Provider Enrollment Checklist for Provider Type 58

Waiver for People with Physical Disabilities
Specialty 205: Specialized Medical Equipment/Supplies

Specialized Medical Equipment and Supplies are those devices, controls or appliances specified in the Plan of Care that enable recipients to increase their abilities to perform activities of daily living (ADLs). This service also includes devices, controls or applications that enable the recipient to perceive, control or communicate with the environment in which they live; items necessary for life support; ancillary supplies and equipment necessary to the proper functioning of such items; and durable and non-durable medical equipment not available under the Medicaid State Plan.

The following is a list of required enrollment documents for this provider type. A copy of each document listed below and this checklist must be included with your Provider Enrollment/Revalidation. If you have any questions, please contact Provider Customer Service at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

- ☐ Current enrollment as a Provider Type 33 in the Nevada Medicaid Program. If you checked this box, proceed to page 2 and complete the Policy Declaration and Attestation sections. You do not need to include the documents listed below with your Provider Enrollment/Revalidation.

OR EACH OF THE FOLLOWING

- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card)
- ☐ Copy of business license from the Nevada Secretary of State (for in-state providers) or a copy of the Secretary of State business license in the provider's home state (for out-of-state providers)
- ☐ Nevada State Board of Pharmacy license:
    a. as a Medical Device, Equipment, and Gases (MDEG) Supplier
    b. as a Pharmacy (Exception to MDEG licensure: A Pharmacy that has a Nevada State Board of Pharmacy license and provides DMEPOS does not require separate licensure as an MDEG)
- ☐ Verification of active participation with the Medicare Part B program for each location of the business. Include a copy of the Accreditation Certification from the Medicare-designated Accreditation Organization and a copy of the Medicare-required surety bond. If available, applicants may submit a copy of National Supplier Clearinghouse (NSC) letter with an effective date of March 1, 2008, or more current when the letter includes the accreditation and surety bond information.
- ☐ For the very limited number of DMEPOS suppliers who are not participating with the Medicare Part B program, a waiver of the requirement in #3 may be requested in writing with a statement from the applicant identifying all products (with HCPCS codes) they plan to dispense and a statement that they will not be supplying any Medicare Part B covered products.
- ☐ Signed Business Associate Addendum (NMH-3820). The Addendum is available at www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

All providers must complete the following declaration and attestations, and provide this signed checklist with your Provider Enrollment/Revalidation.

Waiver for People with Physical Disabilities
Specialty 205: Specialized Medical Equipment/Supplies

Policy Declaration

I hereby declare that as of this date, I have read the current Medicaid Services Manual (MSM) Chapters 100 and 2300, which can be found by going to http://dhcfp.nv.gov and selecting "Medicaid Manuals" from the Index box. I attest that I understand these Policies and how they relate 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 it may occur from time to time and with all applicable state and federal laws.

Owner/Applicant Signature:_____Date:_____

Information Changes

If your information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid within five working days. Changes in business ownership must be reported by resubmitting a new enrollment application and indicating ownership change. 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, Section 103.3: Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, 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/Applicant 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, Section 3303.1B.1). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300, Section 3303.1A.2. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405 or completing the form on the DHCFP website at http://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/.

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/Applicant Signature:_____Date:_____

Owner/Applicant 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/Applicant Signature:_____Date:_____