HP Enterprise Services

Provider Enrollment Application

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 and must be signed by the provider or authorized representative. 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.

Enrollment Type (*check one*):

☐ Initial ☐ Re-enrollment ☐ Ownership change (attach copy of purchase agreement)

Section 1: General Information

The Provider Enrollment Instructions provide guidance on the enrollment process and are essential for completing Questions 4-7 below.

1. Provider name: _____

2. Provider date of birth (*for individual providers only*): _____

3. Social Security Number (*for individual providers only*): _____

4. Enrollment effective date: _____

5. 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: _____

6. Enter the 2-digit number for the provider type you are enrolling: _____

7. Name your board certified specialties that pertain to the provider type you are enrolling. 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 Enrollment Packet must be submitted for each specialty being enrolled.**

   Primary Specialty: _____ Specialty Code: _____ Board Name: _____

   Secondary Specialty: _____ Specialty Code: _____ Board Name: _____

   Other Specialty: _____ Specialty Code: _____ Board Name: _____

8. Enter the following information for the licenses that pertain to the provider type you are enrolling.

   License Number: _____

   Name of Issuing Licensing Board, State or Entity: _____

9. Enter your Drug Enforcement Agency (DEA) number *(if applicable)*: _____

10. Enter your CLIA certification number *(if applicable)*: _____

11. Enter your NCPDP/NABP number *(for provider types 28 and 37 only)*: _____

Provider types 38, 48, 57 and 58 may leave Questions 12-13 blank (HP Enterprise Services will assign an Atypical Provider Identifier (API) to these providers).

12. Applicant's National Provider Identifier (NPI) *(as issued by NPPES)***: _____**

13. Taxonomy Code(s) (A list of taxonomy codes is online at www.wpc-edi.com/reference: _____

Section 2: Tax and Business Information

14. Check the box that most closely describes the entity you are enrolling:

☐ Individual provider ☐ Hospital-based physician ☐ Provider group ☐ Sole proprietorship
☐ Partnership ☐ Limited liability partner ☐ Non-profit ☐ Corporation
☐ Indian health services ☐ Limited liability company ☐ Managed care organization

15. 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? ☐ Yes ☐ No

Nevada Medicaid uses information in questions 16 and 18 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.

16. Legal Name as Registered with the Internal Revenue Service (IRS): _____

17. Doing Business As: _____

18. Tax Identifier (either Federal Tax ID Number or Social Security Number): _____

19. Begin Date of the Federal Tax ID: _____

Questions 20-28 are for billing groups and businesses/practices/facilities only. If enrolling an individual provider, you may leave these questions blank.

20. Nevada Secretary of State Registered Name (for in-state providers only): _____

21. Nevada Secretary of State Issued Business ID (for in-state providers only): _____

22. Date your practice/business/facility opened for business_____

23. Days and hours of operation: _____

24. Do you currently 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

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

26. Languages other than English spoken at your facility: _____

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

28. List any items available for sale from your organization: _____

_____

29. Resale tax number: _____

30. **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: _____

30a. Is the building/facility identified above operated by a property management company? ☐ Yes ☐ No

If yes, provide the property management company's name: _____

31. **Mail-To Address:** HP Enterprise Services 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: _____

32. **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: _____

33. **Remittance Advice Address:** HP Enterprise Services 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: _____

34. Do have one or more off-site storage facilities? ☐ Yes ☐ No

If yes, provide the address(es):_____

_____

35. 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.

Check box if applicable: ☐ I will be receiving payment through the Group NPI listed in Question 5. *(Skip the rest of this question and continue with Question 35.)*

Electronic Funds Transfer (EFT) Authorization: I hereby authorize HP Enterprise Services 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 HP Enterprise Services or the banking institution otherwise. I understand that HP Enterprise Services 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

Questions 36-41 apply to billing groups and to businesses/practices/facilities — individual providers may leave these questions blank. In the following section, "Disclosing Entity" refers to the practice/business/facility that is applying for enrollment — not the individual person/provider of service.

36. Provide the following information for **each person** with an ownership or controlling interest in the disclosing entity *(this includes relatives)* and for *any subcontracting company* in which the disclosing entity has direct or indirect ownership of five percent or more.

Name 1: _____ **Social Security Number or Tax ID:** _____

Address: _____

Percentage of ownership: _____ Relationship to owner: _____

Date of birth *(for persons only)*: _____

Does this person/subcontracting company own five percent or more of any *other* business (healthcare-related *or* non-healthcare-related)? ☐ Yes ☐ No

If yes, how many businesses? _____ Name of all businesses: _____ _____

Business name 1: _____

Business address: _____

Business tax identifier (Federal Tax ID Number or Social Security Number): _____

Name 2: _____ **Social Security Number or Tax ID:** _____

Address: _____

Percentage of ownership: _____ Relationship to owner: _____

Date of birth *(for persons only)*: _____

Does this person/subcontracting company own five percent or more of any *other* business (healthcare-related *or* non-healthcare-related)? ☐ Yes ☐ No

If yes, how many businesses? _____ Name of all businesses: _____ _____

Business name 1: _____

Business address: _____

Business tax identifier (Federal Tax ID Number or Social Security Number): _____

37. Have any **current agents, managing employees or employees** with five percent or more 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 or debarred from participation in Medicare, Medicaid, Title XVIII, or Title XIX or any Medicaid programs 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 name, Social Security Number (SSN), date of exclusion of the agent(s)/managing employee(s) and the state.

Name 1: _____ SSN: _____

Date: _____ State: _____

Name 2: _____ SSN: _____

Date: _____ State: _____

38. If the disclosing entity has a Board of Directors, list the name and address of each member.

Name: _____ Address: _____

Name: _____ Address: _____

Name: _____ Address: _____

39. Is a change of ownership anticipated in the next year? ☐ Yes ☐ No If yes, list anticipated date: _____

40. Has the disclosing entity filed for bankruptcy within the last 10 years? ☐ Yes ☐ No If yes, when? _____

41. Does the disclosing entity anticipate filing bankruptcy within the next year? ☐ Yes ☐ No

42. Are you or any owner, administrator, manager or employee enrolled, or have you ever been enrolled, as a Medicaid provider with another state? ☐ Yes ☐ No

If yes, please list the state(s). _____

43. Do you or any owner, administrator, manager or employee currently have a negative balance with 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? _____

44. Have you or any owner, administrator, manager or employee ever been convicted of a misdemeanor, gross misdemeanor or felony? ☐ Yes ☐ No If yes, provide the following information for each conviction.

Name used when convicted: _____ Date of conviction: _____

Charges: _____ Disposition: _____

Conditions of parole/probation: _____

45. Are you or any owner, administrator, manager or employee currently under investigation by any law enforcement, regulatory or state agency? ☐ Yes ☐ No

45a. Do you or any owner, administrator, manager or employee have any open or pending court cases? ☐ Yes ☐ No

If yes to either part, please explain. If you answered yes to Question 44, please explain.

_____

46. Have you or any owner, administrator, manager or employee ever been placed on the Federal Office of Inspector General, Health and Human Service (OIG/HHS) exclusion list or otherwise been suspended, terminated or debarred from participation in Medicare, Medicaid, Title XVIII, Title XIX or any Medicaid programs 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.

Name used when sanctioned: _____

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

Sanction effective date: _____ Reinstatement date: _____

47. Have you or any owner, administrator, manager or employee ever been denied malpractice insurance? ☐ Yes ☐ No

If yes, explain:_____

48. If you or any owner, administrator, manager or employee has had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked, complete the following for each instance. Denial/Suspension/Restriction/Revocation from and to dates: _____

Explanation: _____

49. Are you or any owner, administrator, manager or employee a state employee *(past or current)*? If yes, complete the following:

Individual's Name: _____ Agency of employment: _____

Title: _____ Dates of employment: _____

For Facilities Only

This section is required for provider types 10-13, 16, 19, 42, 44, 45, 51, 52, 55, 56, 63-68, 75, 78 and 79.

50. Is this entity a subsidiary or parent of another entity? ☐ Yes ☐ No

51. Facility rating: ☐ Profit ☐ Non-profit ☐ Not applicable

52. Facility control: ☐ State ☐ Private ☐ Public ☐ City ☐ Charity ☐ Not Applicable

53. Number of beds: _____Acute __ ___ICF _____SNF _____Swing Bed ____ICF/MR _____ISO

54. Mammography certification number *(FDA-certified mammography providers only)*: _____

For Provider Type 33 Only – Durable Medical Equipment (DME) Providers

55. List the names and addresses, of all manufacturers and suppliers with whom you have a business relationship relative to the provision of services, goods, supplies or merchandise.

Name: _____ Address: _____

56. Enter your National Supplier Clearing House Number: _____

57. Will you bill Medicare crossover claims only? ☐ Yes ☐ No

For Provider Groups Only

58. List the individual names and NPIs of all providers to be affiliated with this group. All providers listed below must be enrolled with Nevada Medicaid or have already submitted their enrollment documents. Each provider must sign this form to accept enrollment in the group. Original signatures are required.

	Provider Name	NPI	Provider Signature
1			
2			
3			
4			
5			
6			

Declaration – For All Providers

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 HP Enterprise Services. 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. This Application and corresponding contract must be dated within the last 60 days.

The person signing below is the *(check all that apply)*: ☐ Provider ☐ Authorized administrator ☐ Business owner

Signature: _____ Date: _____

Print Name: _____

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

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 there under 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 health care 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, statues, 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 C.F.R §§ 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 (HIPAA) of 1996 and adopted hereunder contained in 45 CFR 160, 162 and 164.

1.4 To obtain and maintain all licenses, permits, certification, registration and authority necessary to do business and render service 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 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 1396a(a)(68) of Title 42, United States Code, 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 422.276(3).

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, Nevada Check Up Manual and Nevada Medicaid Billing Manual. 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 after the disqualification date.

2.6 The parties agree that any excessive payment to a Provider 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 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 is 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 in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Accordingly, the Division complies with the HIPAA Privacy Regulations promulgated in 45 CFR 160 and 164. Division health care providers will furnish protected health information about potential or current Division recipients without requiring the individual's authorization in accordance with 45 CFR 164.506 when requested by the Division for treatment, payment or health care operations.

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 service 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 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 medical 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 must comply with the disclosure of ownership or control requirement of 42 CFR Part 455, Subpart B, as now in effect or as may be amended.

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 in 45 CFR 160. Providers who are not covered entities must inform the Division and execute a business associate agreement or other appropriate agreement within 10 business days to protect and secure the privacy of all Recipients' personal 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. The Division may terminate this Contract immediately when the Division receives notification that the Provider no longer meets the professional credential/ licensing requirements.

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 284.173 apply and specifically NRS 284.173.3(b).

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.

To continue as a Nevada Medicaid Provider, a new Enrollment Application and Nevada Provider Contract must be submitted 36 months from the date of DHCFP approval on the signature page of this Contract.

Provider

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: _____