********** FOR INSTRUCTIONAL USE ONLY **********

READ BEFORE COMPLETING YOUR MEDICAID FORM

All Medicaid Providers must complete, sign and return the documents below.
Please submit documents to:

The Ohio Department of Developmental Disabilities
Office of Provider Certification
30 E. Broad Street
13th Floor
Columbus, Ohio 43215

You may also fax these documents to 614-728-7836 or email documents to:
Provider.Certification@dodd.ohio.gov.

Please remember, all documents must be signed to be considered for review of your application to provide HCBS Waiver Services.

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Ohio Department of Job and Family Services

OHIO HEALTH PLANS PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT FOR INDIVIDUALS

Submit completed signed application/agreement with required attachments to:

Provider Network Management Section
Provider Enrollment Unit
P.O. Box 1461
Columbus, OH 43216-1461
Call the Interactive Voice Response (IVR) System at 1-800-686-1516

Individual Provider Types: Required *(Mark only **ONE** box to indicate your Provider Type.)*

- ☐ Chiro/Mechanotherapist (37)
- ☐ Chiropractor (27)
- ☐ Clinical Nurse Specialist (65)
- ☐ Dentist (30)
- ☐ Independent Home Care Attendant (26)
- ☐ Nurse, RN, LPN (38)
- ☐ Non-Agency Personal Care Aide (25)
- ☐ Nurse Anesthetist/Anesthesiologist Assistant (73)
- ☐ Nurse Midwife (71)
- ☐ Nurse Practitioner (72)
- ☐ Occupational Therapist (41)
- ☐ Optician (75)
- ☐ Optometrist (35)
- ☐ Osteopath (22)
- ☐ Physical Therapist (39)
- ☐ Physician (20)
- ☐ Podiatrist (36)
- ☐ Psychologist (42)
- ☐ Waiver Service Provider (45)

Provider Identification: - Required *(Print or type entries.)*

Name *(First)*	*(Middle Initial)*	*(Last)*	Title *(M.D., D.O., etc.)*

Social Security Number	**You must attach a signed W-9 form with individual's name, address, social security number, original signature, and date. Do Not use GROUP tax ID number**	DEA Number

** You must attach copy of Certificate*

Address Information: - Required *(Print or type entries.)*

Physical Location of Practice/Business

Building Name / **or** / Department / **or** / In care of			
Practice Address *(Number,Street, Avenue, Route, etc.. P.O. and Drop Boxes are not acceptable)*			Suite Number
City	County	State	Zip Code
Telephone Number	Email address. Complete only if you wish to be notified of your provider number via email. It will not be used for any other purpose.		

"Pay to" Address *(Name & Address to which Payment and/or Remittance Advice is to be mailed)*

Building Name / **or** / Department / **or** / In care of		
Address		Suite Number
City	State	Zip Code

Mailing/Correspondence Address *(Name & Address to which all other material is to be mailed)*

Building Name / **or** / Department / **or** / In care of		
Address		Suite Number
City	State	Zip Code

National Provider Identifier

Licensure Information: *(Print or type entries)*

License Number	Original License Issue Date* *(mm/dd/yyyy)*	Current License Expiration Date* *(mm/dd/yyyy)*

Please attach a copy of your license and renewal card

Medicare Identification Information:
PTAN is required for Physical/Occupational Therapists and Psychologists

If you are a participating Medicare provider; enter your Medicare information *(Print or type entries)*

PTAN	CLIA

Physician/Oral Surgeon Specialty Certification:

PRIMARY Specialty Type	Board Name	Certification Date *(mm/dd/yyyy)*
SECONDARY Specialty Type	Board Name	Certification Date *(mm/dd/yyyy)*

Enter any Ohio Medicaid 7 - digit Group Provider Numbers you are Affiliated with:

1		2		3		4		5	
6		7		8		9		10	

Nurse Applicants: Required *(Print or type entries)*

All Nurses	RN/LPN License Number*	Current License Expiration Date* *(mm/dd/yyyy)*	
All Advances Practice Nurses	Certificate of Authority Certification Number	Current Renewal Date* *(mm/dd/yyyy)*	
All NP, CNS, And Midwife	Master's Degree Certification Date *(mm/dd/yyyy)*	Please attach a copy of your Master's Degree in Nursing certificate	
All CRNA	CRNA Certificate Number*	CRNA Recertification Card Expiration Date *(mm/dd/yyyy)*	
All Midwife	Am College of Nurse Midwives Certification Number	Am Midwifery Board Certification Number	Please attach a copy of your Certification

Specialty Information (required for all Nurse Practitioners and Clinical Nurse Specialists)

Type of Specialty (Check the box indicating your type of specialty.)
(Nurse Practitioners select from 1-10, Clinical Nurse Specialists select from 5-11)

1. ☐ Family	2. ☐ OB/GYN	3. ☐ Neonatal	4. ☐ Women's Health
5. ☐ Adult Health	6. ☐ Gerontological	7. ☐ Psychiatric	8. ☐ Palliative Care
9. ☐ Acute Care	10. ☐ Pediatric	11. ☐ Oncology	

(Include a copy of your specialty certificate)

Disclosure and Ownership/Control Interest Statement
This information is REQUIRED of all providers.

Answer the following questions by checking "Yes" or "No"; marking the appropriate box; and/or giving the proper dates.

1. A. Have you or any individuals or organizations having a direct or indirect ownership or control interest in the professional association or practice been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX? ☐ **YES** ☐ **NO**

Name	Type of offense and disposition	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Name	Type of offense and disposition	When? Give date *(mm/dd/yyyy)*	SSN/EIN

1. B. Have you or any of the employees of your professional association or practice ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?
☐ **YES** ☐ **NO**

Name	Type of offense and disposition	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Name	Type of offense and disposition	When? Give date *(mm/dd/yyyy)*	SSN/EIN

2. Type of Entity or Practice: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations
☐ Professional Corporation/Association ☐ Other *(specify)*

3. A. Has there been a change in ownership or control within the last year? ☐ **YES** ☐ **NO**
If yes, when? *(mm/dd/yyyy)* **ATTACH EXPLANATION**

3. B. Do you anticipate any change in ownership or control within the year? ☐ **YES** ☐ **NO**
If yes, when? *(mm/dd/yyyy)* **ATTACH EXPLANATION**

4. Is this entity or practice operated by a management company, or leased in whole or part by another organization? ☐ **YES** ☐ **NO**
If yes, give date of change of operations. *(mm/dd/yyyy)*

5. List names, addresses for individuals, and the Employer Identification Number (EIN) for organizations having direct or indirect ownership or a controlling interest in the entity or practice. Place an "X" in the box labeled Related for all names listed who are related to each other.

Name	Related	Address	Employer Identification Number
Name	Related	Address	Employer Identification Number
Name	Related	Address	Employer Identification Number
Name	Related	Address	Employer Identification Number

6. Have you or the entity or practice ever been sanctioned by the Medicare Program? ☐ **YES** ☐ **NO**
If "YES", when? *(mm/dd/yyyy)* How long? *(mm/dd/yyyy)*

Who was it? Give name(s).	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Who was it? Give name(s).	When? Give date *(mm/dd/yyyy)*	SSN/EIN

7. Have you ever been issued an Ohio Medicaid 7-digit Provider Number?
☐ **YES** ☐ **NO** If, YES, you must list them in the boxes below.

7-digit Provider Number	7-digit Provider Number	7-digit Provider Number	7-digit Provider Number

8. Have you or any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice who have ever been indicted or convicted of a violation of State or Federal Law?
☐ **YES** ☐ **NO**

Name	Type of offense and disposition	When, give date? *(mm/dd/yyyy)*	SSN/EIN

All providers must read the statements below, print name and title, initial, and date.

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 grand and may result in the loss of other contracts or grants with the State of Ohio.
Individual Practitioner Name and Title *(please print)*

Individual Practitioner Initial	Date

A copy of Executive Order 2007-01S can be found on our website at: http://jfs.ohio.gov/ohp/

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, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.
Individual Practitioner Name and Title *(please print)*

Individual Practitioner Initial	Date

Occupational Therapy Practitioners only:

I attest that I am an independent Occupational Therapist and I am not associated with an institutional facility or a school system.
Individual Practitioner Name and Title *(please print)*

Individual Practitioner Initial	Date

Ohio Medicaid Provider Agreement

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, sate statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.

2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.

3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.

5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review
purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.

6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;

7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-17.3 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.

8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title X beneficiaries.

9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.

10. Provide to ODJFS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".

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

I accept the terms and conditions

Agreement Date _____ Certain provider agreements may be made retroactive (up to 12 months) to encompass dates on which the provider furnished covered services to a Medicaid consumer and the service has not been billed to Medicaid.
Provision Check (Yes No) circle one A failure to select YES shall be taken by ODJFS to mean that you waive your rights to a retroactive period of months prior to the date ODJFS approves your application. This agreement is limited to 5 years from the effective date.
Signature_____

For help completing the application, please call the Provider Enrollment Customer Service Line. You can reach the Provider Enrollment Unit through the Interactive Voice Response System.
The telephone number is:

800-686-1516

Our business hours are 8:00 am to 4:30 pm Monday through Friday.

For State Use Only

Date Received (**1**)	Date Received (**2**)	Date Received (**3**)	Date Received (**4**)
Date Returned (**1**)	Date Returned (**2**)	Date Returned (**3**)	Date Returned (**4**)

Date Processed	Effective Date	Provider Number
Operator's Number		Ticket Number

Ohio Department of Job and Family Services

OHIO HEALTH PLANS PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT FOR INDIVIDUALS

DISCLOSURE EXPLANATION ATTACHMENT

3.A Has there been a change in ownership or control within the last year?
If yes, when? (mm/dd/yyyy)
Explanation:

3.B Do you anticipate any change in ownership or control within the year?
If yes, when? (mm/dd/yyyy)
Explanation: