Ohio Department of Medicaid

MANAGED CARE ENTITY (MCE) OUT-OF-NETWORK AND MANAGED CARE-ONLY PROVIDER APPLICATION

This form is being used to collect provider information when an MCE needs to contract with an Out-of-Network Provider who is not enrolled and will not enroll with ODM or a managed care-only provider who cannot enroll with ODM. Completion of the form is required to create a provider profile that will enable screening and permit payment through the ODM central claims process.

ODM is required to capture the name, social security number, and date of birth for all individuals, applying to enroll in the Ohio Medicaid program, for the purpose of screening per 42CFR455 subparts (B) and (E) and Ohio Administrative Code 5160-1-17.3 & 17.8.

Completed forms can only be submitted via the MCE and must include the signed application form, signed ODM provider agreement (ODM 10283), Medicaid addendum and attachments, and W-9s .

Section 1: Completed by all

PROVIDER INFORMATION				
Individual Last Name/Organization Name	Individual First Name			
Individual Social Security Number (SSN)	Individual Date of Birth *(MM/DD/YYYY)*			
National Provider Identification (NPI) Number	Organization Federal Employer Identification Number (FEIN)			
Primary Service Address: Number and Street	City	State	County	Zip Code
Telephone Number	Email Address			
Ohio Board License Number	Out-of-State Board License Number			
Out-of-State Board License Issue Date	Out-of-State Board License Expiration Date			
Provider Type	Provider Specialty			
Electronic Signature				
Signature Date	Requested Effective Date			

MCE INFORMATION		
MCE Name	MCE Contact Person	Contract Effective Date

Direct/Indirect Ownership, Controlling Interest, and Managing Employees Disclosure Section

Under 42 C.F.R. 455.10 and O.A.C. 5160-1-17.3, ODM is required to capture the names, social security numbers, and date of birth for all individuals or individuals and persons with 5% or more direct/indirect ownership interest in the applying group or organization, as well as managing employees and/or controlling interest. Please enter all persons with ownership of a group/organization.

Organizations ***(Repeat content to identify all applicable parties, submit with additional pages if needed)***

OWNER WITH 5% OR MORE DIRECT/INDIRECT OWNERSHIP, CONTROLLING INTEREST AND MANAGING EMPLOYEES	
Name	Social Security Number
Date of Birth	Relationship to Organization
% Owner (*if applicable*)	Phone

OWNER WITH 5% OR MORE DIRECT/INDIRECT OWNERSHIP, CONTROLLING INTEREST AND MANAGING EMPLOYEES

Name	Social Security Number
Date of Birth	Relationship to Organization
% Owner (*if applicable*)	Phone

OWNER WITH 5% OR MORE DIRECT/INDIRECT OWNERSHIP, CONTROLLING INTEREST AND MANAGING EMPLOYEES

Name	Social Security Number
Date of Birth	Relationship to Organization
% Owner (*if applicable*)	Phone

OWNER WITH 5% OR MORE DIRECT/INDIRECT OWNERSHIP, CONTROLLING INTEREST AND MANAGING EMPLOYEES

Name	Social Security Number
Date of Birth	Relationship to Organization
% Owner (*if applicable*)	Phone

OWNER WITH 5% OR MORE DIRECT/INDIRECT OWNERSHIP, CONTROLLING INTEREST AND MANAGING EMPLOYEES

Name	Social Security Number
Date of Birth	Relationship to Organization
% Owner (*if applicable*)	Phone

OWNER WITH 5% OR MORE DIRECT/INDIRECT OWNERSHIP, CONTROLLING INTEREST AND MANAGING EMPLOYEES

Name	Social Security Number
Date of Birth	Relationship to Organization
% Owner (*if applicable*)	Phone

OWNER WITH 5% OR MORE DIRECT/INDIRECT OWNERSHIP, CONTROLLING INTEREST AND MANAGING EMPLOYEES

Name	Social Security Number
Date of Birth	Relationship to Organization
% Owner (if applicable)	Phone