Nevada Medicaid and Nevada Check Up

Provider Revalidation Instructions (Individuals)

This document provides instructions for completing the Provider Revalidation Application for Individual providers who have received a revalidation letter. Please answer all questions as of the current date. Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the application. These instructions are designed to clarify certain questions on the application. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

Section 1: General Information

Question 4 (Group Membership)

If you would like to **become a member of an existing Provider Group**, enter the group's National Provider Identifier (NPI) and the date you would like to be affiliated with the group. You may enter a date in the past. Please note that timely filing limits apply. (**Timely Filing Limits:** From the Date of Service or the recipient's date of eligibility, whichever is later, you have 180 days to submit in-state provider claims when Medicaid is the only insurance or 365 days to submit out-of-state provider claims and claims when the recipient has a primary health insurance carrier other than Medicaid.) When the group's NPI is used as the billing provider on a claim, payments will be made to the Provider Group. **Group revalidation is required for provider types 14 and 82.**

Question 5 (Provider Type)

Nevada Medicaid has defined approximately 60 different medical service types, also referred to as "provider types." Enter the appropriate **2-digit provider type number from the left column of Table E-2 found in the Provider Enrollment Information Booklet.**

Some providers provide more than one type of service. You must submit **one complete set of documents for each provider type you are revalidating** (i.e., Provider Revalidation Packet and documents listed on the relevant enrollment checklist for that provider type). For example, if you supply Durable Medical Equipment (provider type 33) as well as pharmaceutical drugs (provider type 28), complete two sets of revalidation documents. The same NPI would be noted on each application. The difference between the two applications would be the provider type number and the attachments required per the enrollment checklists.

Question 6 (Specialties)

Some provider types require you to identify a 3-digit specialty code in Question 6 on the Application. **The 3-digit specialty code is shown next to each bulleted item in Table E-2 found in the Provider Enrollment Information Booklet.**

- **A specialty is required for provider types 14, 17, 19, 20, 34, 38, 48, 57, 58 and 82.** For provider types 14, 17 and 82 only, enter one specialty code per Application. A Provider Revalidation Packet must be submitted for each specialty being revalidated.
- To assist in Medicaid tracking, we recommend that provider types 22, 26, 54 and 76 identify a specialty when applicable.
- All other provider types may leave Question 6 blank.

Section 2: Tax and Business Information

Questions 11-13 (Legal Name, DBA, TIN/SSN) Must match the IRS records

The legal name and Tax Identification Number or Social Security Number listed must match the information registered with the Internal Revenue Service (IRS), what is listed on your IRS Employer ID Number (EIN) confirmation letter and the W-9 form. Include with your Revalidation Packet a copy of the Internal Revenue Service (IRS) acceptance letter.

Questions 14 and 15 (Secretary of State)

Questions 14 and 15 are required for in-state providers only. These questions are not applicable for individual providers joining a group practice.

#14: Enter the entity name listed on your business license or registered with the Secretary of State office.

#15: Enter the Secretary of State issued Nevada Business ID number.

Question 24 (Electronic Funds Transfer)

It is required that all providers must accept Nevada Medicaid and Nevada Check Up payments via Electronic Funds Transfer (EFT). Enter the business or personal bank account number along with the authorized signature. An original voided check or letter from your bank that contains your bank's routing number must accompany the application. Photocopied checks and bank deposit slips are not accepted.

Section 3: Background, Ownership and Disclosure of Disclosing Entity

Completion of this section is a condition of participation in the Nevada Medicaid program and is mandated by 42CFR §455.100 – 106. Click here to view the full regulation.

List 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 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 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:

a) 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);
b) Any Medicare intermediary or carrier; and
c) 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:

a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
d) Owns an interest of 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 5 percent of the value of the property or assets of the disclosing entity;
e) Is an officer or director of a disclosing entity that is organized as a corporation; or
f) Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor means:

a) 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
b) 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).

Declaration (Signature): The individual provider must sign the application.

Nevada Medicaid and Nevada Check Up

Provider Revalidation Application (Individuals)

This Provider Revalidation Application is to be used only by active individual providers who have received a revalidation letter. All questions must be completed by **all providers** unless otherwise marked. Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application. Changes to enrollment information presented herein (except changes in business ownership) must be updated via form FA-33 **within five business days** of the change. **Business ownership changes** must be reported within five business days by resubmitting a complete, new set of enrollment documents and a copy of the purchase agreement.

Section 1: General Information

1. Provider name: _____
2. Provider date of birth: _____
3. Social Security Number: _____
4. To become affiliated or remain with an existing Medicaid Provider Group, enter the Group's NPI and the date to begin the affiliation. Otherwise, leave this field blank. **This is required for provider types 14 and 82.**
   Group NPI: _____ Affiliation begin date: _____
5. Enter the 2-digit number for the provider type you are revalidating: _____
   See the Provider Enrollment Information Booklet for the list of provider types and corresponding 2-digit numbers.
6. Name your board certified specialties that pertain to the provider type you are revalidating. This is required for provider types 14, 17, 19, 20, 34, 38, 48, 57, 58 and 82. It is recommended for provider types 22, 26, 54 and 76 when applicable. All other provider types may leave this question blank. **For provider types 14, 17 and 82 only, enter one specialty code per Application. A Provider Revalidation Packet must be submitted for each specialty being revalidated. See the Provider Enrollment Information Booklet for the list of specialty codes.**

   Primary Specialty: _____ Specialty Code: _____ Board Name:_____
7. Enter the following information for the licenses that pertain to the provider type you are revalidating.

   License Number: _____

   Name of Issuing Licensing Board, State or Entity: _____
8. Are you enrolled in Medicare? ☐ Yes ☐ No
9. Applicant's National Provider Identifier (NPI) *as issued by NPPES*: _____

Section 2: Tax and Business Information

10. Check the box that most closely describes the entity you are revalidating:

☐ Individual Provider	☐ Hospital-Based Physician	☐ Sole Proprietorship
☐ Corporation	☐ Limited Liability Company	☐ Non-Profit

Nevada Medicaid uses information in questions 11-13 to generate the annual 1099 form for tax reporting purposes. Individual providers may provide a Social Security Number if a Federal Tax ID Number is not available.

11. Legal Name as registered with the Internal Revenue Service (IRS): _____
12. Doing Business As: _____
13. Tax Identifier (either Federal Tax ID Number or Social Security Number): _____
14. Nevada Secretary of State Registered Name (in-state providers only): _____
15. Nevada Secretary of State Issued Business ID (in-state providers only): _____
16. Days and Hours of operation: _____

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

☐ Fee For Service Only ☐ Managed Care Only ☐ Both Fee For Service and Managed Care

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

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

20. **Service Address:** Enter 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.

Address (Line 1): _____

Address (City, State, Zip and COUNTY): _____

Office phone: _____ Extension: _____ E-mail address: _____

Fax: _____ TDD phone: _____

Contact name: _____ Contact phone: _____

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

Address (Line 1): _____

Address (City, State, Zip and COUNTY): _____

Office phone: _____ Extension: _____ E-mail address: _____

Fax: _____ TDD phone: _____

Contact Name: _____ Contact phone: _____

22. **Pay-To address:** Paper checks will be mailed here while Electronic Funds Transfer (EFT) testing is performed.

Address (Line 1): _____

Address (City, State, Zip and COUNTY): _____

Office Phone: _____ Extension: _____ E-mail address: _____

Fax: _____ TDD phone: _____

Contact name: _____ Contact phone: _____

23. **Remittance Advice Address:** Nevada Medicaid recommends using electronic instead of paper Remittance Advices (RAs) for faster account reconciliation. However, if you wish to receive paper RAs and have them mailed to an address different from the addresses listed above, please complete the fields below.

Address (Line1): _____

Address (City, State, Zip and COUNTY): _____

Office phone: _____ Extension: _____ E-mail address: _____

Fax: _____TDD phone: _____

Contact name: _____Contact phone: _____

24. **If the provider is already enrolled in EFT, skip this question.** All providers must accept Nevada Medicaid and Nevada Check Up payments via Electronic Funds Transfer (EFT). If a provider does not have an active EFT account enrolled with Nevada Medicaid, that provider's Nevada Medicaid enrollment may be terminated or denied.

Check box if applicable: ☐ I will be receiving payment through the Group NPI listed in Question 4 that is already enrolled in EFT. *(Skip the rest of this question and continue with Question 25.)*

Electronic Funds Transfer (EFT) Authorization: I hereby authorize Nevada Medicaid (Nevada Medicaid refers to the fiscal agent for Nevada Medicaid) and its subsidiaries to transfer my Nevada Medicaid and Nevada Check Up payments to the personal or business bank account shown below. I also authorize any necessary debit entries to correct payment errors. 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 or the banking institution otherwise. I understand that Nevada Medicaid 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.

Business or personal bank account number: _____

Authorized signature: _____ Date: _____

TAPE AN ORIGINAL, VOIDED CHECK HERE

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

PHOTOCOPIED CHECKS AND BANK DEPOSIT SLIPS ARE NOT ACCEPTED.

Section 3: Background, Ownership and Disclosure of Disclosing Entity

Please attach additional sheets if necessary.

25. Provide the following information for each person having direct or indirect ownership interest or controlling interest in the disclosing entity and for any subcontracting company in which the disclosing entity has direct or indirect ownership interest of 5 percent or more.

    Owner 1: _____

    Social Security Number: _____ Date of Birth: _____

    Address:_____

    Percentage of ownership: _____

    Owner 2: _____

    Social Security Number: _____ Date of Birth: _____

    Address:_____

    Percentage of ownership: _____

26. Provide the name, Social Security Number, date of birth and address of all agents and managing employees.

    Name: _____

    Social Security Number: _____ Date of Birth: _____

    Address:_____

    Is the person listed a(n): ☐ Agent ☐ Managing Employee ☐ Both

27. Does anyone listed in questions #25 and/or #26 own 5 percent or more of any other business (health-care related or non health-care related)? ☐ Yes ☐ No If yes, please provide the following:

    How many businesses? _____ Name of all businesses: _____

    Address of all businesses: _____

    Tax ID of all businesses:_____

28. Does any individual and/or corporation have an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity? ☐ Yes ☐ No If yes, complete the following:

    Name: _____

    Social Security Number: _____ Tax ID: _____

    Address: _____

    Percentage of ownership: _____ Date of birth: _____

29. Is anyone listed in questions #25 and #26 related (includes spouses, children, siblings)?

☐ Yes ☐ No If yes, please list names and relationship:

Name: _____ Relationship: _____

30. Who is authorized to make changes to enrollment and billing information?_____

_____

31. Are you or any owner, agent, managing employee or person with controlling interest currently enrolled, or have ever been enrolled, as a Medicare or Medicaid provider with another state (including Nevada)?

☐ Yes ☐ No If yes, complete the following:

Program(s):_____ State(s):_____ Date(s):_____

32. Do you or any owner, agent or managing employee or person with a controlling interest currently have a negative balance or owe money to any state or federal program (including Medicare and Medicaid)?

☐ Yes ☐ No If yes, complete the following for all applicable entities/providers/employees.

Provider/Entity/Employee name: _____ Amount Owed: _____

To whom is the money owed? _____

33. Have you or any owner, agent, managing employee or person with controlling interest ever been convicted of a misdemeanor, gross misdemeanor or felony, including but not limited to, criminal offenses related to any program under Medicare, Title XVIII, Title XIX or any Medicaid program since the inception of these programs?

☐ Yes ☐ No If yes, provide the following information for each conviction:

Name used when convicted: _____ Date of conviction: _____

Charges: _____ Disposition: _____

Conditions of parole/probation: _____

34. Have you or any owner, agent, managing employee or person with controlling interest ever been placed on the Federal Office of Inspector General, Health and Human Service (OIG/HHS) exclusion list or otherwise been suspended, terminated, denied or debarred from participation in any program established under Medicare, Medicaid, Title XVIII, Title XIX or any other Medicaid program since the inception of these programs? This includes termination from the Nevada Medicaid program or any other state Medicaid program.

☐ Yes ☐ No If yes, provide the following information related to the sanction as well as specific details.

Name used when sanctioned: _____

Provider ID number(s): _____ Group ID number(s): _____

Sanction effective date: _____ Reinstatement date: _____

35. Are you or any owner, agent, managing employee or person with controlling interest currently under investigation by any law enforcement, regulatory or state agency? ☐ Yes ☐ No

If yes, please provide details._____

36. Do you or any owner, agent, managing employee or person with controlling interest have any open or pending court cases? ☐ Yes ☐ No

If yes, please provide details including court documentation. _____

37. Have you or any owner, agent, managing employee or person with controlling interest ever been denied malpractice insurance? ☐ Yes ☐ No

If yes, explain:_____

38. Have you or any owner, agent, managing employee or person with controlling interest had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked?

☐ Yes ☐ No If yes, complete the following for each instance.

Denial/Suspension/Restriction/Revocation from and to dates: _____

Explanation: _____

39. Have you or any owner, agent, managing employee or person with controlling interest ever voluntarily surrendered any professional license or certificate? ☐ Yes ☐ No If yes, complete the following for each instance:

    Voluntary Surrender from and to dates: _____

    Explanation: _____

40. Are you or any owner, agent, managing employee or person with controlling interest a Nevada state employee *(past or current)*?

    ☐ Yes ☐ No If yes, complete the following:

    Individual's Name: _____ Agency of employment: _____

    Title: _____ Dates of employment: _____

    If you are a current employee, please provide your supervisor's name: _____

Declaration

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(s) listed on this Application. I understand that Nevada Medicaid will rely on this information in entering into or continuing a Nevada Medicaid Provider Contract and that this form will be incorporated into and become a part of my Nevada Medicaid Provider Contract.

I understand that I am required to **notify Nevada Medicaid within five days** of changes to information on this Application.

I understand that **I am responsible for the presentation of true, accurate and complete information on all invoices/claims** 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.

Use dark blue or black ink only. *The provider enrolling must sign below.*

Signature: _____ Date: _____

Print Name: _____

Enrollment checklists list the documents (e.g., licenses, certifications) that must be submitted with your Provider Revalidation Packet. Checklists for all provider types are at http://www.medicaid.nv.gov (select "Provider Enrollment" from the "Providers" menu, then click "Enrollment Checklists").

Application Review

Review your Provider Revalidation Application to ensure all applicable questions are answered.

If you cannot check "Yes" next to each applicable question below, your **Provider Revalidation Application will be returned and your revalidation with Nevada Medicaid will be delayed**.

Does the legal name entered for Question 11 (***page 1***) (Legal name as registered with the Internal Revenue Service) match Line 1 on your W-9?	Yes ☐
Did you sign the Application? (***page 5***)	Yes ☐
Did you provide all of the documentation as outlined on the Provider Enrollment Checklist for your provider type?	Yes ☐
If additional sheets are required, does each additional sheet display the relevant question number from the Application? Please follow the instructions shown on page 1 of the Revalidaion Instructions and Application. Reminder: Documents attached per the Provider Enrollment Checklists, such as a license, do not need to be signed.	Yes ☐

You do not need to mail this page with your revalidation documents.

NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

Nevada Medicaid and Nevada Check Up Provider Contract

This Contract, effective on the date specified on the signature page of this document, between the State of Nevada Division of Health Care Financing and Policy, which includes Nevada Medicaid and Nevada Check Up, (hereinafter called the "Division") and the undersigned Provider or Provider Group and its members or Practitioner(s) (hereinafter called the "Provider"), is made pursuant to Title XIX and Title XXI of the Social Security Act, Nevada Revised Statutes Chapter 422, and state regulations promulgated thereunder to provide medical, paramedical, home and community based services and/or remedial care and services (hereinafter called "Service(s)") as defined in the Nevada Medicaid Services Manual to eligible Division Recipients (hereinafter called "Recipient(s)"). On its effective date, this Contract supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients.

Section 1. Provider Agrees

1.1 To adhere to standards of practice, professional standards and levels of Service as set forth in all applicable local, state and federal laws, statutes, rules and regulations as well as administrative policies and procedures set forth by the Division relating to the Provider's performance under this Contract and to hold harmless, indemnify and defend the Division from all negligent or intentionally detrimental acts of the Provider, its agents and employees.

1.2 To provide Services to Recipients without regard to age, sex, race, color, religion, national origin, disability or type of illness or condition. This includes providing Services in accordance with the terms of Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794). To provide Services in accordance with the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and regulations adopted hereunder contained in 28 CFR §§ 36.101 through 36.999, inclusive.

1.3 To provide Services in accordance with the terms, conditions and requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended and the HITECH Act and related regulations at 45 CFR 160, 162 and 164.

1.4 To obtain and maintain all licenses, permits, certifications, registrations and authority necessary to do business and provide Services under this Agreement. Where applicable, the Provider shall comply with all laws regarding safety, unemployment insurance and workers compensation. Copies of applicable licensure/certification must be submitted at the time of each license/certification renewal.

1.5 To check the List of Excluded Individuals/Entities on the Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors.

1.6 To comply with protocols set forth in the Nevada Medicaid Services Manual, the Nevada Check Up Manual and the Medicaid Operations Manual, including but not limited to, verifying Recipient

eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of Provider.

1.7 To adhere to the provisions in 42 U.S.C. 1396a(a)(68), should the Division notify the provider it has reached the threshold of $5,000,000 in annual payments from Medicaid; classifying the provider as an "entity", and making the provider subject to this regulation.

1.8 To safeguard all information on applicants and Recipients, in accordance with the requirements set forth in 42 CFR 431 subpart F and NRS 422.2749. To ensure appropriate security, Provider agrees that no processing or storage of Protected Health Information as defined by HIPAA or electronic transactions with the Division will be conducted from outside the geographic limits of the United States.

1.9 To exhaust all Administrative remedies, including the QIO-like vendor's reconsideration and appeal process and the Fair Hearing process described at NRS 422.306, prior to initiating any litigation against the Division.

Section 2. Reimbursement

2.1 The Division agrees to provide for payment of Services to the Division-enrolled Provider for all Services properly authorized, timely claimed, and actually and properly rendered by Provider in accordance with federal and state law and the state policies and procedures set forth in the Nevada Medicaid Services Manual, the Nevada Check Up Manual and the Nevada Medicaid Billing Manual and Guides. Other claims are not properly payable Division claims.

2.2 The Provider is responsible for the validity and accuracy of claims whether submitted on paper, electronically or through a billing service.

2.3 The Provider agrees to pursue the Recipient's other medical insurance and resources of payment prior to submitting a claim for Services to the Division's Fiscal Agent. This includes but is not limited to Medicare, private insurance, medical benefits provided by employers and unions, worker compensation and any other third party insurance.

2.4 The Provider shall accept payment from the Division as payment in full on behalf of the Recipient, and agrees not to bill, retain or accept payments for any additional amounts except as provided for in item number 2.3 above. The Provider shall immediately repay the Division in full for any claims where the Provider received payment from another party after being paid by the Division.

2.5 Upon receipt of notification that the Provider is disqualified through any federal, State and/or Medicaid administrative action, the Provider will not submit claims for payment to the Division for services performed on or after the disqualification date.

2.6 The Provider agrees that any overpayment or improper payment may be immediately deducted from future Division payments to any payee with the Provider's Tax Identification Number at the discretion of the Division.

2.7 Continuation of this Agreement beyond the current biennium is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State Legislature and/or federal sources. The Division may terminate this Agreement and the Provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified

therein) if for any reason the Division's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired.

Section 3. Notices

All written notices or communication shall be deemed to have been given when delivered in person; or, if sent to address on file by first-class United States mail, proper postage prepaid. Provider shall notify the Division and/or Fiscal Agent within five (5) working days of any of the following:

3.1 Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest or felony conviction or any criminal charge.

3.2 Change in any ownership and control information described in 42 CFR 455 subpart B. Among other information, this will include corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Division Funds.

3.3 When there is a change in ownership, the terms and agreements of the original Contract are assumed by the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined. Change in ownership requires full disclosure of the terms of the sale agreement, a new enrollment application and a newly signed Medicaid provider contract.

Section 4. Records

4.1 The Division is a covered entity as defined by HIPAA. Accordingly, the Division complies with the HIPAA Privacy Regulations promulgated in 45 CFR 160 and 164. In accordance with 45 CFR 164.506, when requested by the Division for treatment, payment or health care operations, Division health care Providers will furnish Protected Health Information about potential or current Division Recipients without requiring the individual's authorization.

4.2 For six years from the date of payment, or longer if required by law, Provider shall maintain adequate medical, financial and administrative records as necessary to fully justify and disclose the extent of Services provided to Recipients under this Contract, including the requirements stated in the Nevada Medicaid Services Manual. The Division, its Fiscal Agent, the Medicaid Fraud Control Unit (MFCU), U.S. Department of Health and Human Services' employees, and/or authorized representatives shall be given access to the Provider's business or facility and all related Recipient information and records, including claims records, within 14 days from the date the request was made, except in the case of an audit by the Division, its Fiscal Agent, the MFCU, federal employees, and/or authorized representatives in which case such access shall be given at the time of the audit. If requested by the Division, its Fiscal Agent, or the MFCU, the Provider shall provide copies of such records free of charge. The Provider further agrees to give the Division, the authorized representatives and/or the MFCU, access to private interviews with any and all Recipients upon request. It is the Provider's responsibility to obtain any Recipient consent required in order to provide the Division, its Fiscal Agent, the MFCU, federal employees, and/or authorized representatives with requested information and records or copies of records.

4.3 Failure to timely submit or failure to retain adequate documentation for Services billed to the Division may result in recovery of payments for Services not adequately documented, and may result in the termination or suspension of the Provider from participation as a Medicaid Provider.

4.4 The Provider agrees to furnish all information as described in 42 CFR Part 455, subpart B, as now in effect or as may be amended, including ownership or control information.

4.5 For Facility Providers Only: The Provider agrees to maintain records as are necessary to fully disclose to the Recipient, his/her representative and/or the Division, the management of Recipient trust funds and upon demand transfer to the Recipient, his/her representative and/or the Division the balance of his/her Recipient trust funds held by the Provider. Upon discharge, the Provider agrees to return monies and valuables of the Recipient to him/her or, in the event of the death, to the Recipient's legal representative.

Section 5. Miscellaneous

5.1 Both parties mutually agree that the Division Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Contract and is a part hereof as though fully set forth herein.

5.2 For Provider Groups Only: Group Provider affirms that it has authority to bind all member Providers to this Contract and that it will provide each member Provider with a copy of this Contract. The Provider Group also agrees to provide the Division with names and proof of current licensure for each member Provider as well as the name(s) of the individual(s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.

5.3 For Hospital, Nursing Facility, Hospice, Home Health Agency and Personal Care Service Providers Only: Provider shall provide all Recipients with written information regarding their rights to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives (durable power-of-attorney for health care decisions and declarations).

5.4 For Facility Providers Only: Provider shall cooperate in the transfer of Recipients from level to level as prescribed by the attending physician and all pertinent federal and state regulations.

5.5 For Providers Not Defined as Covered Entities under HIPAA in 45 CFR 160. Providers who are not required to comply with HIPAA privacy rules must inform the Division in writing and execute a business associate agreement or other appropriate confidentiality agreement concurrent with this Contract to protect and secure the privacy of all Recipients' Protected Health Information in accordance with the HIPAA requirements of 45 CFR 160, 162 and 164.

5.6 The Division does not guarantee the Provider will receive any Recipients as clients and the Provider does not obtain any property right or interest in any Division Recipient business by the Contract.

5.7 The Division may terminate this Contract with cause at any time with twenty (20) days prior written notice to the Provider.

5.8 The Division may terminate this Contract immediately when the Division receives notification that the Provider no longer meets the professional credential/ licensing requirements, or the enrollment screening criteria described at 42 CFR 455 subpart E.

5.9 It is further expressly understood and agreed that either party to this Contract, may terminate this Contract without cause at any time by 90 days prior written notice to the other party.

The parties agree that all questions pertaining to validity, interpretation and administration of this Contract shall be determined in accordance with the laws of the State of Nevada, regardless of where any Service is performed. The parties consent to the exclusive jurisdiction of the First Judicial District court, Carson City, Nevada for enforcement of this Contract.

Both parties mutually agree that the Provider is an independent contractor and all of the provisions of NRS 333.700 apply.

To continue as a Nevada Medicaid Provider, a new Enrollment Application and Nevada Provider Contract must be submitted and approved within 36 months for Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS Provider Type 33) and within 60 months for all other Provider Types from the date of DHCFP approval on the signature page of this Contract.

By signature below, Provider attests it is a Covered Entity in compliance with the HIPAA privacy rule at 42 CFR 164, or has complied with section 5.5 above.

All matters stated herein are true and accurate, signed by a natural person who is the Provider or is authorized to act for the Provider, under the pains and penalties of perjury.

Provider Signature: _____ Date: _____

Please Print or Type the following:

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Atypical Provider Identifier (API) (if applicable and for use only when resubmitting this contract or re-enrolling): _____

Provider Type: _____

Federal Tax ID Number or Social Security Number:_____

Legal Business Name: _____

Physical/Street Address of the Practice/Business Facility (*cannot be a P.O. Box)*:

_____

Nevada Division of Health Care Financing and Policy

Date: _____