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1. Group Application

1.1. Welcome and Enrollment Information

To begin an application for enrollment with the Nevada Medicaid and Nevada Check Up programs:

1. Select the “Start Application” button from the Provider Flex dashboard,
<https://flex.medicaid.nv.gov/a/3b8917dc-5086-49c9-8e1b-8c748320d7fd/t/0de061ea-dc68-4cb8-b6c3-e7fb7e8cb2c1/v>.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

FAQs Contact Us My Account Logout

Hello Misses Training
Friday, 4/11/2025

Provider Enrollment Booklet Enrollment Checklist **Start Application**

Applications List

ATN	NPI	Provider Type	Provider Name	Application Type	Status	Submitted On	Updated On	Contact
112338	1972380921	20	Family Orthopedics	NEW	Incomplete	04/11/2025		Harper Leigh

2. The Welcome page is displayed. Select “Next” to continue.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

Sections

- Welcome
- Enrollment Information

Welcome to the Online Provider Enrollment System

To begin billing for Nevada Medicaid services, you must enroll as a provider by completing the required documentation, using the checklist provided for guidance. Submit all materials, including any supplementary documents, via Gainwell Technologies' online system, ensuring no delays from incomplete applications. If extended responses are necessary, attach them as separate documents. Retain copies for your records, and await written confirmation of your application status.

Urgent/Emergency Enrollment

For urgent/emergency enrollment, individual providers must link with their separate billing provider once both are enrolled with Nevada Medicaid. Similarly, groups enrolling urgent/emergency must link with individual servicing providers post-enrollment for claims processing. Use the Provider Search tool to check enrollment status.

For claims submission, ensure both servicing and billing providers are enrolled, then follow billing instructions available on the Medicaid website.

For enrollment questions, call Provider Enrollment at (877) 638-3472 (choose "Provider Enrollment") from 8 a.m. to 5 p.m. PT, Monday to Friday.

Cancel & Return To Dashboard **Next**

Provider Flex Enrollment Portal
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3. Select the application type:

- Enroll a new provider or add a new service location to existing provider
- Change of Ownership
- Re-enroll a provider that was previously enrolled

4. Select the “Next” button to continue with the application.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Portal

Sections

- Welcome
- Enrollment Information

What would you like to do today?

- ☐ Enroll a new provider or service location
- ☐ Change Ownership
- ☐ Re-Enroll a provider

Previous

Cancel & Return To Dashboard Next

Provider Flex Enrollment Portal
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5. Select “Search NPI” to enter the NPI of the enrolling provider.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Portal

Sections

- Welcome
- Enrollment Information

What would you like to do today?

- ☒ Enroll a new provider or service location
- ☐ Change Ownership
- ☐ Re-Enroll a provider

Start Application

To start a new application you must first enter a valid NPI. Click the Search NPI button, enter the NPI and hit search. Confirm the NPI is correct and then click Accept

Search NPI

Enrollment Type
Select

Provider Type

The search will verify and return information for the NPI based on National Plan & Provider Enumeration System (NPPES) data.

6. Select “Accept” to confirm the NPI matches the provider enrolling.

NPI Search

* Enter NPI


Results

Name	HEALTH LLC
Address	1301 BERTHA HOWE AVE, MESQUITE, NV, 890277502

6

7. Select the provider enrollment type.


The “Enrollment Type” list will display the available enrollment options based on the NPI Type.



Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Portal

Sections

- Welcome
- Enrollment Information




Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

What would you like to do today?

- ☒ Enroll a new provider or service location
- ☐ Change Ownership
- ☐ Re-Enroll a provider

Start Application

 To start a new application you must first enter a valid NPI. Click the **Search NPI** button, enter the NPI and hit search. Confirm the NPI is correct and then click **Accept**

NPI: 1972380921

7

* Enrollment Type

Select

Select

Group

Urgent/Emergency Group

Add Your Specialties

8. Select the “Provider Type”.

The Provider Type drop-down menu will display the available provider types based on the enrollment type selected.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

Sections

- Welcome
- Enrollment Information

8

enrollment type

Group

Provider Type

Select

- 10 - Outpatient Surgery, Hospital Based
- 11 - Hospital, Inpatient
- 12 - Hospital, Outpatient
- 13 - Psychiatric Hospital, Inpatient
- 14 - Behavioral Health Outpatient Treatment
- 15 - Registered Dietitian
- 16 - ICF - for Intellectually Disabled / Public
- 17 - Special Clinics
- 19 - Nursing Facility
- 20 - Physician, M.D., Osteopath, D.O.
- 21 - Podiatrist
- 22 - Dentist
- 23 - Hearing Aid Dispenser and Related Supplies
- 24 - Advanced Practice Registered Nurses
- 25 - Optometrist
- 26 - Psychologist
- 27 - Radiology and Non-Invasive Diagnostic Centers
- 28 - Pharmacy
- 29 - Home Health Agency

Primary

Actions

its political subdivisions, e.g. state agency, county, entity or school district?

enrolling

Previous

Cancel & Return To Dashboard

Next

9. Select “Click To Add A Specialty.”

A pop-up box will display the available specialties based on the provider type selected.

Add Your Specialties 9

* Code Description Primary Actions

+ Click To Add A Specialty

Specialties

Specialty

Select

- 300 - Qualified Mental Health Professional (QMHP)
- 301 - Qualified Mental Health Associate (QMHA)
- 302 - Qualified Behavioral Aide (QBA)
- 305 - Licensed Clinical Social Worker
- 306 - Licensed Marriage and Family Therapist
- 307 - Clinical Professional Counselor

10. A primary specialty is required. Use the checkbox to indicate whether the selected specialty is the primary specialty for this provider.

NOTE: The first specialty selected will default to the primary specialty.

Specialties

* Specialty

300 - Qualified Mental Health Professional (Q... ♥

Primary 10

☒

Cancel Save

11. Is this entity owned or operated by the State of Nevada or any of its political subdivisions, e.g., state agency, county, entity or school district, or a Non-Profit entity? – Select “Yes” or “No”

- If “Yes”, select the “Special Ownership Type” from the drop-down menu.

* Special Ownership Type

Select ▼

12. Select the applicable “Billing Type” for the enrolling provider.

- Group providers that do not link individuals are required to select “Biller and Performer”

* Billing Type ⓘ 12

Select ♥

* Select

Biller

Biller and Performer

Previous

13. Choose the option that most closely describes the entity you are enrolling in.

Group Entity Types:

- Provider Group


- Corporation
- Partnership
- Limited Liability Partner (LLP)
- Limited Liability Company (LLC)
- Indian Health Program (IHP)
- Indian Health Services (IHS)
- Non-Profit

* Choose the option that most closely describes the entity you are enrolling

13

[Previous](#)

14. Once all required fields have been completed, select “Next”.



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Division of Health Care Financing and Policy Portal

Sections

- Welcome
- Enrollment Information

* Code

Code	Description	Primary	Actions
300	Qualified Mental Health Profess...	Yes	Remove

[Click To Add A Specialty](#)

* Billing Type

* Choose the option that most closely describes the entity you are enrolling

[Previous](#)

[Cancel & Return To Dashboard](#)

14 [Next](#)

1 of 2 Completed

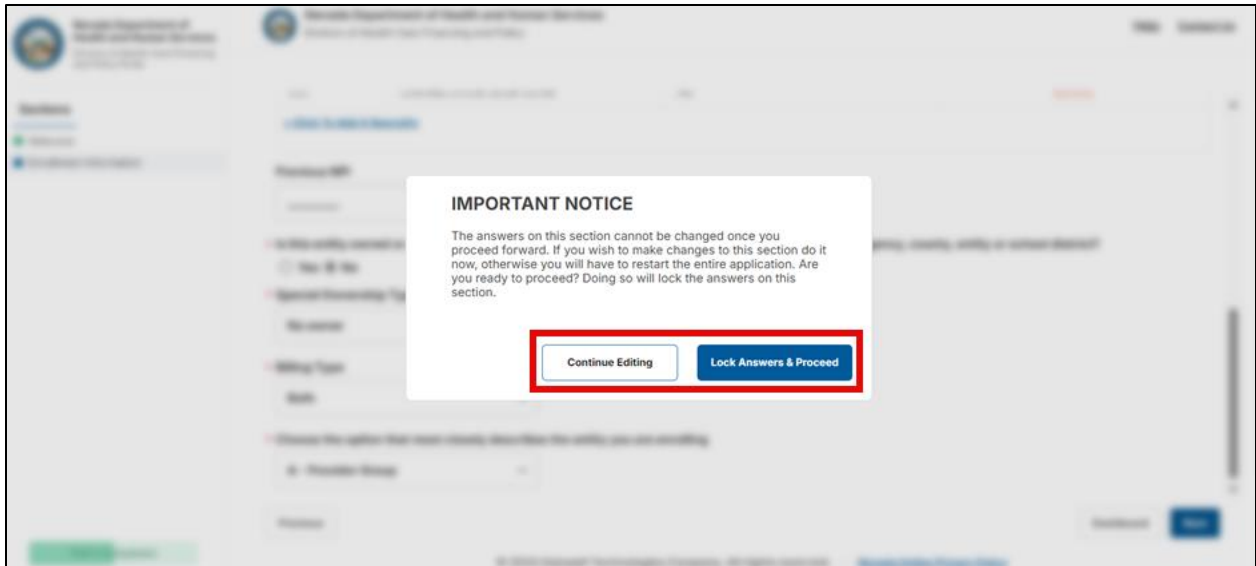
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A pop-up warning message will appear asking the user to verify all information is correct before proceeding with the application.

- If changes need to be made, select “Continue Editing” to make the necessary changes.
- If no changes are needed, select “Lock Answers & Proceed.”

Once these answers have been locked, this information cannot be changed. The current application will need to be withdrawn and a new application will need to be started.



1.2. Provider Information

The provider information page allows the user to enter provider information, such as Legal Name, Business Name and any identification numbers, such as Tax IDs, License Numbers, Certified Laboratory Improvement Amendments (CLIA) number and Drug Enforcement Administration (DEA) number.

Please answer all required questions that are marked with a (*) red asterisk. The following instructions are designed to clarify certain questions.

1. Enter Federal Tax ID.
2. Upload documentation showing Taxpayer Identification Number (TIN).

3. Requested Enrollment Effective Date - Enter the date on which you wish the provider enrollment to begin.
 - The date in this field cannot be a future date.
 - The date can be backdated up to six months but may not be prior to all provider enrollment requirements being met. All timely filing guidelines apply.

- i. If the Requested Enrollment Effective Date is greater than 180 days in the past, you will be required to answer, “Will you be submitting secondary claims to Nevada Medicaid?”
- ii. If “No” is selected and the date exceeds the six-month back limitation, provide a written explanation and supporting documentation as an attachment to this application.

*** Requested Enrollment Effective Date** ⓘ

04/01/2025

📅 ✕

4. Indicate if the provider is enrolled in Medicare.

NOTE: Active enrollment in Medicare is required for some provider types.


*** Are you enrolled in Medicare?** 4

☒ Yes ☐ No

5. Enter Provider Legal Name

- Provider Legal Name and Doing Business As (DBA) must match the information on file with the Internal Revenue Service (IRS) for the Tax- ID entered in the Provider Information section.

Enter Provider Legal Name

 The provider name displayed has been populated based on the information currently on file with National Plan & Provider Enumeration System (NPPES) for the enrolling NPI. If the name shown is incorrect, please verify the NPI entered belongs to the enrolling provider. If the NPI is correct and provider name differs, please update below. Provider Legal Name must match the information on file with the IRS for the FEIN entered in the Provider Information section.

*** Provider Legal Name** ⓘ

Doing Business As ⓘ

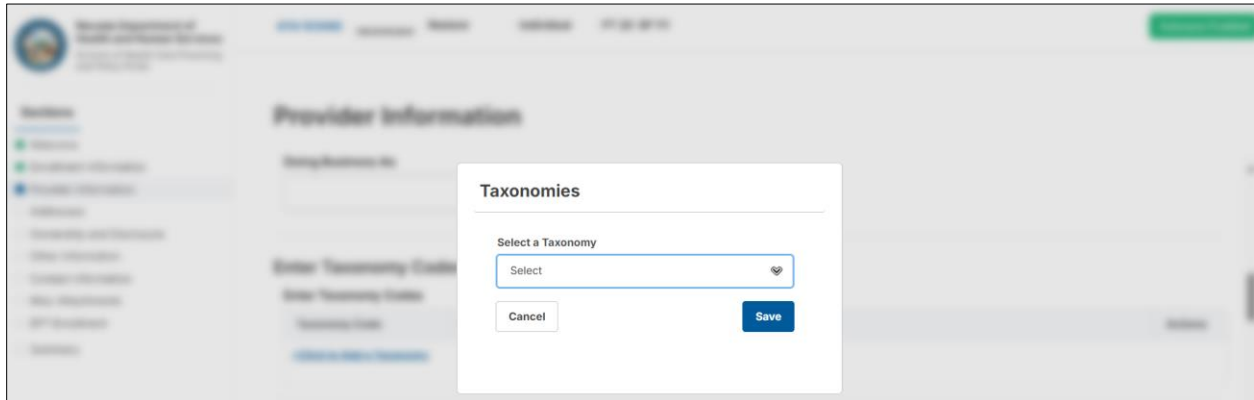
6. Select “Click to Add a Taxonomy” to add the appropriate taxonomy code from the drop-down list.

- If the provider has multiple provider types enrolled using the same NPI, a unique taxonomy code is required for each provider type.

Enter Taxonomy Codes

*** Enter Taxonomy Codes** 6

Taxonomy Code	Description	Actions
+Click to Add a Taxonomy		



7. Enter Provider Business Information – Enter the Secretary of State (SOS) issued business license information and upload a copy of the business license.

- Business license must be active, and the Provider name or DBA on the enrollment must match the Registered Name. Additionally, the Formation Date must be on or before the application requested effective date.

Enter Provider Business Information

7

Corporations, Limited Liability Companies (LLCs), Limited Liability Partners (LLPs), Partnerships, Provider Groups, or Sole Proprietorship, are required to provide their Secretary of State information. If your business is incorporated in another state or your business is located outside of Nevada, please provide the information on file with the state of incorporation.

*** Secretary of State Issued Business ID** ⓘ

*** Secretary of State Registered Name** ⓘ

*** Formation Date** ⓘ *** Renewal Date** ⓘ

SOS-IssuedBusID.pdf
Secretary of State Business License
Remove

8. Select “Click to Add License” to add the appropriate license or certification information and upload a copy of the license.
- License information must be active and match documentation on file with a licensing board for the enrolling provider. The original issue date of a license must be on or before the requested effective date of enrollment.

NOTE: If the license will expire within 30 calendar days, renewed license information should be entered into the application and both the current and renewed license should be attached.

Enter Provider License Information 8

*** Licenses**

License/Certifi...	State	Licensing Boar...	Start Date	End Date	Actions
+Click To Add License					

License Search


*** License/Certification (State)** ⓘ

Select

*** Name of Issuing Board**

Select

*** License/Certification Number** ⓘ

 **Select A File**
PDF ONLY, file size no more than 15MB

SELECT FILES

Filename

*** Start Date**

*** End Date**

*** Document Type**

Select

Close

Add

9. Enter Drug Enforcement Administration (DEA) information for the enrolling provider, if applicable.

- If "Yes" is selected, a DEA Number and End Date will be required. The information supplied must belong to the enrolling provider. The system will validate the DEA number entered.
- DEA Number is required for Provider Type 28 (Pharmacy)

Drug Enforcement Administration (DEA) Number 9

* Do you have a DEA Number to prescribe, dispense, administer, or procure controlled substances?

☒ Yes ☐ No

* DEA Number ⓘ

Search

* End Date

10. If applicable, enter the Clinical Laboratory Improvement Amendments (CLIA) number.

- The CLIA number must belong to the enrolling provider/entity.
- The name on the CLIA certificate must match the Provider Legal Name or DBA.
- If CLIA information is entered, a copy of the CLIA license is required to be uploaded.

CLIA Certification


CLIA Number ⓘ

Search

Effective Date ⓘ

End Date ⓘ

Please provide your Clinical Laboratory Improvement Amendments

 Upload files here
PDF ONLY, file size no more than 15MB

Select files

The following questions are Provider Type specific fields:

Provider Type 27 (Radiology & Non- Invasive Diagnostic Centers):

1. Select “Yes” or “No” to indicate if the provider is enrolling to be a certified sleep study center.
 - If the answer is yes, upload certification or accreditation by one of the following entities:
 - i. The American Academy of Sleep Medicine (AASM)
 - ii. Accreditation Commission for Health Care (ACHC)
 - iii. The Joint Commission (TJC)
 - iv. Centers for Medicare & Medicaid Services (CMS)-approved Independent Diagnostic Testing Facility (IDTF)

Sleep Study

* Are you applying to be a certified sleep study center?

☒ Yes ☐ No

Please upload certification or accreditation.

[Upload Files](#)

Provider Type 28 (Pharmacy) is required to enter the National Counseling for Prescription Programs/National Association of Boards of Pharmacy (NCPDP/NABP) Number.

* **NCPDP/NABP Number**

1.3. Associated Providers

Group or Urgent/Emergency Group Provider Types 14, 15, 20, 21, 22, 24, 25, 26, 32 with specialty 249, 34, 36, 38, 72, 74, 76, 77, 82, 85, 90 and 93 can add individuals to their group using the Associated Providers page. To be affiliated with a group, the individual providers must be enrolled with Nevada Medicaid or have already submitted their enrollment application. Electronic signatures are required for each individual being linked to the group. The associated provider form will be forwarded to the individual for electronic signature.

1. Select “Add Associated Provider” to enter the individual’s information.

The screenshot shows a web interface with a sidebar on the left containing a 'Sections' menu. The main area is titled 'Enter Associated Providers'. A red circle with the number 1 is placed over the '+ Add Associated Provider' link in the table. The table has columns for NPI, First Name, Last Name, Phone Number, Email, and Actions.

2. Enter NPI, individual name, phone number and email address. Select the “Add” button to add individual to the group.

- Effective date for the affiliation will be the date the application is submitted (if a different effective date is requested, please upload a written explanation in the “Miscellaneous Attachments” section of the application).

The screenshot shows a modal form titled 'Enter Associated Provider'. A red circle with the number 2 is placed over the 'Add' button. The form has fields for NPI, First Name, Last Name, Phone Number, and Email Address.

1.4. Addresses


Provider addresses identify the location where a provider performs services, as well as locations that are used for billing and payment. Only one address can be added for each address type.

A Service Address is required for Group and Urgent/Emergency Group enrollments. This is the location where services are rendered and must be a physical location of the practice/business/facility. This must be a street address and cannot be a gated community, a post office box or virtual office. Each service address for an organization requires a separate application.

Paper checks will be mailed to Pay To address while Electronic Funds Transfer (EFT) testing is performed. If you do not supply a Pay To address, paper checks will be mailed to the service address.

Nevada Medicaid will mail written correspondence to the Mail To address. If you do not supply a Mail To address, written correspondence will be mailed to the service address.

1. For each applicable address type select “Click to Add...” and enter the required information.



Nevada Department of
Health and Human Services

Division of Health Care Financing
and Policy Portal

Sections

● Welcome

● Enrollment Information

○ Provider Information

● Addresses

○ Ownership and Disclosure

○ Other Information

○ Contact Information

● Misc Attachments

○ EFT Enrollment

○ Summary

6 of 12 Completed

ATN 104251 | INOVA HEALTH CARE SERVICES (1831220714) | New Application | Group Enrollment | PT 11 SP 911

Autosave Enabled

Enter Your Addresses

1

Service

The service address is the physical location of the practice/business/facility where services will be rendered. This must be a street address and NOT a post office box.
The service address is required.

Street Address

City

State

Zip+4

Actions

+ Click to Add a Service Address

Pay-To

Street Address

City

State

Zip+4

Actions

+ Click to Add a Pay-To Address

Paper checks will be mailed to Pay-To address while Electronic Funds Transfer (EFT) testing is performed. If you do not supply a Pay-To address, paper checks will be mailed to the service address.

Mail-To

Street Address

City

State

Zip+4

Actions

+ Click to Add a Mail-To Address

Nevada Medicaid will mail written correspondence, excluding remittance advices, to Mail-To address. If you do not supply a Mail-To address, written correspondence will be mailed to the service address.

Previous

Save & Finish Later

Next


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2. When an address is entered, select “Verify Address” to verify correct address information based on US Postal Service Information.

Enter Service Address 2

 All addresses need to be verified

* Street Address

6500 LONGLEY LN

Street Address 2

* City

RENO

* State

Nevada

* Zip+4

89511-2632

* County

Washoe

Verify Address

3. Select the Original Address or Verified Address.

Verify Address

3

* Click on SELECT to chose the address

Type	Address	City/State	Zip	Actions
Original Address	6500 LONGLEY LN	RENO,NV	895112632	<div>Select</div>
Verified Address	6500 LONGLEY LN	RENO,NV	895112632	<div>Select</div>

4. After verification, complete the remaining required fields for the contact information for the address type and select “Add”.

- The email address associated with the Service Address and Mail To address are used for provider notifications and outreach related to the enrollment, billing, and prior authorizations.

06/06/2025

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89521-3103

Washoe

Verify Address

* Email Address

* Confirm Email Address

* Office Phone Number

Ext

Phone TDD

* Contact Name

* Contact Phone Number

Ext

Cancel

4

Add

1.5. Ownership and Disclosure

Enter owners (individuals or parent corporations) with five (5) percent or more direct or indirect interest, Board Members, Managing Individuals and/or Agents into the entity information.

NOTE: If a parent corporation is listed, Nevada Medicaid will require information for the owners, managing individuals or agents of parent corporations with at least five (5) percent indirect interest.

Please see the Ownership and Disclosure section of the [Medicaid Provider Enrollment Compendium \(MPEC\)](#) for additional instructions and requirements. Ownership information should match Medicare enrollment, if applicable.

Completion of this section is a condition of participation in the Nevada Medicaid program and is mandated by 42CFR §455.100 – 106.

Provide the names of all individuals and organizations having direct or indirect ownership interests or controlling interest separately or in combination amounting to an ownership interest of five (5) percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health-related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of five (5) percent or more in the disclosing entity. Example: If A owns 10 percent of the stock in a

corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Other definitions:

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic or health maintenance organization that participates in Medicare (Title XVIII),
- Any Medicare intermediary or carrier; and
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

- Has an ownership interest totaling five (5) percent or more in a disclosing entity,
- Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity,
- Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity,
- Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity,
- Is an officer or director of a disclosing entity that is organized as a corporation; or
- Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor means:

- An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmaceutical firm).

NOTE: Group and Individual Enrollment applications are required to enter all Agents and Managing Employees.

Group applications are required to enter all board member(s) if applicable. County owned organizations, Non-Profit organizations, and school districts are required to disclose Board Members.

Ownership information is not required for Groups with a Special Ownership type of Government Owned or State Owned selected on the Provider Information page.

All group applications, regardless of Special Ownership, are required to enter at least one Managing Employee.

1. Select “Add a record” to add provider ownership information.

Provider Ownership 1

Provider Ownership and Control Structure
List all person(s) / entities with an ownership of 5% or more or controlling interest in the provider (including managing employees)
Family Orthopedics

Type of Entity	Legal Name	SSN/FEIN	Ownership %	Authorized Representative	Actions
Corporation	ABC Medical Incorporated	123456789	50	No	Remove
Owner	Atticus Finch	345678912	25	Yes	Remove
Owner	Harper Leigh	987699999	25	Yes	Remove
Managing Employee and/or A...	Jean Finch	456789123		Yes	Remove

[Add a record](#)

2. Select the “Type of Entity” – the values displayed in the dropdown list are dependent on the Enrollment Type.

Ownership 2

Type of Entity

Select

Select

Authorized Representative

Board Member/Trustee

Corporation

Managing Employees and/or Agent

Owners

Add

3. Enter the required information for the Type of Entity.

Ownership 3

Type of Entity % of Ownership

Corporation ♥

* Corporation Name

* Federal Tax ID

* Street Address Street Address 2

* City * State Select * Zip + 4

* Does this entity own 5 percent or more of any other business (healthcare related or non-healthcare related)?
☐ Yes ☐ No

Ownership

Type of Entity % of Ownership

Owners ♥

* First Name Middle Initial * Last Name

Title * SSN * Birth Date

* Street Address Street Address 2

* City * State Select * Zip + 4

* Email Address

* Does this entity own 5 percent or more of any other business (healthcare related or non-healthcare related)?
☐ Yes ☐ No

Is the Entity an Authorized Representative?
☐ Yes ☐ No

Ownership

Type of Entity

Managing Employees and/or A... ♥

* First Name Middle Initial * Last Name

Title * SSN * Birth Date

* Street Address Street Address 2

* City * State Select * Zip + 4

* Email Address

* Does this entity own 5 percent or more of any other business (healthcare related or non-healthcare related)?
☐ Yes ☐ No

Is the Entity an Authorized Representative?
☐ Yes ☐ No

Employee Indicator

Ownership

Type of Entity

Board Member/Trustee ♥

* First Name Middle Initial * Last Name

Title * SSN * Birth Date

* Street Address Street Address 2

* City * State Select * Zip + 4

* Email Address

* Does this entity own 5 percent or more of any other business (healthcare related or non-healthcare related)?
☐ Yes ☐ No

Is the Entity an Authorized Representative?
☐ Yes ☐ No

Ownership

Type of Entity

Authorized Representative ♥

* First Name Middle Initial * Last Name

Title * SSN * Birth Date

* Email Address

- If a corporation is entered as having direct ownership, complete the Indirect Ownership Disclosure page. Select “Add a record” to provide ownership information for the corporation entered.

The screenshot shows the 'Indirect Ownership Disclosure' page. The left sidebar has 'Indirect Ownership Disclosure' selected. The main content area has a table with columns: Type of Entity, Legal Name, SSN / FEIN, Ownership %, and Actions. A red box highlights the 'Add a record' link below the table. The bottom of the page shows '6 of 13 Completed' and navigation buttons.

Indirect Ownership Disclosure
List all person(s) / entities with an ownership of 5% or more or controlling interest in the provider (including managing employees)

ABC

Type of Entity	Legal Name	SSN / FEIN	Ownership %	Actions
Add a record				

Previous Save & Finish Later Next

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- If any owner or managing employee selected “Yes” to owning five (5) percent or more of any other business, the Other Business Interests page will display. Select “Click to Add Additional Businesses” to disclose individuals with five (5) percent or more ownership or controlling interest in another business/entity, if applicable. Please list all businesses/entities under the appropriate individual.

The screenshot shows the 'Other Business Interests' page. The left sidebar has 'Other Business Interests' selected. The main content area has a table with columns: Business/Ent..., Federal Tax ID, Street Address, Street Address..., City, State, Zip+4, and Actions. A red box highlights the '+ Click To Add Additional Businesses' link below the table. The bottom of the page shows '6 of 12 Completed' and navigation buttons.

Below is a list of disclosed individuals with ownership or controlling interest in another business/entity. Please list all businesses/entities under the appropriate individual.

Example: If John Doe is listed, you must disclose all additional ownership of entities.

Test Tester

Business/Ent...	Federal Tax ID	Street Address	Street Address...	City	State	Zip+4	Actions
+ Click To Add Additional Businesses							

Previous Save & Finish Later Next

Provider Flex Enrollment Portal
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Additional Business Interests

Business/Entity Name Federal Tax ID

[Use Previous Address](#)

Street Street 2

City State

Zip+4

[Close](#) [Add](#)

Disclosure Questions

1. Answer the disclosure questions listed in Background and Disclosure of Disclosing Entity as required by State and Federal policy. If “Yes” is selected, the user will be prompted and required to provide additional details.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Portal

ATN 104251 | INOVA HEALTH CARE SERVICES (1831220714) | New Application | Group Enrollment | PT 11 SP 911 | [Autosave Enabled](#)

Sections

- Welcome
- Enrollment Information
- Provider Information
- Addresses
- Ownership and Disclosure
 - Introduction
 - Provider Ownership
 - Indirect Ownership Disclosure
 - Other Business Interests
 - Disclosure Questions**
 - Other Information

6 of 13 Completed

Background and Disclosure of Disclosing Entity

- * Does any individual and/or corporation have an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity?
☐ Yes ☒ No
- * Is any person (individual or corporation) with an ownership or control interest in the disclosing entity related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling?
☐ Yes ☒ No

These questions capture information regarding final adverse legal actions, such as convictions, exclusions, revocations and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged, or any appeals are pending.

- * Are you or any owner, agent, managing employee, or person with controlling interest currently enrolled, or have ever been enrolled, as a Medicaid provider with another state or owned a business enrolled as a Medicaid provider in Nevada or with another state?
☐ Yes ☒ No
- * Do you as an individual or any owner, agent, managing employee or person with controlling interest currently have a negative balance or owe money to any state or federal program (including Medicare and/or Medicaid)? Does a group for which you were the owner or person?

[Previous](#) [Save & Finish Later](#) [Next](#)

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1.6. Other Information

The Other Information page displays questions and fields based on enrollment type and provider type. This page will not display for Urgent/Emergency Group Enrollment Types.

Provide other additional information, such as, Subsidiary or Parent, Facility Rating, Facility Control, Number of Beds, Mammography Certification Number (FDA-Certified mammography providers only), Clinical Supervisor, and Medical Director.

Please answer all required questions that are marked with a (*) red asterisk. The following instructions are designed to clarify certain questions.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Portal

ATN 103076 KENMAR RESIDENTIAL SERVICES (1285782572)

New Enrollment Group Enrollment PT 11 SP 100

Autosave Enabled

Sections

- Welcome
- Enrollment Information
- Provider Information
- Addresses
- Ownership and Disclosure
- Other Information
- Contact Information
- Misc Attachments
- EFT Enrollment
- Summary

Enter Your Provider Directory Information

Days and Hours of Operation

Do you currently or will you provide service to recipients in the Fee For Service program, the Managed Care program or both?

Select

Are you currently accepting new patients?

Yes No

Can you accommodate recipients with special needs?

Yes No

Does this facility provide ESRD Services?

Yes No

Subsidiary or Parents

Is the entity a subsidiary or parent of another entity?

Yes No

Facility Rating

Rating

Select

Number of Beds

Swing Bed Acute ICF SNF ICF/MR ISO

Mammography Certification Number (FDA - Certified Mammography Providers Only)

Please upload FED Certification for Mammography (only applicable if the facility is providing this service)

Mammography Certification Number

Upload Files

Previous

2 of 14 Completed

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Dashboard Next

Billing Disclosure

Provider Type 14 Behavioral Health Outpatient Treatment specialty 814 Behavioral Health Community Network Entity/Agency/Group is required to disclose information regarding their billing.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Portal

ATN 103076 KENMAR RESIDENTIAL SERVICES (1285782572)

New Enrollment Group Enrollment PT 11 SP 100

Autosave Enabled

Sections

- Welcome
- Enrollment Information
- Provider Information
- Associated Providers
- Addresses
- Ownership and Disclosure
- Other Information
- Contact Information
- Misc Attachments
- EFT Enrollment
- Summary

Billing Disclosure

Is your billing handled by an Employee or Vendor? Please provide their information.

Select

Phone Number

Street Address Street Address 2

City State Zip + 4

1. From the drop-down menu, select "Employee" or "Vendor"

- Employee - if billing will be handled by an employee of the agency, enter their information.

• Is your billing handled by an Employee or Vendor? Please provide their information. **1**

Employee

• First Name • Last Name

• Phone Number • Birth Date

• SSN

• Street Address Street Address 2

• City • State • Zip + 4

• 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.

- Vendor – if billing will be handled by a third-party, enter the vendor information.

• Is your billing handled by an Employee or Vendor? Please provide their information.

Vendor

• Vendor Name

• Phone Number

• FEIN

• Street Address Street Address 2

• City • State • Zip + 4

Consultant/Contract/Investor Disclosure

Group Provider Type 14 Behavioral Health Outpatient Treatment specialty 814 Behavioral Health Community Network Entity/Agency/Group Entity/Agency/Group Structure is required to disclose the name of any investors, contractors, and/ or consultants associated with the group.

1. Select “Click to Add Consultant/Contract/Investor” to add information.

Consultants/Contractors/Investors Disclosure 1

Please disclose all consultants, contractors, investors associated with the disclosing provider.

Disclosures

Type	First Name	Last Name	Street Ad...	Street Ad...	City	State	Zip+4	Phone N...	Primary ...	Actions
+ Click To Add Consultant/Contractor/Investor										

Please upload supporting documentation related to this disclosure.

[Upload Files](#)

2. Select “Consultant/Contract/Investor” from the Type dropdown list and enter all required information.

Add Consultant/Contractor/Investor 2

Type: Select

First Name: Last Name:

Street Address: Street Address 2:

City: State: Select Zip+4:

Phone Number: Primary Contact:

[Close](#) [Add](#)

- After adding all individuals, select “Upload” to attach a copy of the legal contract between the parties (all pages).

Please upload supporting documentation related to this disclosure.

[Upload Files](#)

Consultants/Contractors/Investors

Please upload supporting documentation related to this disclosure.

Select A File
PDF ONLY, file size no more than 15MB [SELECT FILES](#)

File Name:

File Type: Select [Upload](#)

No Files Currently Uploaded

[Done](#)

Supervisor Disclosure

The following provider types and specialties are required to disclose the agency Clinical and Direct Supervisor information:

- 14 - Behavioral Health Outpatient Treatment specialty 814 Behavioral Health Community Network Entity/Agency/Group Entity/Agency/Group Structure
- 82 - Behavioral Health Rehabilitative Treatment specialty 882 Behavioral Health Rehabilitative Treatment Group

The following provider types and specialties are required to disclose Clinical Supervisor information:

- 85 - Applied Behavior Analysis (ABA) specialty 885 Applied Behavior Analysis (ABA) Group
- 93 - Substance Use Treatment (SUT) specialties 704 Residential Substance Use Treatment in an Institution for Mental Disease (IMD), 707 Substance Use Treatment Clinic, and 708 Opioid Treatment Program

1. Select “Click to Add Supervisors” to add a supervisor.

Supervisor Disclosure

Please disclose all supervisors associated with the disclosing provider.

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

First Name	Last Name	NPI	Supervisor Type	Primary	Location	Agency	Actions
+Click To Add Supervisors							

Please upload supervisor credentials/license.

[Upload Files](#)

2. Enter NPI and select “Search” to enable the remaining fields.

- Supervisor(s) must be actively enrolled with Nevada Medicaid.
- Supervisor(s) must be a provider type that is allowed to supervise for the enrolling entity.

Supervisor 2

* NPI

Type

Select ▼

First Name

MI

Last Name

Email Address

Professional Title

3. Select the supervisor type from the “Type” dropdown list and the location from the “Location” dropdown list.

Supervisor

* NPI

3

Type

Clinical ▼

* First Name

Tom

MI

* Last Name

Jones

* Email Address

Tom.Jones@gmail.com

Professional Title

Tom.Jones@gmail.com

Location

Select ♥

Select

5061 N RAINBOW BLVD STE 180 (9535)

4. Complete the remaining required fields and select “Add” to return to the application.

*** Location** 4

5061 N RAINBOW BLVD STE 180 (9535) ▼

*** Agency Name** *** Phone Number** **Ext**

ABC Behavioral Agency (999) 555-1212

*** Begin Date** **End Date**

11/01/2024

☒ **Primary Supervisor**

5. Select “Upload Files” to upload supervisor credentials/license.

Supervisor Disclosure 5

Please disclose all supervisors associated with the disclosing provider.

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

First Name	Last Name	NPI	Supervisor Type	Primary	Location	Agency	Actions
Tom	Jones	1356367734	Clinical	Yes	8838	ABC Behavior...	Remove

[+Click To Add Supervisors](#)

Please upload supervisor credentials/license.

Medical Director

The following Group Provider Types are required to disclose the facility’s Medical Director:

- 17 (Specialty 174) – Public Health Clinic
- 17 (Specialty 179) – School Based Health Centers (SBHC)
- 19 – Nursing Facility,
- 20 (Specialty 699) – Children’s Cancer and Rare Diseases Clinic
- 63 – Residential Treatment Center (RTC)/Psychiatric Residential Treatment Facility (PRTF),
- 64 – Hospice,
- 65 – Hospice, Long Term Care

The Medical Director must be actively enrolled with Nevada Medicaid.

Medical Director			
* NPI			
<input type="text"/>			
* First Name	MI	* Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
* Phone Number	Phone Ext	* Email Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

The following Group Provider Types are required to provide proof of business automobile insurance if they provide transportation in any owned, leased, hired and non-owned vehicles:

- 48 – Waiver for the Frail Elderly specialties 209 Social Adult Day Care, Home,303 Private Case Management,039 Homemaker Services,191 Respite Care, and 208 Adult Companion Service.
- 39 – Adult Day Health Care Center
- 55 – Home Based Habilitation Services
- 57 – Waiver for Adult Group Care specialty 303 Private Case Management
- 58 – Waiver for Persons with Physical Disabilities (PD) specialties 303 Private Case Management, 039 Homemaker Services, 189 Attendant Services, 191 Respite Care
- 59 – Facility Based Assisted Living specialties 303 Private Case Management and ,959 Facility Based Assisted Living).

<p>* Do you provide transportation in any owned, leased, hired and non-owned vehicles?</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>Provide proof of business automobile insurance of \$750k min</p> <p>Upload Files</p>

1.7. Contact Information

If questions arise during application processing, Nevada Medicaid may attempt to contact the person listed on the Contact Information page regarding this application.

The screenshot shows the 'Contact Information' form. On the left is a 'Sections' sidebar with radio buttons for: Welcome, Enrollment Information, Provider Information, Addresses, Ownership and Disclosure, Other Information, Contact Information (selected), Misc Attachments, EFT Enrollment, and Summary. The main form area is titled 'Contact Information' and contains the following fields: 'First name' and 'Last name' (text boxes), 'Telephone Number' (text box with a placeholder '() - - -') and 'Ext' (text box), 'Contact Email' and 'Confirm Email Address' (text boxes), and 'Preferred Communication Method' (dropdown menu). At the bottom are 'Previous' and 'Next' buttons, with a 'Dashboard' button also visible.

1.8. Misc Attachments

Additional supporting documentation can be uploaded with the application if necessary. All documents must be uploaded at the time of submission for the application to be considered complete.

1. Select “Upload Files” button. Attachments must be in PDF format and have a file size maximum of 15MB.

The screenshot shows the 'Upload Miscellaneous Attachments' form. The 'Sections' sidebar on the left has 'Misc Attachments' selected. The main form area is titled 'Upload Miscellaneous Attachments' with a red circle containing the number '1'. Below the title is the instruction: 'Please upload any documents that you believe to be relevant in reviewing and approving your application.' A blue 'Upload Files' button is highlighted with a red rectangle.

2. Select “Upload” button.

Miscellaneous File Uploads

Select A File
PDF ONLY, file size no more than 15MB

SELECT FILES

File Name

* File Type

Select

Upload

No Files Currently Uploaded

Done

- File is successfully uploaded.

3. Select “Done” to return to application.

1.9. Electronic Funds Transfer (EFT) Enrollment

All providers who will be receiving payment from Nevada Medicaid and Nevada Check Up must accept payments via EFT. If a provider does not have an active EFT account enrolled with Nevada Medicaid, that provider’s Nevada Medicaid enrollment may be terminated.

EFT information must belong to the enrolling provider.

- Enter the 9-digit Financial Institution Routing Number.
- Provider's Account Number with Financial Institution.
- Upload Bank Letter or Voided check.
 - Voided checks must be pre-printed. Checks cannot be handwritten or temporary.
 - The printed name on the voided check or bank letter must match the legal name or the Doing Business As (DBA) name entered on the application.
 - The routing number on the voided check must match the routing number entered on the EFT page.
 - The bank account number listed on the voided check must match the bank account number entered on the EFT page.
 - Deposit slips and direct deposit slips are not acceptable.
 - If a bank letter is attached in lieu of a voided check:
 - i. It must be printed on the bank's letterhead.
 - ii. It cannot be handwritten.

Electronic 1099 Consent

To authorize a 1099 delivered electronically, download the Electronic 1099 Consent Document.

Do you consent to electronic delivery?

- Select "Yes" to receive electronic 1099.
- Select "No" to receive paper 1099.

1.10. Application Review/Summary

The summary page provides a summary of the information that was included on the provider enrollment application. If changes are required when viewing the Summary page, select the appropriate “Go to Section” button or select the section from the Table of Contents panel to navigate back to that page.

Sections	Errors (3)
<input checked="" type="radio"/> Welcome	
<input checked="" type="radio"/> Enrollment Information	
<input checked="" type="radio"/> Provider Information	
<input checked="" type="radio"/> Associated Providers	
<input checked="" type="radio"/> Addresses	
<input checked="" type="radio"/> Ownership and Disclosure	
<input checked="" type="radio"/> Other Information	
<input checked="" type="radio"/> Contact Information	
<input checked="" type="radio"/> Misc Attachments	
<input type="radio"/> EFT Enrollment	
<input type="radio"/> Summary	

Special Ownership Type
State-owned

Choose the option that most closely describes the entity you are enrolling
A - Provider Group

Provider Information

[Go to Section](#)

Tax Information

Does the enrolling individual have a Federal Tax ID on file with the IRS for tax purposes?
Yes

Federal Tax ID
123456789

Requested Enrollment Effective Date
01/01/2025

Are you enrolled in Medicare?
No

Provider Legal Name

1.10.1. Error Identification

Once on the Summary page, a tab will appear with any validation errors in the application. This will check the application information to ensure all required fields are completed for the provider type entered, and the information entered meets field requirements. Any errors identified must be corrected prior to submission.

1. Select the red arrow to be directed to the page containing the error.

Sections

Errors (4)

1

General You are missing required files.	→
Financial Institution Routing Number Financial Institution Routing Number is a required field.	→
Provider's Account Number with Financial Provider's Account Number with Financial Institution is a required field.	→
Provider Ownership You are required to enter at least one Managing Employee and/or Agent.	→

- If any required attachments are missing, navigate to the Summary page for a list of “Missing Files”.

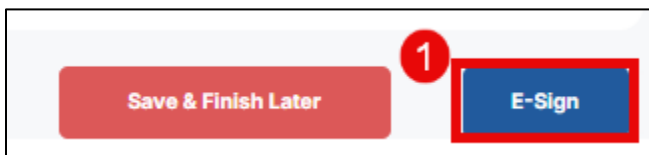
Missing Files

Description	
Voided Check or Bank letter for EFT, if applicable	Go To Section
Secretary of State Business License	Go To Section
Documentation showing Taxpayer Identification Number: SS-4 or CP575 or W-9 or SS Card	Go To Section

- Once corrections are made to the field, the error count will update automatically. When all errors are resolved, the application may be submitted.

1.11. Application Submission

1. To begin the application submission process, select “E-Sign”



2. Select the signers from the drop-down list. If no drop down is available, the signer is the individual listed on the application.
3. Select “Submit” to submit the enrollment application.

A screenshot of the "Nevada Medicaid Provider Enrollment e-Sign" application form. At the top, a red circle with the number "2" is placed over the title. Below the title is a yellow notice box. The main content area lists three documents: "10-Associated Providers List", "53-Provider Enrollment Agreement (Group)", and "55-Nevada Medicaid and Nevada Check Up Provider Contract (Group)". Each document has a table with columns for "Associated Provider", "Test Individual", and "me@me.com". At the bottom right, a red circle with the number "3" is placed over the "Submit" button, which is highlighted with a red rectangular border. A "Dashboard" button is also visible next to it.

1.12. After Submission

Once the application is ready for approval, the Dashboard shows “Awaiting Signatures” as the Status to indicate that the application is ready to begin the electronic signature process.

All documents must be signed electronically before the enrollment application will be finalized.

To view the signature status:

1. Click the application's row in the Dashboard to check the status of all signatures.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

FAQs Contact Us My Account Logout

Hello Misses Training
Thursday, 2/20/2025

Provider Enrollment Booklet Enrollment Checklist Start Application

Applications List

Import Search Quick Filters All

ATN	NPI	Provider Type	Provider Name	Applic...	Status	Submitted On	Update...	Contact
105914	123456789	14	Provider Name	NEW	Awaiting Signatures	02/20/2025	02/20/2025	Test Contac
105930	234567891	24	Provider Name	NEW	Incomplete		02/19/2025	
105928	345678912	24	Provider Name	NEW	Withdrawn		02/19/2025	
105875	123456789	20	Provider Name	NEW	Withdrawn		02/19/2025	

2. Select the "Signing Status" button.

ATN: 105914

Status: Awaiting Signatures
Enrollment Type: NEW
Provider Name:
Provider Type: 14

Cancel Signing Status

The Signing Status page displays. Review the page to see the status of each signer.

The Providers List will show each signer, the status, and expiration date of each DocuSign envelope.

Note the following statuses:

- "Created" means the document/envelope has been created. Please allow 24 hours for the initial envelope to be sent. Subsequent envelopes will be sent within 24 hours when the previous is completed.
- "Sent" means the document/envelope has been sent for signature to the email address listed in the application. If the email address listed is not correct, the user may select "Edit Email" to update the DocuSign email address.

NOTE: This will not update the email address on file with the enrollment.

- “Completed” means the document/envelope has been signed.

Once an envelope is sent, an expiration date will appear next to the status icon.

The expiration date is 30 calendar days from the date the envelope was sent. If the date expires without all the signatures, the provider must re-submit the application.

If a provider cannot locate the email requesting signature, they can select the “Resend” button to have the email re-sent.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

FAQs Contact Us My Account Logout

Application Status: **Awaiting Signatures**

Last Change 5/5/2025 3:02:41 PM 1 / 2 Done

Dashboard Refresh

Recipients List Filter by: v

NV Medicaid Enrollment Documents **Sent** Expires: 6/4/2025 2:48:53 PM

1	ictrainingquestions@gainwelltechnologies.com	Signed Date: 5/5/2025 2:56:05 PM	Completed
2	Test Provider @gainwelltechnologies.com	Sent Date: 5/5/2025 3:02:43 PM	Edit Email Resend Sent

Once documents are signed, the “Signing Status” page will change to reflect the updates.

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

FAQs Contact Us My Account Logout

Application Status: **Awaiting Signatures**

Last Change 5/5/2025 3:02:41 PM 1 / 2 Done

Dashboard Refresh

Recipients List Filter by: v

NV Medicaid Enrollment Documents **Sent** Expires: 6/4/2025 2:48:53 PM

1	ictrainingquestions@gainwelltechnologies.com	Signed Date: 5/5/2025 2:56:05 PM	Completed
2	Test Provider @gainwelltechnologies.com	Sent Date: 5/5/2025 3:02:43 PM	Edit Email Resend Sent

When all required signatures have been obtained, the application will be finalized. The finalized contract will be sent to the signer(s), or the user may download enrollment documents in the Provider Web Portal by selecting [Report Download](#).