Nevada Medicaid and Nevada Check Up

Provider Information Change

Purpose: With the exception of change in ownership, use this form to report any changes to your information on file with Nevada Medicaid.

Policy: Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, any change in address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery (per Medicaid Services Manual, Chapter 100).

Change of ownerships must be reported within 5 days by using an initial enrollment application (form FA-31C for individuals or FA-31D for groups/facilities).

Instructions:

- The individual provider (or, for a facility, an authorized administrator) must sign and date page 4.
- Attach a copy of certifications, licenses, IRS forms, etc., only when there has been a change.
- Use additional forms if needed to record all changes.
- The changes requested with this form will be effective the date processed by Nevada Medicaid, unless otherwise indicated.
- All changes can be faxed to (775) 335-8593 or mailed to Nevada Medicaid, Provider Enrollment, P.O. Box 30042, Reno NV 89520-3042.

Questions? If you have questions, please contact the Provider Enrollment Unit at (877) 638-3472. Select 2 for provider, then 0, then 5 for Provider Enrollment.

1. (*Required*) Enter the name of the provider/facility reporting changes: _____
2. (*Required*) List the National Provider Identifier/Atypical Provider Identifier (NPI/API) that is affected. (Only one NPI/API per form):_____

   Please note: If the only change is linking an individual provider to a group, provide only the individual NPI/API in the space above.

Please check all changes you are reporting and provide the requested information. Only complete the field if the information in the field has changed.

☐ 3. To change an address, check the relevant address box(es) and complete the fields that follow. Use additional forms if needed to record all address changes. Please ensure the contact names and telephone numbers are updated as needed.

- ☐ Service address: This is the physical location of your practice/business/facility (cannot be a P.O. box).
- ☐ Mail-To address: Written correspondence other than Remittance Advices is mailed to this address if supplied.
- ☐ Remittance advice address: Paper remittance advices will be mailed to this address if supplied.
- ☐ Pay-To address: Paper checks will be mailed here while Electronic Funds Transfer (EFT) testing is performed.

Address: _____

City: _____ State: _____ Zip Code: _____

☐ 4. Phone: _____ Fax: _____ TDD: _____

☐ 5. E-mail Address: _____

☐ 6. Contact Name: _____ Contact Phone: _____

☐ 7. National Provider Identifier (NPI): _____

Reason for NPI change:_____

Taxonomy codes: _____

A list of taxonomy codes is available at www.wpc-edi.com/taxonomy.

☐ 8. IRS Information: When updating IRS name or Tax ID Number, attach IRS form CP575, SS-4 or W-9 showing the new name and/or number.

IRS Name: _____ Tax ID Number: _____

☐ 9. Doing Business As (DBA) name. Please attach W-9 or business license showing new name.

Name: _____

☐ 10. Provider name change (individual providers only). Please attach license or supporting documentation showing new name.

Name: _____

☐ 11. Add provider to a group.

Provider group's NPI: _____ Individual provider's NPI:_____

Effective Date (cannot be backdated more than 6 months from current date):_____

Provider Signature (individual provider): _____

☐ 12. Exclude provider from a group.

Provider group's NPI: _____ Individual provider's NPI:_____

Effective Date:_____

☐ 13. Supervisor update (applicable to provider type 14 and 82 agencies). Please attach the appropriate provider type 14 or 82 Enrollment Checklist and credentials for new supervisor.

☐ Medical Supervisor ☐ Clinical Supervisor ☐ Direct Supervisor

Name of new supervisor:_____

Effective Date:_____

☐ 14. License. Please attach a copy of the new license.

New license number:_____

☐ 15. Specialty Codes. Refer to the list under "Nevada Medicaid Provider Types and Specialties" in the Provider Enrollment Information Booklet.

New specialty code(s):_____ Effective date_____

☐ 16. Person's authorized to make changes to provider enrollment information.

☐ Add ☐ Remove

Name(s):_____

If individual provider, provider signature:_____

☐ 17. Change in Agent or Managing employee.

☐ Add ☐ Remove

Name: _____

SSN: _____ Date of Birth: _____

Address:_____

If individual provider, provider signature:_____

☐ 18. Are you currently accepting new patients? ☐ Yes ☐ No

☐ 19. Can you accommodate recipients with special needs? ☐ Yes ☐ No

☐ 20. Electronic Funds Transfer (EFT) Authorization: I hereby authorize Nevada Medicaid (DXC Technology) and its subsidiaries to transfer my Nevada Medicaid and Nevada Check Up payments to the personal or business bank account shown below. I understand the payments made through electronic funds transfers will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws. This agreement will remain in effect until I notify Nevada Medicaid (DXC Technology) or the banking institution otherwise. I understand that Nevada Medicaid (DXC Technology) and/or my banking institution may also cancel this agreement at any time. All such cancellation notices must be made in writing and acted upon in a reasonable and timely manner.

I understand that cancellation of an EFT account may result in termination of my Nevada Medicaid enrollment.

Business or personal bank account number: _____

Authorized signature: _____ Date: _____

TAPE VOIDED CHECK HERE

OR ATTACH A LETTER FROM YOUR BANK THAT CONTAINS YOUR BANK'S ROUTING NUMBER.

BANK DEPOSIT SLIPS ARE NOT ACCEPTED.

Declaration (*required*)

I declare under penalty of perjury under the laws of the State of Nevada that the information in this document and any attachments are true, accurate and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the Provider. I understand that Nevada Medicaid, Nevada Check Up and DXC Technology, which is the Nevada Medicaid fiscal agent, will rely on this information and that this form will be incorporated into and become a part of my provider information on file with DXC Technology and the State of Nevada. I understand that any change in ownership, address or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds must be reported to Medicaid within five working days. Failure to do so may result in termination of the contract at the time of discovery.

I understand that I am responsible for the presentation of true, accurate and complete information on all invoices submitted to Nevada Medicaid. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

For facility changes, an authorized administrator may sign below; for changes to individual provider information, the signature must be the provider's.

Use either blue or black ink to complete the following.

The person signing this application below is the (*check all that apply*):

☐ Provider ☐ Authorized administrator ☐ Business owner

Signature: _____ Date: _____

Print name: _____