Provider Enrollment Checklist for Provider Type 65

Hospice, Long Term Care

The following is a list of required enrollment documents for this provider type. A copy of each document listed below must be included with your provider enrollment or revalidation.

A complete and signed copy of this checklist must also be included with your provider enrollment or revalidation.

If you have any questions, please contact the Provider Enrollment Unit at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9)
- ☐ Bureau of Health Care Quality and Compliance (BHCQC) license
- ☐ Copy of current Nevada Secretary of State Business License
- ☐ Active enrollment in Medicare is required for all Hospice facilities. Enrollment will be validated by Nevada Medicaid. The information on the application, including ownership or interest of 5% or more, must match Medicare enrollment.
- ☐ I understand that this facility's Administrator must be disclosed on the application for screening purposes and updated when a change occurs and in compliance with Medicaid Services Manual (MSM) Chapter 100, Section 103. Failure to disclose will delay application processing and may result in application denial.

  Name of Owner/Managing Employee (print):_____

  Signature of Owner/Managing Employee: _____
- ☐ Disclosure of this facility's Medical Director (must be actively enrolled with Nevada Medicaid):

  Name (print): _____

  NPI Number: _____

  I understand if I leave my position as Medical Director of (group's name)_____,

  I will report this change to Nevada Medicaid within the the time required by policy found in the MSM Chapter 100, Section 103.

  Signature of Medical Director: _____
- ☐ I understand if the Medical Director of (group's name) _____ leaves or resigns as Medical Director, I will notify Nevada Medicaid of the replacement Medical Director within the time required by policy found in the MSM Chapter 100, Section 103.

  Name of Owner/Managing Employee (print):_____

  Signature of Owner/Managing Employee: _____
- ☐ A completed and signed Nevada Department of Public Safety Fingerprint Background Waiver for each owner with 5% or more direct or indirect ownership interest, as persons meeting this ownership criteria may be subject to the Fingerprint-based Criminal Background Check (FCBC) requirement per 42 CFR 455.434.
  - Fingerprint Background Waiver Form
- ☐ Complete and submit to DHCFP the following form, which does not need to be included with your enrollment/revalidation documents. The return email and mailing address to DHCFP are provided at the bottom of the form. The form is available by clicking on the link below and is also available on the Provider Enrollment webpage under "Required Enrollment Documents."
  - Advance Directives Compliance Self-Evaluation & Certification (NMH-3827)

Hospice, Long Term Care

Complete the following declaration and attestations, and provide this signed checklist with your provider enrollment or revalidation.

Policy Declaration

I hereby declare that I have read the current Medicaid Services Manual (MSM) Chapters 100, 500 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 500. 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.

Name of Owner/Managing Employee (print):_____

Owner or Managing Employee signature: _____ **Date**: _____

Changes in Medicaid Information

If there are any pertinent information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid in compliance with Medicaid Services Manual (MSM) Chapter 100, Section 103. 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/hcp42/provider/Home/tabid/477/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 compliance with MSM Chapter 100, Section 103, any change in ownership, address, 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:

Name of Owner/Managing Employee (print):_____

Owner or Managing Employee 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:

Name of Owner/Managing Employee (print):_____

Owner or Managing Employee signature: _____ **Date**: _____

Hospice, Long Term Care

Owner or Managing Employee 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.

Name of Owner/Managing Employee (print):_____

Owner or Managing Employee signature: _____ **Date**: _____

Resources:

The Provider Enrollment webpage provides instruction materials that will assist providers with enrolling in Nevada Medicaid.