Nevada Medicaid and Nevada Check Up

Provider Enrollment Application Instructions for Ordering, Prescribing or Referring (OPR) Providers

This Application is to be used by individual providers and only if you are enrolling for the sole purpose of ordering, prescribing or referring services/supplies, i.e., prescriptions, durable medical equipment, referrals to specialists, etc. All questions must be completed. Attach additional sheets if necessary to answer each question completely and each additional sheet must display the relevant question number from the Application. Changes to information presented herein must be updated **within five business days** of the change.

If you are currently enrolled solely to order, prescribe or refer services/supplies and need to update your information, please complete form FA-33 within five business days of the change.

If you are voluntarily withdrawing your Medicaid enrollment to solely order, prescribe or refer services/supplies, please complete form FA-34.

Requirements

Enrolling as an OPR provider allows Medicaid reimbursement to the provider rendering covered services and supplies for their Medicaid patients. OPR providers do not bill Nevada Medicaid for services rendered; they only order, prescribe and/or refer services/supplies for their Nevada Medicaid patients. A simplified application process requires minimal information and time and makes participation easy. Before completing the Application, note the following:

- If you are already enrolled as a Nevada Medicaid provider, you do not need to enroll as an OPR provider.
- As an OPR provider, you cannot seek reimbursement for services rendered to Medicaid recipients and cannot submit claims to Nevada Medicaid. If at any time you would like to become a fully participating Nevada Medicaid provider, you must enroll by submitting a Provider Initial Enrollment Application (form FA-31C or FA-31D). You must have a National Provider Identifier (NPI).
  - The National Provider Identifier (NPI) is the standard, unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES).
  - The NPI must be for an individual physician or non-physician practitioner (not an organizational NPI).
  - Applying for the NPI is a process separate from Nevada Medicaid enrollment.
  - To obtain an NPI, apply online at https://nppes.cms.hhs.gov.
  - For more information about NPI enumeration, visit www.cms.gov/NationalProvIdentStand.
- The physician or non-physician practitioner must be of a provider/specialty type that is eligible to order and refer. These individuals include, but are not limited to:
  - Certified Nurse Midwives (provider type 74)
  - Clinical Psychologists (provider type 26, specialty 162)
  - Clinical Social Workers (provider type 14, specialty 305)
  - Nurse Practitioners (provider type 24)
  - Optometrists (provider type 25)
  - Physician's Assistants (provider type 77)
  - Physicians (Doctors of Medicine or Osteopathy, Doctors of Dental Medicine, Doctors of Dental Surgery, Doctors of Podiatric Medicine or Doctors of Optometry) (provider type 20)
  - Interns, Residents and Fellows*

* Interns, residents and fellows must have an NPI to order, prescribe and refer for Nevada Medicaid recipients. This OPR Application does not permit interns, residents and fellows to bill for services rendered to Nevada Medicaid recipients.

Section 1: General Information

Question 4 (Social Security Number)

The Social Security Number disclosed on this form is used to determine whether the person attempting to enroll as an OPR provider is a federally excluded party. Refusal to provide a Social Security Number will result in rejection of this Application.

Question 6 (Provider Type)

Nevada Medicaid has defined approximately 60 different medical service providers 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.**

Question 7 (Licenses)

Please be sure to attach a copy of your license(s) to this Application and complete question 6.

Submission Instructions

You may submit this completed application and supporting documentation by mail or email.

- Mail: Nevada Medicaid, Provider Enrollment Unit, P.O. Box 30042, Reno, NV 89520-3042.
- Email: nv.providerapps@hpe.com. Attach all scanned or saved documents to one email.

If you have any questions regarding your Application, call Nevada Medicaid customer service at (877) 638-3472.

Nevada Medicaid

Provider Enrollment Application for Ordering, Prescribing or Referring (OPR) Providers

Section 1: General Information

1. Would you like to be a fully enrolled Nevada Medicaid provider to seek reimbursement for services rendered to Medicaid recipients and submit claims to Nevada Medicaid? ☐ Yes ☐ No

   If you checked **Yes**, please STOP. You will need to complete a Provider Initial Enrollment Application Packet (FA-31C) instead of this application.

   If you checked **No**, please check the appropriate boxes explaining why you **do not** wish to be a fully enrolled Nevada Medicaid provider:

   ☐ Reimbursement Rates ☐ Medicaid Policy ☐ Practice Capacity

   ☐ Other (*please explain*):_____

2. Provider name: _____
3. Provider date of birth: _____
4. Social Security Number: _____
5. Enrollment effective date: _____
6. Enter the 2-digit number for the provider type you are enrolling: _____

   See the **Provider Enrollment Information Booklet** for the list of provider types and corresponding 2-digit numbers.

7. Enter the following information for the licenses that pertain to the provider type you are enrolling. Attach a copy of your license(s) to this Application.

   License Number: _____

   Name of Issuing Licensing Board, State or Entity: _____
8. Enter your Drug Enforcement Agency (DEA) Number (*if applicable*):_____
9. Applicant's National Provider Identifier (NPI) *as issued by NPPES*: _____

Section 2: Business Information

10. **Mail-To Address:** Nevada Medicaid will mail written correspondence to this address and attempt to make contact at the phone number provided.

    Address (Line 1): _____

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

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

    Fax: _____ TDD phone: _____

11. **Contact Person Information:** If questions arise during the processing of this Application, Nevada Medicaid will attempt to contact you directly at the location given above. If you are not available, you may designate an alternate contact person below.

    Name: _____

    Address (P.O. Box or Street Name and Number): _____

    Address (Suite, Room, Apt. #, etc.): _____

    City/Town/State/Zip Code: _____

    Telephone Number: _____ Fax Number (if applicable): _____

    E-mail Address (if applicable): _____

    Relationship or Affiliation to You: _____

    NOTE: The Contact Person reported in this section will only be authorized to discuss issues concerning this Application. Nevada Medicaid will not discuss any other enrollment or Medicaid issues about you with the above Contact Person.

Section 3: Background Disclosure of Final Adverse Legal Actions

Please attach additional sheets if necessary.

This section captures 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.

12. Have you 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: _____

13. Have you 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: _____

14. Are you currently under investigation by any law enforcement, regulatory or state agency? ☐ Yes ☐ No

    If yes, please provide details._____

15. Do you have any open or pending court cases? ☐ Yes ☐ No

    If yes, please provide details including court documentation. _____

16. Have you ever been denied malpractice insurance? ☐ Yes ☐ No

If yes, explain:_____

17. Have you 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: _____

18. Have you 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: _____

19. Are you 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 a current employee, please provide supervisor's name.

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.

As an individual practitioner, you are the only person who can sign this Application. The authority to sign this Application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous registration in the Medicaid program solely to order, prescribe or refer items and services for Medicaid recipients. Review these requirements carefully. By signing the Certification Statement, you agree to adhere to all of the requirements listed herein and acknowledge that you may be denied or revoked from enrolling in the Medicaid program if any requirements are not met.

CERTIFICATION STATEMENT

You **MUST SIGN AND DATE** the certification statement below in order to be enrolled in the Medicaid program. In doing so, you are attesting to meeting and maintaining the Medicaid requirements stated below.

Under the penalty of perjury, I, the undersigned, certify to the following:

1. I understand that if I wish to be reimbursed by Medicaid for services I have performed, I must first enroll in Medicaid as an individual practitioner.
2. I have read the contents of this Application and the information contained herein is true, correct and complete. If I become aware that any information in this Application is not true, correct and complete, I agree to notify Nevada Medicaid immediately.
3. I authorize Nevada Medicaid to verify the information contained herein. I agree to notify Nevada Medicaid of any changes to the information to this form within 5 days of the effective date of change. I understand that any change to my status as an individual practitioner may require the submission of a new Application.
4. I will not knowingly order, prescribe and/or refer an item and/or service that allows a false or fraudulent claim to be presented for payment by Medicaid.
5. I further certify that I am the individual practitioner who is enrolling for the sole purpose of ordering, prescribing or referring items or services to Medicaid recipients, and I have signed and dated this Application.

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

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

Signature: _____ Date: _____

Print Name: _____