	8
Name [Detail]	Name of the sanctioned individual.	Field	Character	10
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?	Indicates if the practitioner has ever been sanctioned by a Medicare program. Valid values: 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	Drop Down List Box	0
Sanction From Date [Detail]	Begin date of the sanction period.	Field	Date (MM/DD/CCYY)	8
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)	8
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)	8

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Field	Description	Field Type	Data Type	Length
Name [List]	Name of the sanctioned individual.	Listview	Character	10
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the sanctioned individual. Only pertains to "Individual" providers.	Listview	Character	0
Sanction From Date [List]	Begin date of the sanction period.	Listview	Date (MM/DD/CCYY)	8
Sanction To Date [List]	End date of the sanction period.	Listview	Date (MM/DD/CCYY)	8
Answer [List]	Represents the answer to the question - "Yes" or "No"	Menu Item	Character	3

Field Edits – Medicare Sanctions – Managed Care Provider

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 required when answering "Yes" to the question.	Enter date occurred in mm/dd/ccyy format
Name [Detail]	Field	5100	Name required when answering "Yes" to the question.	Enter Name
Question	Field	5100	A "Yes" or "No" response to the Question is required, when click on "Add"	Click "Yes" or "No"
SSN/FEIN [Detail]	Field	5100	SSN/FEIN required when answering "Yes" to the question.	Enter SSN/FEIN
Sanction From Date [Detail]	Field	5100	Date From required when answering "Yes" to the question.	Enter Date From
	Field	5116	Sanction From Date must be less than or equal to Sanction To	Enter Sanction From Date as less than or equal

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Field	Field Type	Error Code	Error Message	To Correct
			Date	to Sanction To Date

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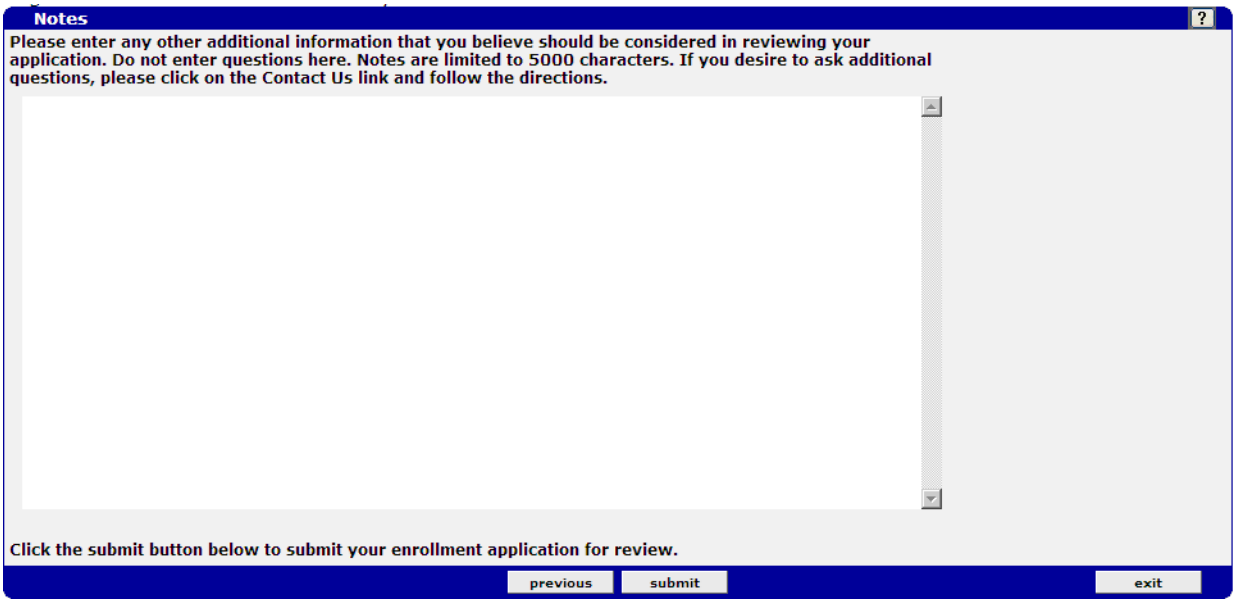
Notes – Managed Care Provider

The Notes panel is used to enter additional information or notes associated with the application for the enrolling organization. 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 – Managed Care Provider

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 – Notes – Managed Care Provider

None.

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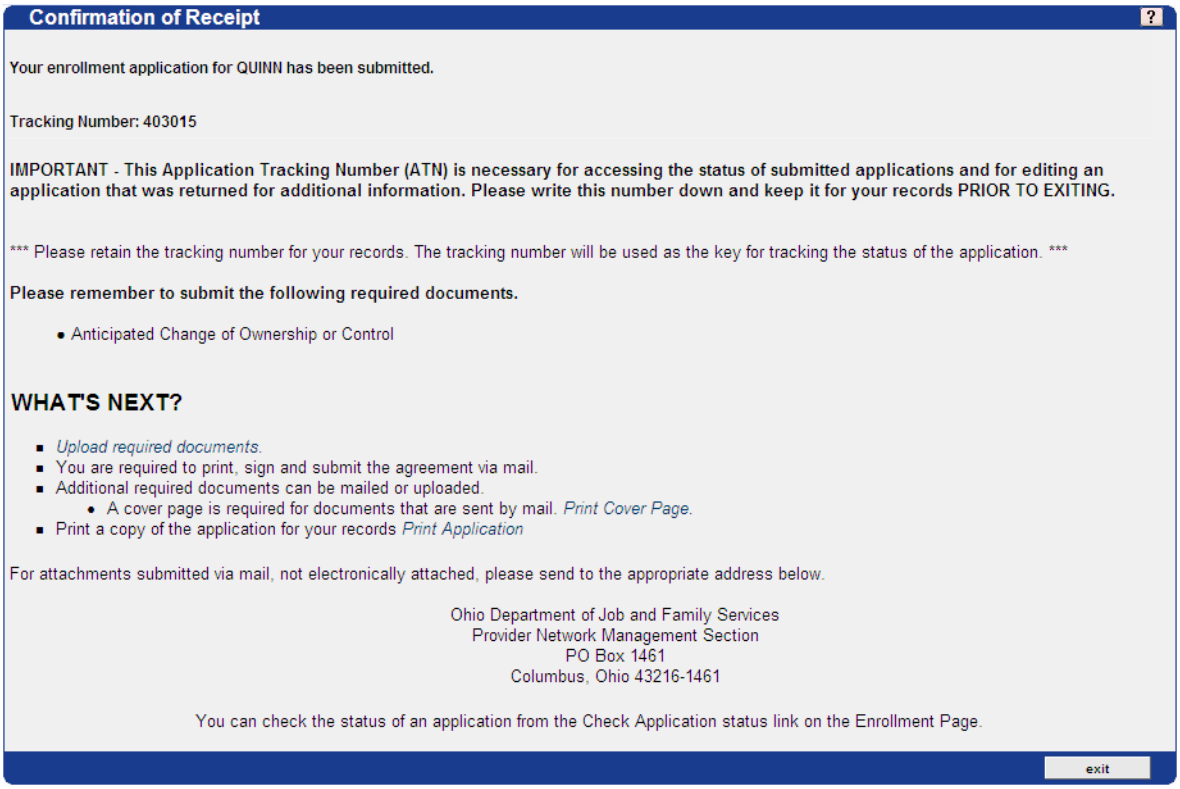
Confirmation of Receipt – Managed Care Provider

The Confirmation of Receipt panel displays the Application Tracking Number for the submitted application.

Note: 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.

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Field Descriptions – Confirmation of Receipt – Managed Care Provider

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

This is the end of the Managed Care Provider process.

4.1 What's Next?

When ODJFS has approved the enrollment application, the applicant will be sent a PIN letter with instructions for completing portal registration. When this PIN letter is received, please refer to the "Getting Started" section in volume 02 of this manual, *Provider Medicaid Portal User Manual: Introduction*.

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