Provider Enrollment Checklist for Behavioral Health Community Network

Provider Type 14: Specialty 814, Entity/Agency/Group

This checklist must be completed and submitted with the attachments listed below. If you have any questions regarding this form, please contact the Nevada Medicaid Provider Enrollment Unit at (877) 638-3472.

Entity/agency/group name: _____ Date: _____

Entity/agency/group National Provider Identifier (NPI): _____

Please check one of the following boxes. Updates to Clinical and Direct Supervisors are reported using this form.

☐ New Enrollment, Re-enrollment, Revalidation or Change of Ownership: Complete all sections. Include a copy of all documents in the Attachments section below.

☐ Clinical Supervisor Update

☐ Direct Supervisor Update

☐ Provider is adding Partial Hospitalization Program (PHP) and/or Intensive Outpatient Program (IOP) Services: Complete all sections. Include a copy of all documents in the Attachments section below.

Please attest to the following statements by initialing each applicable section below.

Business Information – *(Initial and complete all that apply)*:

The agency/entity/group provides behavioral health services in the following locations:

_____ In an office location. - Is this setting a gated community? ☐ Yes ☐ No

_____
Office Address-(No P.O. Box or Virtual Address)

_____ In the community. - Is this setting a gated community? ☐ Yes ☐ No

_____ In the recipient's residence. - Is this a gated community? ☐ Yes ☐ No

_____ In the provider's residence. - Is this setting a gated community? ☐ Yes ☐ No

_____ Recipient's records are secured per policy and located:

_____
Physical Address (If a P.O. Box or Virtual Address is provided, this application may be denied)

_____ Should any of the above location information change, I acknowledge and will abide by the requirement to report this change/update to Nevada Medicaid in accordance with policy time frame found in the Medicaid Services Manual, Chapter 100: Section 103.3(A)

DISCLOSURES

Billing:

Please disclose your biller's information.

Name:_____

SSN:_____ DOB_____

Direct Phone Number:_____

Primary Address:_____

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Is this person employed solely by the entity/agency/group? ☐ Yes ☐ No

If No, please provide the name of the entity/agency/group who employs this individual.

Entity/agency/group name:_____

Entity/Agency/Group Structure:

Please disclose the name of any investors/contractors/consultants associated with the entity/agency/group. (If more than one, attach additional sheets, include all information and reference this Entity/Agency/Group Structure section.) Please provide a copy of the legal contract (all pages).

Name:_____

Address: _____

Phone Number:_____

Primary Contact Person:_____

Attachments

Initial each space below to signify that the specified item is attached.

_____ SS-4 or CP575 showing Employer Identification Number.

_____ Business license.

_____ Clinical Supervisor's professional license (include licensure for all designated Clinical Supervisors, as applicable).

_____ Direct Supervisor's professional license, if applicable (include licensure for all designated Direct Supervisors, as applicable).

_____ When applicable, the BHCN must include its Intensive Outpatient Program (IOP) description and schedule; these documents will be forwarded to the Division of Health Care Financing and Policy (DHCFP) for review.

_____ When applicable, the BHCN must include its contract to provide a Partial Hospitalization Program (PHP), which specifically outlines the roles and responsibilities of both parties (hospital or Federally Qualified Health Center and BHCN) in providing this program; these documents will be forwarded to the Division of Health Care Financing and Policy (DHCFP) for review.

_____ When applicable, the BHCN must complete an additional and separate enrollment for the delivery of Day Treatment services under PT 14 Specialty 308.

_____ Associated Providers List with Original Provider Signature(s).

Required Policies Attestations (to be initialed by the Clinical Supervisor)

As the Clinical Supervisor, I attest that I have reviewed and approved the policy for this entity/agency/group documented according to the requirements outlined in MSM Chapter 400:

_____ Clinical Supervision Policy (Section 403.2A)

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Required Services (to be initialed by the Clinical Supervisor)

A Behavioral Health Community Network (BHCN) entity/agency/group must offer the following services directly or through a written agreement with other qualified providers. (Nevada Medicaid is not responsible for direct reimbursement to contracted providers of the entity/agency/group.)

As the Clinical Supervisor, I acknowledge that this entity/agency/group offers the following services:

_____ Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) services such as assessments, therapy and testing

_____ Medication management and medication training and support (by medical professionals practicing under the scope and experience of their licensure in the State of Nevada)

_____ 24-hour per day emergency response for recipients (via referral or after-hours answering service)

_____ Screening for recipients under consideration for admission to inpatient facilities

_____ Access to psychiatric services, when medically appropriate (via referral or coordination of care)

_____ Discharge Planning and care coordination

Clinical Supervisor Attestation (to be completed by the Clinical Supervisor)

As the Clinical Supervisor for the Behavioral Health Community Network (BHCN) entity named below, I hereby pledge to ensure that the BHCN works on behalf of recipients to ensure effective care coordination with other providers.

I acknowledge that I am licensed to practice in the State of Nevada, that I am enrolled as an Independent Professional with Nevada Medicaid, that I am practicing under the scope of my licensure, and that I have the competency to oversee and evaluate a comprehensive mental health treatment program.

Behavioral Health Community Network entity/agency/group name: _____

Clinical Supervisor name (print or type): _____

Clinical Supervisor professional title: _____

Clinical Supervisor NPI: _____ Contact phone: _____

Clinical Supervisor signature: _____ Date: _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____

Facility/Provider Name NPI

_____

Signature of notarial officer Notary Stamp

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Policy Acknowledgement *(to be completed by the owner or director)*

By initialing each of the bolded items below, I understand and agree to operate my BHCN under these MSM Chapter 400 policy requirements:

_____ Outpatient Service Delivery Models (Section 403.1)

_____ Provider Standards (Section 403.2)

_____ Supervision Standards (Section 403.2A)

_____ Documentation (Section 403.2B)

_____ Provider Qualifications (Section 403.3)

_____ Outpatient Mental Health Services (Section 403.4)

_____ Outpatient Mental Health Services – Utilization Management (Section 403.5)

_____ Rehabilitative Mental Health Services (Section 403.6)

Supervisors (to be completed by the owner or director)

I understand that proper Clinical and Direct Supervision must be provided when services are rendered to Nevada Medicaid recipients. The name, title, contact phone and signature of the current, primary Clinical and Direct Supervisors are provided below.

Primary Clinical Supervisor name: _____

Professional title (attach a copy of credentials/license): _____

NPI:_____ Contact phone: _____

Primary Clinical Supervisor signature: _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____

Facility/Provider Name NPI

_____

Signature of notarial officer Notary Stamp

Additional Clinical Supervisor name (as applicable) _____

Additional Clinical Supervisor Professional title (attach copy of credentials/license): _____

NPI:_____ Contact phone: _____

Additional Clinical Supervisor signature: _____

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State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____

Facility/Provider Name NPI

_____

Signature of notarial officer Notary Stamp

Primary Direct Supervisor name: _____

Professional title (attach a copy of credentials/license): _____

NPI:_____ Contact phone: _____

Primary Direct Supervisor signature: _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____

Facility/Provider Name NPI

_____

Signature of notarial officer Notary Stamp

Additional Direct Supervisor name (as applicable): _____

Professional title (attach a copy of credentials/license): _____

NPI:_____ Contact phone: _____

Additional Direct Supervisor signature: _____

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____

Facility/Provider Name NPI

_____

Signature of notarial officer Notary Stamp

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Policy Declaration

I hereby declare that I have read the current MSM Chapters 100, 400 and 3300 as of the date above and understand this policy and how it relates to my scope of practice. I acknowledge that, as a Nevada Medicaid-contracted provider, I am responsible for complying with the MSM, with any updates to this policy as may occur from time to time and with applicable state and federal laws. This entity meets all provider qualifications outlined in MSM Chapters 100 and 400. I also understand that I am responsible for ensuring that all owners, administrators, managing employees, and all other employees providing direct services have a fingerprint-based criminal background check through the Department of Public Safety and Federal Bureau of Investigation. Failure to comply may result in administrative action including recoupment of Medicaid reimbursement and/or termination from the Medicaid program.

Owner or director signature: _____ Date: _____

Changes in Medicaid Information

If your Clinical Supervisor changes or any other pertinent information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid within the time frame established in MSM Chapter 100, Section 103.3(A). Changes or additions in Clinical or Direct Supervision may be reported using this form. Changes in business ownership must be reported by resubmitting a new enrollment application and indicating ownership change. All ownership changes must include documentation of the purchase agreement. All other changes must be reported by using the Provider Web Portal at https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx. After logging in, click on the "Revalidate – Update Provider" link under Provider Services. The Online Provider Enrollment User Manual Chapter 3 Revalidation and Updates on the Provider Enrollment webpage at https://www.medicaid.nv.gov provides instructions on navigating the Update Provider tool.

(Per MSM Chapter 100, Medicaid providers, and any pending contract approval, are required to report, in writing within the time frame established in MSM Chapter 100, Section 103.3(A), any change in ownership, 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.)

I hereby accept Nevada Medicaid's change notification requirements:

Owner or director signature: _____ Date: _____

Reporting Fraud

Providers have an obligation to report to the Division of Health Care Financing and Policy (DHCFP) any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers (MSM Chapter 3300). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405.

I understand that Nevada Medicaid payments are made from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

I hereby agree to abide by Nevada Medicaid's fraud reporting requirements:

Owner or director signature: _____ Date: _____

Owner/Director Attestation

I certify under penalty of perjury under the laws of the State of Nevada, that the information I have provided is true and correct and that I have read, understood, and agree to comply with all parts of this Provider Enrollment Checklist.

Owner/Director signature: _____ Date: _____

Provider Type 14: Specialty 814, Entity/Agency/Group

State of Nevada

County of _____

Signed and sworn before me on _____ by _____

For_____ _____

Facility/Provider Name NPI

_____

Signature of notarial officer Notary Stamp