

Personal Care Services Provider Training

Provider Types 30 and 83



Nevada Medicaid Provider Training

2019



Objectives



Objectives

- Locate Medicaid Policy
- Navigate to Web Announcements
- Locate Prior Authorization Forms
- Login to the Electronic Verification System (EVS) secure Provider Web Portal
- Successfully Submit a Prior Authorization
- View Prior Authorizations
- Locate Billing Information
- Access the Search Fee Schedule and DHCFP Rates Unit
- Submit Claims using Direct Data Entry via the EVS secure Provider Web Portal



Medicaid Website

Medicaid Website

www.medicaid.nv.gov

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

Contact Us [Twitter](#) [Facebook](#) [DHCFP Home](#)

Search

Providers EVS Pharmacy Prior Authorization Claims Quick Links Calendar

Announcements Latest News

[Web Announcement 1834](#)
Modernization: Attention All Providers: New MMIS is Now Live!

[Web Announcement 1833](#)
Modernization Known System Issue: Date of Decision for Recipient Eligibility Not Currently Available

[Web Announcement 1832](#)
Modernization: Prior Authorization and Claims Webinars in February

[Web Announcement 1831](#)
Modernization: Attention Out-of-State Providers: Use the Online Provider Enrollment Tool to Enroll in Nevada Medicaid

[Web Announcement 1830](#)
Modernization: Attention All Providers: New MMIS is Going Live!

[View All Web Announcements](#)

Welcome

New, Modernized Medicaid Management Information System

- Will Improve Electronic Claims Submission
- Will Enhance Electronic Options
- Will Implement in Early 2019

CLICK HERE FOR MORE DETAILS

Nevada Medicaid

Welcome to the Nevada Medicaid and Nevada Check Up Provider Web Portal. Through this easy-to-use internet portal, healthcare providers have access to useful information and tools regarding provider enrollment and revalidation, recipient eligibility, verification, prior authorization, billing instructions, pharmacy news and training opportunities. The notifications and web announcements keep providers updated on enhancements to the online tools, as well as updates and reminders on policy changes and billing procedures.

Thank you for your participation in Nevada Medicaid and Nevada Check Up.

Notifications

Claim adjustment and void transactions are temporarily unavailable on the portal. This message will be removed when they are available. We apologize for any inconvenience.

Known Modernization System Issues-Click HERE

Attention Waiver Providers: Submit Claims with the Prior Authorization Number [See [Web Announcement 1806](#)]

PASRR can be accessed using the following link: <https://pasrrprod.medicaid.nv.gov/wps/portal/usp>

Due to portal unavailability, for PAs due on January 29, 2019, providers will be given one extra day to submit their PA. PAs due on January 28, 2019 were already given a 3 business-day leniency.

Provider Links

- [Billing Information](#)
- [E-Prescribing Forms](#)
- [Provider Enrollment](#)
- [Provider Newsletters](#)
- [Provider Training](#)

Scheduled Site Maintenance

During the scheduled site maintenance window the Provider Web Portal will be unavailable. The table below shows the regularly scheduled maintenance window. All times will be in the Pacific time zone.

Featured Links

- [Authorization Criteria](#)
- [DHCFP Home](#)
- [EDI Information](#)
- [EVS User Manual](#)
- [Modernization Project](#)
- [Online Provider Enrollment](#)
- [Provider Login \(EVS\)](#)
- [Prior Authorization](#)
- [Search Fee Schedule](#)
- [Search Providers](#)
- [Claims](#)
- [Trading Partner](#)

EVS

EVS is available 24 hours a day, seven days a week except during the scheduled weekly maintenance period.

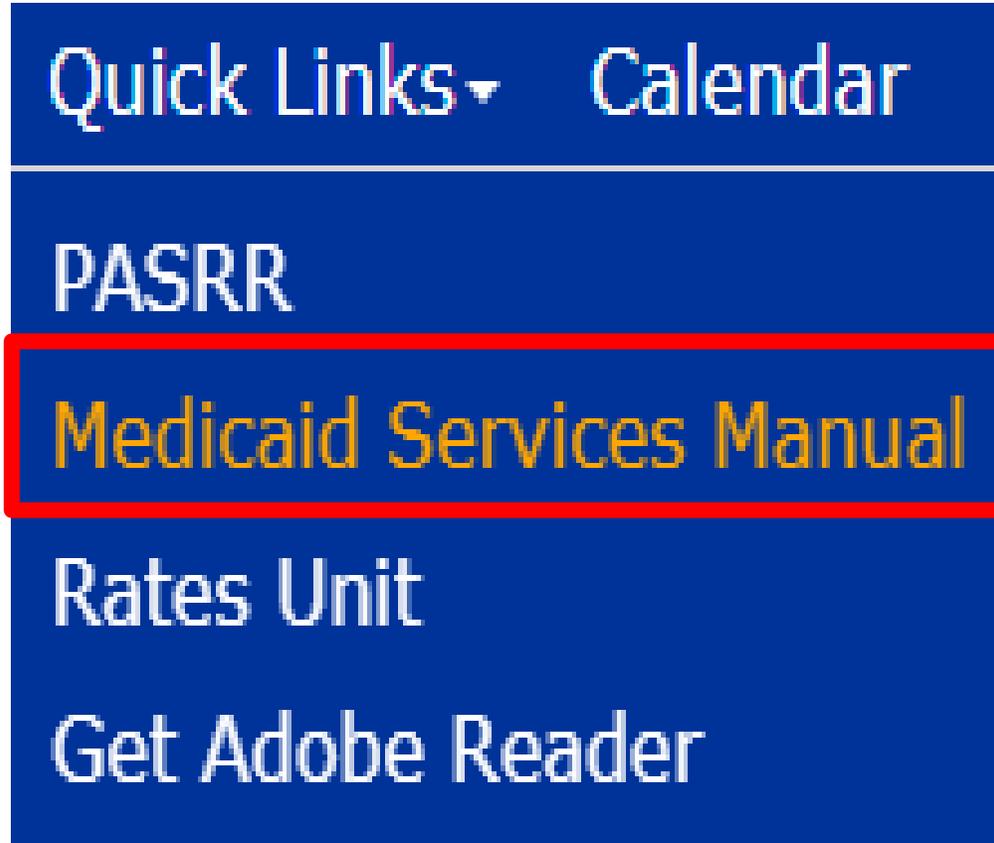
System Requirements

To access EVS, user must have internet access and a computer with a web browser. (Microsoft Internet Explorer 9.0 or higher recommended)



Medicaid Services Manual (MSM)

Locating Medicaid Services Manual (MSM)



- Step 1: Highlight “Quick Links” from top blue tool bar at www.medicaid.nv.gov.
- Step 2: Select “Medicaid Services Manual” from the drop-down menu.
- Note: MSM Chapters will open in new webpage through the DHCFP website.

Locating Medicaid Services Manual, continued

Meetings, Workshops,
Public Notices

CaseloadData

**Medicaid Services
Manual**

To do a keyword search on any .PDF document, click Cntrl F to generate the search box. Enter the desired search word and click Previous or Next.

- Medicaid Services Manual - Complete
- 100 Medicaid Program
- 200 Hospital Services
- 300 Radiology Services
- 400 Mental Health and Alcohol and Substance Abuse Services
- 500 Nursing Facilities
- 600 Physician Services
- 700 Reimbursement, Analysis and Payment
- 800 Laboratory Services
- 900 Private Duty Nursing
- 1000 Dental
- 1100 Ocular Services
- 1200 Prescribed Drugs
- 1300 DME Disposable Supplies and Supplements
- 1400 Home Health Agency
- 1500 Healthy Kids Program
- 1600 Intermediate Care for Individuals with Intellectual Disabilities
- 1700 Therapy
- 1800 Adult Day Health Care
- 1900 Transportation Services
- 2000 Audiology Services
- 2100 Home and Community Based Waiver for Individuals with Intellectual Disabilities
- 2200 Home and Community Based Waiver for the Frail Elderly
- 2300 Waiver for Persons with Physical Disabilities
- 2400 Home Based Habilitation Services
- 2500 Case Management
- 2600 Intermediary Service Organization
- 2700 Certified Community Behavioral Health Clinic
- 2800 School Based Child Health Services
- 3000 Indian Health
- 3100 Hearings
- 3200 Hospice
- 3300 Program Integrity
- 3400 Tribal Health Services
- 3500 Personal Care Services Program
- 3600 Managed Care Organization
- 3800 Care Management Organization
- 3900 Home and Community Based Waiver for Assisted Living
- Addendum

- Select “2600 Intermediary Service Organization”
- Select “3500 Personal Care Services Program”
- All providers are responsible for knowing the information in Chapter 100 “Medicaid Program” and the Addendum
- From the next page, always make sure to select the “Current” policy



Viewing Web Announcements

Web Announcements

The screenshot shows the Nevada Department of Health and Human Services website. The header includes the department logo and name, along with navigation links for 'Providers', 'EVS', 'Pharmacy', 'Prior Authorization', 'Quick Links', and 'Calendar'. A search bar is located in the top right. The main content area features a large banner for 'New Provider Orientation' with a 'REGISTER TODAY' button. Below the banner is a list of topics: Introduction to Nevada Medicaid, Website Navigation, Getting Started on EVS - Access to the Provider Portal, EDI System - Enrollment Training, and Overview of Claims Process. To the left of the banner is a sidebar with 'Announcements' and 'Latest News' sections, listing several web announcements with dates and brief descriptions. A red box highlights the 'View All Web Announcements' link at the bottom of the announcements list. To the right of the banner is a 'Notifications' section with three items regarding the selection of LIBERTY Dental Plan, the PWP upgrade, and the website update.

- Select “View All Web Announcements” to view Web Announcements

Web Announcements, continued

The screenshot shows the Nevada Medicaid Provider Portal interface. At the top right, there is a search box with a magnifying glass icon. Below the search box is a navigation bar with 'Quick Links' and 'Calendar'. The main content area is titled 'Announcements & Newsletters'. On the left side of this area, there is a 'Search by Category:' dropdown menu. The dropdown menu is open, showing a list of categories: 'All Announcements', 'Inpatient', 'Outpatient', 'Pharmacy', 'Dental/Orthodontia', 'Vision', 'Physician/Medical', 'Personal Care Services (PCS)', 'Durable Medical Equipment (DME)', 'Behavioral Health', 'Waiver Providers', and 'All Providers'. A red box highlights this dropdown menu. Below the dropdown menu is a table of announcements. The table has columns for 'Date', 'ID', and 'Topic'. The first row of the table is highlighted in blue. To the right of the table, there is a 'Notifications' section with a red header, containing several text-based announcements. Below the notifications is a 'Provider Links' section with a blue header and a link for 'Billing Information'. A red arrow points from the search box at the top right to the 'Search by Category:' dropdown menu.

Date	ID	Topic
Oct 02, 2017		Legislative Assembly Bill AB473 Extends NRS 422.4025 Sunset until June 30, 2019
Sep 27, 2017		Payerpath Claim Submission Training for October 2017
Sep 26, 2017		Medicaid Services Manual Chapter 3800 Updated
Sep 25, 2017		Attention Hospice Provider Types 64 and 65: Do Not Include Prior Authorization Number on Claim Forms
Sep 21, 2017		Attention All Providers: Claims for ICD-10 Diagnosis Code A68.54 Denying in Error
Sep 21, 2017	1447	Updated Nevada Medicaid Informational Bulletin on Medications and Services for Substance Use Disorders
Sep 19, 2017	1446	Behavioral Health Provider Types 14 and 82 Invited to Take DHCFF Provider Training Survey
Sep 19, 2017	1445	Attention Practitioners, Ambulatory Surgical Centers, Outpatient Hospitals and Durable Medical Equipment Providers: Reminder Regarding National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs)
Sep 19, 2017	1444	Attention Provider Type 32 (Ambulance, Air or Ground): Urgent Notification Regarding Claims for Ambulance Services Denied as Duplicate Claims
Sep 14, 2017	1443	Influenza and Polio Vaccine Procedure Codes Opened for Billing
Sep 11, 2017	1442	New Managed Care Dental Benefits Administrator Selected
Sep 11, 2017	1441	Reminder Regarding Durable Medical Equipment (DME) Procedure-to-Procedure (PTP) Edits for Procedure Code Combinations
Sep 11, 2017	1440	Reminder: Wheelchair Repair Form (FA-1D) Must Be Filled Out Completely
Sep 08, 2017	1439	Update Regarding Some Claims that Cut Back or Denied in Error with Edit Code 0476
Sep 05, 2017	1438	Attention Provider Type 22 (Dentist): Claims for Dental Codes D3110, D3120, D3220 and D8660
Sep 05, 2017	1437	Attention All Providers: Important Reminders Regarding Online Prior Authorizations
Sep 01, 2017	1436	Attention Provider Types 56 (Inpatient Rehabilitation and Long Term Acute Care (LTAC) Specialty Hospitals) and 75 (Critical Access Hospital (CAH), Inpatient): Notification Regarding Claims for Room & Board Revenue Codes 113 and 129
Aug 30, 2017	1435	Provider Types Allowed to Bill Secondary Diagnosis Codes
Aug 29, 2017	1434	Upcoming Nevada Medicaid Community Paramedicine Provider Training and Enrollment Sessions
Aug 25, 2017	1433	Payerpath Claim Submission Training for September 2017
Aug 24, 2017	1432	Attention Provider Type 17, Specialty 181 (FQHC): Notification Regarding Dental Services Claims for Medicaid Managed Care Recipients

- Results can be narrowed selecting a category from the drop-down menu or utilizing the “Ctrl F” to bring up a Search Box

Web Announcements, continued

Web Announcement 1463

Recipient's Eligibility Changes from Managed Care Organization (MCO) to Fee-for-Service (FFS)

- Submit the most current authorization letter that specifies the dates of service and the number hours approved by the MCO.
- Submit an FA-24 marked as “Information Only” and on lines beneath state that this recipient’s eligibility has now changed from an MCO to Medicaid FFS.



October 26, 2017

Web Announcement 1463

Attention Personal Care Services Provider Types 30 and 83: **Instructions Regarding Recipient Eligibility Transfers from Managed Care Organization to Fee-for-Service**

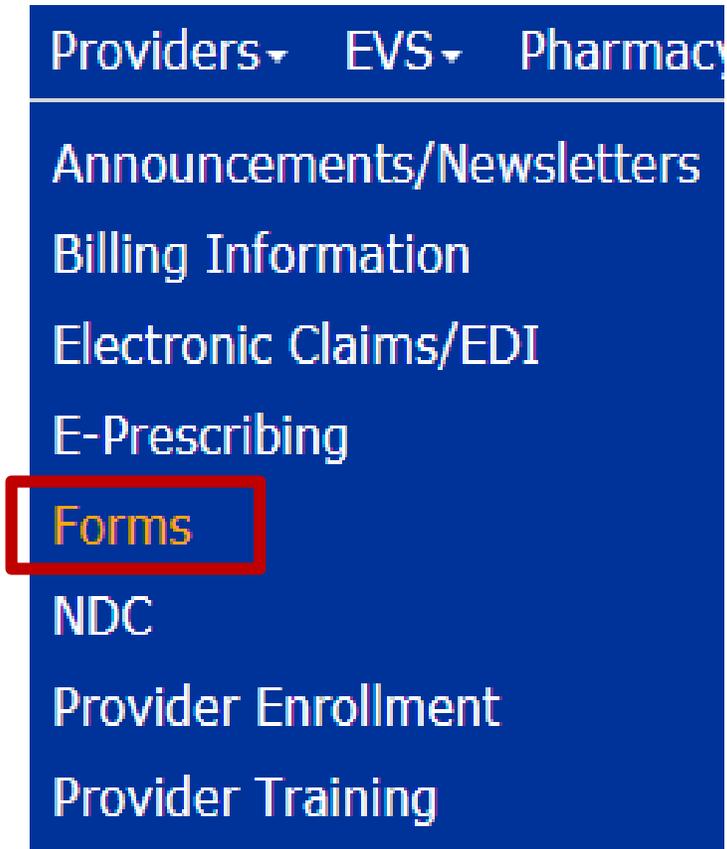
When a prior authorization (PA) request for Personal Care Services (PCS) has been approved by one of the Managed Care Organizations (MCOs) and the recipient's eligibility subsequently transfers to Fee-for-Service (FFS), Nevada Medicaid will authorize PCS services in order to ensure continuity of care while awaiting completion of an in-home functional assessment (FASP). PCS providers please upload or submit by fax an [FA-24 \(Authorization Request for Personal Care Services \(PCS\)\)](#) with the Significant Change in Condition checkbox selected, along with a copy of the approved authorization from the MCO. This MCO documentation must include the service type (PCS), approved dates of services and authorized units. The MCO documentation must be uploaded as a separate attachment from the FA-24 when submitted through the Provider Web Portal.

Upon receipt of the PA request and required documentation, Nevada Medicaid will issue a temporary authorization at the level of service provided by the MCO and obtain an in-home functional assessment. Once the in-home functional assessment has been completed, the provider will be notified of the outcome. Failure to include the required MCO authorization will result in a delay in processing the request for authorization of continued PCS services.



Prior Authorization Forms

Locating Prior Authorization Forms



- Step 1: Highlight “Providers” from top blue tool bar.
- Step 2: Select “Forms” from the drop-down menu.

Locating Prior Authorization Forms, continued

FA-24	Personal Care Services (PCS) Prior Authorization PCS Assessment Forms
FA-24 Instructions	Personal Care Services (PCS) Prior Authorization Instructions
FA-24A	Coordination of Hospice and Waiver or Personal Care Services (PCS)
FA-24A Instructions	Coordination of Hospice and Waiver or Personal Care Services (PCS) Instructions
FA-24B	Legally Responsible Individual (LRI) Availability Determination for the Personal Care Services Program
FA-24C	Authorization Request for Self-Directed Skilled Services
FA-24C Instructions	Authorization Request for Self-Directed Skilled Services Instructions
FA-24T	Personal Care Services Recipient Request for Provider Transfer

- While on the “Forms” page, locate the appropriate FA-24 form and its instructions, if applicable.
- Make sure to follow the instructions for each required form.
- All active forms are fillable for easy uploading for PA submission online.
- Any form that is not legible will not be accepted.
- **Only Physical Therapists/Occupational Therapists (PT/OT) will use the “PCS Assessment Forms” which are also known as the Functional Assessment Service Plan (FASP).**

Authorization for Personal Care Services (PCS) – FA-24

- Indicate the Date of Request at the top of the form.
- Section 1: To be filled out by Nevada Medicaid Only.
- Section 2: Indicate the purpose of the request.
- Section 3: Contact information for the recipient and agency information.
- The Legally Responsible Individual (LRI) portion must be completed and marked Yes or No, and when Yes, submit form FA-24B.

When the recipient’s Eligibility Changes from Managed Care Organization (MCO) to Fee-for-Service (FFS):

- Submit the most current authorization letter that specifies the dates of service and the number of hours approved by the MCO.
- Submit an FA-24 marked as “Information Only” and on lines beneath state that this recipient’s eligibility has now changed from an MCO to Medicaid FFS.

Nevada Medicaid and Check Up
Authorization Request for Personal Care Services (PCS)

Upload this request through the Provider Web Portal.

Questions? Call: (800) 525-2395

For information on completing this form, see the instructions online at www.medicaid.nv.gov (select “Forms” from the “Providers” menu, then click on Form Number FA-24-I).

DATE OF REQUEST: ___/___/___

SECTION 1: FOR NEVADA MEDICAID USE ONLY		

SECTION 2: PURPOSE OF REQUEST		
<input type="checkbox"/> Update Visit (annual)	<input type="checkbox"/> Information Only	<input type="checkbox"/> Cancel Authorization
<input type="checkbox"/> Significant Change in Condition		Agency's last date of service: ___/___/___
<input type="checkbox"/> Temporary Service Authorization		Reason: <input type="checkbox"/> Recipient Ineligible
<input type="checkbox"/> One-Time Service		<input type="checkbox"/> Recipient Expired
		<input type="checkbox"/> Other: _____

SECTION 3: CONTACT INFORMATION			
RECIPIENT INFORMATION			
Last Name:		First Name:	
Recipient Medicaid ID:		Date of Birth:	
Translator Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		Language:	
Address:			
City:	State:	Zip Code:	Phone:

PCS AGENCY INFORMATION			
PCS Agency Name:		City:	
NPI/API:	Phone:	Fax:	

LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION (if applicable*)
**Complete this section if the definition of LRI is met. Individuals who are legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney (POA)], and parents of minor recipients, including stepparents, foster parents and adoptive parents. Attach a completed copy of form FA-24B (LRI Availability Determination for the Personal Care Services Program) with any submitted request when the recipient resides with an LRI. It is the responsibility of the provider to attach a current work note (availability) or a copy of the permanent disability form or an updated disability form if the disability was/is temporary (capability). If this section is not addressed and appropriate paperwork not attached, this request will be denied and the form will be returned to the provider. See the FA-24 Instructions on the Forms webpage at www.medicaid.nv.gov for additional instructions regarding this section.*

Does recipient have an LRI? (see definition above) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
LRI Name:		Phone:	
Relationship to Recipient:		Does LRI reside with recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the LRI also on the PCS Program: <input type="checkbox"/> Yes <input type="checkbox"/> No		Receives _____ hrs/wk	
LRI Employment Status: <input type="checkbox"/> Employed # Hrs/wk: _____ Days Off: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Other			

Authorization for Personal Care Services (PCS) – FA-24, continued

- Fill out Recipient Information on top and provide any alternative contact information.
- Section 4: PCS provider will need to indicate only 1 Diagnosis Code.
- Section 5: Indicate any additional information that is not notated on the form. Information must be clear and specific as to why this service is being requested.
- Section 6: To be filled out by person requesting the services being rendered.

Nevada Medicaid and Check Up
Authorization Request for Personal Care Services (PCS)

Recipient Name:		Recipient Medicaid ID:	
ALTERNATE CONTACT INFORMATION <i>(An alternate contact is needed for scheduling purposes in the event the recipient and/or LRI are unavailable.)</i>			
Alternate Contact Name:			
Phone:		Relationship to Recipient:	
Can this person be contacted in case we are unable to contact recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION 4: DIAGNOSES AND INCIDENTS			
DIAGNOSIS/DIAGNOSES AFFECTING THE INDIVIDUAL'S ABILITY TO COMPLETE TASKS:			
Is anyone else in the home receiving PCS at this time? <input type="checkbox"/> Yes - Who: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			
INCIDENTS, INCLUDING A SUMMARY OF ALL REPORTED SERIOUS OCCURRENCES, WITHIN PAST 90 DAYS <i>(Check all that apply. The Summary of Reported Serious Occurrences section is mandatory.)</i>			
<input type="checkbox"/> Hospitalization Discharged date or anticipated discharge date: _____			
<input type="checkbox"/> Recent Fall		<input type="checkbox"/> Surgery Type: _____	<input type="checkbox"/> Loss of non-paid caregiver
<input type="checkbox"/> New Medical Condition/Diagnosis <i>(specify):</i> _____			
<input type="checkbox"/> Addition or loss of other services <i>(specify):</i> _____			
<input type="checkbox"/> Summary of Reported Serious Occurrences: _____			
<input type="checkbox"/> No Serious Occurrences			
SECTION 5: COMMENTS <i>(General comments that would assist an assessor in completing an accurate assessment; include reason for request):</i>			
SECTION 6: PERSON COMPLETING/SUBMITTING THIS REQUEST <i>(This person will be contacted with questions or if additional information is needed to process this request.)</i>			
Name:		Phone:	

The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received. This referral/authorization is not a guarantee of payment.

Legally Responsible Individual (LRI) – FA-24B

- Follow instructions located at the top of the form.
- As of December 1, 2017, this form is required when applicable.
- This form will be used to determine if an LRI is unavailable or incapable of providing PCS services.
- Not providing completed LRI information could delay authorization for the following year of PCS services.

LRI:

- A spouse.
- A parent, foster parent or step parent of a minor child and legal guardians who obtained such through a legal proceeding.
- A recipient’s power of attorney (POA) is not a legally responsible individual.
- A legally responsible individual can never be the Personal Care Attendant (PCA).

Please see page 2 of this form for LRI definition.

SECTION 1: DATE OF REQUEST: ____/____/____	
SECTION 2: RECIPIENT REQUESTING TO BEGIN OR CONTINUE PERSONAL CARE SERVICES	
Recipient Name: _____	
Recipient ID: _____	Date of Birth: _____
SECTION 3: LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION (Submit one form for each LRI)	
LRI Name: _____	Phone: _____
SECTION 4: LRI RELATIONSHIP	
Check the relationship the LRI identified in Section 3 has to the recipient: (If this is a guardianship, attach a copy of the guardianship papers)	
Recipients 18 years and older: A. <input type="checkbox"/> Spouse B. <input type="checkbox"/> Legal Guardian	
Recipients under 18 years of age: C. <input type="checkbox"/> Parent D. <input type="checkbox"/> Step Parent E. <input type="checkbox"/> Foster Parent F. <input type="checkbox"/> Legal Guardian	
SECTION 5: LRI UNAVAILABLE OR NOT CAPABLE OF PROVIDING CARE	
Identify the reason the LRI identified in Section 3 is unavailable or not capable of providing care. (See page 2 for definitions and required documents)	
<input type="checkbox"/> Unavailable to provide the recipient with necessary medical support due to the LRI’s work or school schedule . Attach copy of proof of employment or school. If this option is checked, proceed to Section 7 to submit the form.	
<input type="checkbox"/> Incapable to provide the recipient with necessary medical support due to LRI’s own health condition. If this option is checked, complete section 6.	
SECTION 6: LRI LIMITATIONS (A licensed healthcare professional must complete this section)	
Enter the name of the LRI identified in Section 3: _____	
Identify specific limitations of the LRI:	
The LRI has: <input type="checkbox"/> No limitations to provide care.	
<input type="checkbox"/> Cognitive limitations (cannot learn care tasks, memory deficits)	
<input type="checkbox"/> Physical limitations (cannot render care such as ability to lift recipient)	
<input type="checkbox"/> Significant health or emotional issues that directly prevent or interfere with provision of care	
Limitations: Describe in detail specific limitations and/or issues: _____	

The limitations and/or issues described above are: <input type="checkbox"/> Temporary through _____ (date) <input type="checkbox"/> Permanent	
Date LRI was last seen in the healthcare professional’s office: _____	
LRI’s Physician Name (please print): _____ Contact Phone: _____	
LRI’s Physician Signature: _____ Date: _____	
Credentials of healthcare provider signing the form: _____	
SECTION 7: NOTES	
SECTION 8: SUBMIT THIS FORM	
Submit this form through the Provider Web Portal using the prior authorization number referenced on the related Notice of Decision. For questions regarding this form, call: (800) 525-2395	

Legally Responsible Individual (LRI) – FA-24B, continued

– Additional Information is listed on Page 2.

Nevada Medicaid and Nevada Check Up
Legally Responsible Individual (LRI)
Availability Determination For the Personal Care Services Program

Submit one form for each LRI.

NOTE: This form is not required but may be used for determining if an LRI is unavailable or incapable of providing Personal Care Services (PCS).

Purpose: This form is a tool to assist in determining whether a Medicaid recipient's LRI is available and capable in assisting the recipient with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs).

Definitions:

Legally Responsible Individual (LRI) - Individuals who are legally responsible to provide medical support. These individuals include: spouses of recipients, legal guardians, and parents of minor recipients, including stepparents, foster parents and adoptive parents. Power of Attorney is not an LRI.

Available Caregiver - An LRI who is physically present in the recipient's home or is physically present with the recipient while in settings outside the home (including employment sites) at the time necessary maintenance, health/medical care, education, supervision, support services, and/or assistance with ADLs and IADLs is needed by a Medicaid recipient.

Capable Caregiver - An LRI who can safely manage carrying out necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of needed ADLs and IADLs.

Policy: Per Nevada Medicaid Services Manual, Chapter 3500 and 2600, **an LRI may not be reimbursed for providing PCS.** The LRI must provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury, or not available, due to hours of employment and/or school attendance, to provide services. Additional documentation may be required on a case-by-case basis. Without this verification, PCS will not be authorized.

Instructions for LRI: Complete the date of request, the "Recipient Information" and the "Legally Responsible Individual (LRI) Information" sections. Ask your physician to complete the "LRI Limitations" Section 6.

Instructions and Required Documents to Demonstrate LRI's Limitations

If LRI is incapable of safely providing the recipient with medical support due to a **health condition:**

Instructions: Section 6 on page 1 must be completed by the primary care physician before this form is returned to Nevada Medicaid.

If LRI is unavailable to provide the recipient with necessary medical support due to **work schedule:**

- Instructions:** Provide verification of LRI's employment schedule. The verification MUST:
- Be written on company letterhead or other stationery which contains the employer name;
 - List your specific days of work and hours of work on each day;
 - Be signed by a human resources representative or your manager;
 - Include the professional title of the person signing the verification; AND
 - Contain contact information for the person signing the verification.

If LRI is unavailable to provide the recipient with necessary medical support due to **school schedule:**

- Instructions:** Provide verification of LRI's school schedule. The verification MUST:
- List the day, time and duration of each class;
 - Be signed by an authorized school representative;
 - Include the professional title of the person signing the verification; AND
 - Contain contact information for the person signing the verification.

The Notes Section 7 is available for providers to communicate any special requests or additional information the Nevada Medicaid reviewers may find helpful.

This waiver is not a guarantee of services. Service provision is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.

Authorization Request for Self-Directed Skilled Services – FA-24C

- *This form is to be used only by Provider Type 83.*
- Fill out form in its entirety.
- Indicate **Date** of Request.
- Section 1:
 - Initial – No current authorization for self-directed skilled services.
 - Reauthorization – previous request for Medically Necessary Skilled Services has changed within an authorized period or for annual request for authorization.
 - Indicate Date of Request.
- Personal Care Representative (PCR) cannot be the Personal Care Attendant (PCA).

Nevada Medicaid and Check Up
 Authorization Request for Self-Directed Skilled Services
 (For use only by Provider Type 83 – Intermediary Service Organization – ISO)

Upload this request through the Provider Web Portal. Questions? Call: (800) 525-2395

DATE OF REQUEST: ____ / ____ / ____

NOTES:			
SECTION 1: Contact Information			
PURPOSE OF REQUEST			
<input type="checkbox"/> Initial <input type="checkbox"/> Reauthorization			
RECIPIENT INFORMATION			
Last Name, First Name, Middle Initial:			
Recipient's Medicaid ID:			Date of Birth:
Address:			
City:	State:	Zip Code:	Phone:
Check the appropriate box:			
<input type="checkbox"/> The recipient has no Legally Responsible Individual (LRI) and is able to self-direct their own care. <i>(If this option is checked, complete Section 4; do not complete Section 5)</i>			
<input type="checkbox"/> The recipient is not able to direct their own care, and the LRI or Personal Care Representative understands that they must be present to direct the care while it occurs and cannot be the paid caregiver for the recipient. <i>(If this option is checked, complete Section 5; do not complete Section 4)</i>			
LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION		<i>Complete this section if this definition of an LRI is met: Individuals who are legally responsible to provide medical support, including spouses of recipients, legal guardians [not power of attorney (POA)], and parents of minor recipients, including stepparents, foster parents and adoptive parents.</i>	
<i>If LRI is not available or not capable, complete and attach form FA-24B (LRI Availability Determination for the Personal Care Services Program)</i>			
LRI Name (if applicable):			Relationship to Recipient:
LRI Address:			
City:	State:	Zip Code:	Phone:
PERSONAL CARE REPRESENTATIVE INFORMATION		<i>Complete this section if recipient is unable to direct his/her own care and has no legally responsible individual available or capable to perform or direct the care. The Personal Care Representative cannot be the Personal Care Assistant.</i>	
Contact Name (other than recipient):			Relationship to Recipient:
Contact Address:			
City:	State:	Zip Code:	Phone:
ISO PROVIDER INFORMATION			
ISO Provider Name:			
NPI/API:			
Phone:			Fax:

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 2 must be completed by the Physician, Physician’s Assistant (PA) or Advanced Practice Registered Nurse (APRN).

SECTION 2: Request for Medically Necessary Skilled Services
(Must be completed by a Physician, Physician’s Assistant (PA) or Advanced Practice Registered Nurse (APRN))

RECIPIENT *(Last Name, First Name, Middle Initial):*

I, the undersigned, do hereby certify the following statements about my patient (listed above) are true to the best of my knowledge:

- The services I am requesting are simple and would usually be performed by the individual if not for the patient’s disability.
- I have determined that my patient’s condition is stable and predictable.

The personal care assistant agrees to refer the patient back to my attention when:

1. The condition of the patient changes or a new medical condition develops;
2. My patient or their personal care or legal representative becomes unable to self-direct the services/care authorized;
3. The progress or condition of the patient after the provision of a service is different than expected;
4. An emergency situation develops;
5. Any other situation described by me occurs: (describe) _____

I will complete a new FA-24C for the following reasons:

- The patient/recipient’s condition changes in regard to stable and predictable.
- Annually.

Note: Per NRS 629.091, a provider of health care who determines in good faith that a personal care assistant has complied with and meets the requirements of NRS 629.091 is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.

I hereby authorize a personal care assistant who has met the requirements as outlined in NRS 629.091 to perform the following service(s) under the direction of my patient or their personal care or legal representative. I authorize these services to continue until *(date)* _____, at which time I wish to have my patient’s condition re-evaluated by myself or by _____. The services listed must address a medical need, i.e., wound care, bowel care with suppository or digital stimulation, etc., and describe the complexity of the recipient’s care and the frequency of the skilled intervention.

	Frequency of Service	Instructions/Steps to Complete the Task(s)
Skilled Service: <i>Wound Care</i> Diagnosis: <i>Decubitus Ulcer Stage 1</i>	<i>EXAMPLE ONLY</i> 1xDay	<i>Clean with H2O2, apply prescription ointment, apply duoderm</i>
1 Skilled Service: Diagnosis:		
2 Skilled Service: Diagnosis:		

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Fill out recipient information at the top of the page.
- If there are more than 10 skilled services needed, complete additional Section 2.
- Health care provider **must** sign to certify the statements are true.
- If any rows have been left blank, the health care provider who is signing the form must cross out the blank rows.

SECTION 2: Request for Medically Necessary Skilled Services (continued) <i>(Must be completed by a Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN))</i>		
RECIPIENT (Last Name, First Name, Middle Initial):		
	Frequency of Service	Instructions/Steps to Complete the Task(s)
3	Skilled Service:	
	Diagnosis:	
4	Skilled Service:	
	Diagnosis:	
5	Skilled Service:	
	Diagnosis:	
6	Skilled Service:	
	Diagnosis:	
7	Skilled Service:	
	Diagnosis:	
8	Skilled Service:	
	Diagnosis:	
9	Skilled Service:	
	Diagnosis:	
10	Skilled Service:	
	Diagnosis:	
Health Care Provider's Signature and Attestation: I certify the statements on this form are true and certify that I have read NRS 629.091 (reproduced in Section 7 of this form). Health Care Provider: Please cross out any rows above that have been left blank.		
Signature:		Date:
Printed Name:		Title:

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 3 must be completed by a licensed health care provider.
- The name of the PCA must be on the form.
- Skills that the PCA can perform must be listed.
- Page must be signed by a licensed health care provider acting within the scope of their licensure.

Note: Complete Section 3 for each competent Personal Care Attendant. Each time a new PCA is hired to perform skilled services for this recipient during an approved authorization period, the new PCA must sign the existing Section 6 and complete a new Section 3. All currently authorized PCAs must have a completed Section 3 and Section 6 on file with the ISO.

Section 3: Confirmation of PCA Competency <i>(This Section must be completed by a licensed health care provider as outlined in NRS 629.091 within the scope of their licensure)</i>	
RECIPIENT (Last Name, First Name, Middle Initial):	
<i>Complete this section for each authorized Personal Care Assistant. Each time a new PCA is hired to perform skilled services for this recipient during an approved authorization period, the new PCA must sign the existing Section 6 and complete a new Section 3. All currently authorized PCAs must have a completed Section 3 and Section 6 on file with the ISO.</i>	
Name of PCA:	
Skilled services this PCA may perform for the above listed recipient: <i>(Do not list non-skilled services, for example, mouth care, incontinence cleanup, bathing and transferring. The skilled services listed below must be in the Request for Medically Necessary Skilled Services.)</i>	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
I have reviewed with the Personal Care Assistant the reasons outlined in Section 2 for when the patient should be referred back to the health care provider requesting services.	
Note: Per NRS 629.091, a provider of health care who determines in good faith that a personal care assistant has complied with and meets the requirements of NRS 629.091 is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.	
I, the undersigned health care provider, have determined that the above listed personal care assistant has the knowledge, skill and ability to competently perform the services listed above.	
Health Care Provider's Signature	
Signature:	Date:
Printed Name:	Title:

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- If the recipient is able to self-direct their own care, complete Section 4. Section 4 must be read and understood by the recipient.
 - If the recipient is unable to self-direct their own care, do not complete Section 4, and move to Section 5.
- ISO provider must sign and date the section.

Section 4: Recipient Agreement (for recipients who are capable of directing their own care)	
RECIPIENT (Last Name, First Name, Middle Initial):	
<i>Complete this Section only if the recipient is able to direct their own care; if the recipient is unable to direct their own care, please leave this section blank and complete Section 5.</i>	
I, the undersigned Recipient, do hereby attest the following:	
I have chosen to direct the delivery of the specific medical, nursing or home health care services through an ISO as defined by NRS 629.091 (reproduced in Section 7 of this form).	
I have the ability and desire to self-direct my care, to choose the ISO provider, to select personal care assistants (PCA), to arrange the PCA's schedule and to direct the PCA in the delivery of specific medical, nursing or home health care services.	
I am capable of making choices about my specific medical, nursing or home health care services, understanding the impact of these choices and assuming responsibility for these choices. I am capable of directing all the tasks related to the delivery of my self-directed skilled services.	
I will comply with all Medicaid policies and procedures as outlined in the Medicaid Services Manual, Chapters 100, 2600 and 3300.	
I will direct the PCA to provide only the specific medical, nursing or home health care services approved in this authorization.	
I agree to hold the State of Nevada harmless from any such liability whatsoever for any injuries, damages, loss, whether physical or financial, associated with or resulting from self-directing my skilled services.	
I am responsible for developing a back-up plan and for obtaining back-up coverage in the absence of a regularly scheduled PCA.	
The ISO is the employer of record for PCAs.	
I am responsible for reviewing and verifying service delivery records to ensure the Request for Medically Necessary Skilled Services has been followed, thereby authorizing Medicaid to be billed. Misrepresentation within these documents constitutes fraud per NRS 422.540, attached, and will be referred to the Surveillance and Utilization Review (SUR) Unit for investigation and appropriate action.	
I am responsible for selecting, scheduling and managing all PCAs who will provide my services according to the Request for Medically Necessary Skilled Services.	
A newly completed FA-24C must be submitted annually for consideration of continued services.	
I may discontinue the option to self direct my skilled services at any time and receive my specific medical, nursing or home health care services through a Home Health Agency, if eligible to do so and there is a Home Health Agency available to provide care.	
I agree to contact my physician if any of the following occur: <ul style="list-style-type: none"> • My condition changes or a new medical condition develops; • I become unable to direct the services/care authorized; • My progress or condition after the provision of services is different than expected; and/or • An emergency situation develops. 	
Recipient's and ISO Provider's Signatures	
Recipient's Signature:	Date:
ISO Provider Name: (please print)	
ISO Provider Signature:	Date:

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 5 is to be filled out only if the recipient is unable to direct their own care.
 - Do not complete Section 4.
- The Personal Care Representative (PCR) cannot be the PCA.
- This section must be completed by:
 - LRI & directing care, but unable to perform the care and FA-24B is on file or
 - PCR designated due to no LRI or
 - PCR designated by the LRI due to the LRI being unavailable and FA-24B is on file
- ISO provider must sign and date the section.

Section 5: Personal Care Representative Agreement	
RECIPIENT (Last Name, First Name, Middle Initial):	
<i>Complete this section only if the recipient is unable to direct his/her own care and a Personal Care Representative (PCR) has been appointed. The Personal Care Representative cannot be the Personal Care Assistant.</i>	
Name of Personal Care Representative:	
I, the undersigned Personal Care Representative, do hereby attest the following:	
<p>_____ (name of recipient or LRI) has chosen me to direct the delivery of specific medical, nursing or home health care services through an Intermediary Service Organization (ISO), as defined in NRS 629.091 (reproduced in Section 7 of this form). I have the ability and desire to direct, manage and take responsibility to direct his/her care, to choose the ISO provider, to select personal care assistants (PCAs), to arrange the PCA's schedule and to be present to direct the PCA in the delivery of specific medical, nursing or home health care services. As the PCR, I must be capable of making choices about specific medical, nursing or home health care service needs, understand the impact of these choices, assume responsibility for these choices, and be capable of directing all the tasks related to specific medical, nursing or home health care services delivery.</p> <p>As the PCR, I must comply with all Medicaid policies and procedures as outlined in the Medicaid Services Manual, all relevant chapters, including Chapters 100, 2600 and 3300.</p> <p>I will direct the PCA to provide only the specific medical, nursing or home health care services approved on the active/current authorization.</p> <p>As the PCR, I agree to hold the State of Nevada harmless from any liability whatsoever for any injuries, damages, loss, whether physical or financial, associated with or resulting from directing the recipient's care in this option.</p> <p>As the PCR, I am not eligible to receive reimbursement for acting as a PCR or for providing specific medical, nursing or home health care services, and that I must be present when services are delivered.</p> <p>As the PCR, I am responsible for developing a back-up plan and for obtaining backup coverage for the recipient in the absence of a regularly scheduled PCA.</p> <p>The ISO is the employer of record for PCAs.</p> <p>As the PCR, I am responsible for reviewing and verifying service delivery records of the recipient to ensure the authorized services have been provided, thereby authorizing Medicaid to be billed. Misrepresentation within these documents constitutes fraud per NRS 422.540 (reproduced in Section 7 of this form) and will be referred to the Surveillance and Utilization Review (SUR) Unit for investigation and appropriate action.</p> <p>As the PCR, I am responsible for selecting, scheduling and managing all PCAs who will provide services for the recipient according to the Request for Medically Necessary Skilled Services.</p> <p>A newly completed FA-24C must be submitted annually for consideration of continued services.</p> <p>I may discontinue the option to direct the recipient's skilled services at any time and the recipient may receive specific medical, nursing or home health care services through a Home Health Agency, if eligible to do so and there is a Home Health Agency available to provide care.</p> <p>I agree to refer the patient back to the physician when:</p> <ul style="list-style-type: none"> • The condition of the patient changes or a new medical condition develops; • The patient or their personal care or legal representative becomes unable to self-direct the services/care authorized; • The progress or condition of the patient after the provision of a service is different than expected; and/or • An emergency situation develops. 	
Personal Care Representative's and ISO Provider's Signatures	
Personal Care Representative Signature:	Date:
Personal Care Representative Name: <i>(please print)</i>	
ISO Provider Signature:	Date:
ISO Provider Name: <i>(please print)</i>	

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 6 must be signed by the following:
 - Recipient
 - Legally Responsible Individual/Personal Care Representative *(if the recipient is not able to self-direct the care)*
 - ISO Provider
 - PCA(s)

SECTION 6: Required Signatures	
RECIPIENT <i>(Last Name, First Name, Middle Initial):</i>	
<ul style="list-style-type: none"> By signing this form, I have read and understood Section 2, the Request for Medically Necessary Skilled Services. By signing this form, I understand I am not an employee of Nevada Medicaid (Division of Health Care Financing and Policy) or the requesting Health Care Provider. 	
Recipient Signature:	Date:
Recipient Name: <i>(please print)</i>	
LRI or Personal Care Representative Signature:	Date:
LRI or Personal Care Representative Name: <i>(please print)</i>	
ISO Provider Signature:	Date:
ISO Provider Name: <i>(please print)</i>	
Personal Care Assistant Signature:	Date:
Personal Care Assistant Name: <i>(please print)</i>	
Personal Care Assistant Signature:	Date:
Personal Care Assistant Name: <i>(please print)</i>	
Personal Care Assistant Signature:	Date:
Personal Care Assistant Name: <i>(please print)</i>	
Personal Care Assistant Signature:	Date:
Personal Care Assistant Name: <i>(please print)</i>	
Personal Care Assistant Signature:	Date:
Personal Care Assistant Name: <i>(please print)</i>	

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 7 must be read and understood by all parties involved.

Section 7: Applicable Nevada Revised Statutes (NRS)
RECIPIENT (Last Name, First Name, Middle Initial):
NRS 422.540 Offenses regarding false claims, statements or representations; penalties. <ol style="list-style-type: none">1. A person, with the intent to defraud, commits an offense if with respect to the Plan the person:<ol style="list-style-type: none">(a) Makes a claim or causes it to be made, knowing the claim to be false, in whole or in part, by commission or omission;(b) Makes or causes to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false, in whole or in part, by commission or omission;(c) Makes or causes to be made a statement or representation for use by another in obtaining goods or services or services pursuant to the plan, knowing the statement or representation to be false, in whole or in part, by commission or omission; or(d) Makes or causes to be made a statement or representation for use in qualifying as a provider, knowing the statement or representation to be false, in whole or in part, by commission or omission.2. A person who commits an offense described in subsection 1 shall be punished for a:<ol style="list-style-type: none">(a) Category D felony, as provided in NRS 193.130, if the amount of the claim or the value of the goods or services obtained or sought to be obtained was greater than or equal to \$650.00.(b) Misdemeanor if the amount of the claim or the value of the goods or services obtained or sought to be obtained was less than \$650.00. Amounts involved in separate violations of this section committed pursuant to a scheme or continuing course of conduct may be aggregated in determining the punishment.3. In addition to any other penalty for a violation of the commission of an offense described in subsection 1, the court shall order the person to pay restitution. <p>(Added to NRS by 1991, 1049; A 1997, 457, 2011, 174)</p>
NRS 629.091 Personal assistant authorized to perform certain services for person with disability if approved by provider of health care; requirements. <ol style="list-style-type: none">1. Except as otherwise provided in subsection 4, a provider of health care may authorize a person to act as a personal assistant to perform specific medical, nursing or home health care services for a person with a disability without obtaining any license required for a provider of health care or his assistant to perform the service if:<ol style="list-style-type: none">(a) The services to be performed are services that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care;(b) The provider of health care determines that the personal assistant has the knowledge, skill and ability to perform the services competently;(c) The provider of health care determines that the procedures involved in providing the services are simple and the performance of such procedures by the personal assistant does not pose a substantial risk to the person with a disability;(d) The provider of health care determines that the condition of the person with a disability is stable and predictable; and(e) The personal assistant agrees with the provider of health care to refer the person with a disability to the provider of health care if:<ol style="list-style-type: none">(1) The condition of the person with a disability changes or a new medical condition develops;(2) The progress or condition of the person with a disability after the provision of the service is different than expected;(3) An emergency situation develops; or(4) Any other situation described by the provider of health care develops.2. A provider of health care that authorizes a personal assistant to perform certain services shall note in the medical records of the person with a disability who receives such services:<ol style="list-style-type: none">(a) The specific services that he has authorized the personal assistant to perform; and(b) That the requirements of this section have been satisfied.3. After a provider of health care has authorized a personal assistant to perform specific services for a person with a

Authorization Request for Self-Directed Skilled Services – FA-24C, continued

- Section 8 must be read and understood by all parties involved.

disability, no further authorization or supervision by the provider is required for the continued provision of those services.

4. A personal assistant shall not:
 - (a) Perform services pursuant to this section for a person with a disability who resides in a medical facility.
 - (b) Perform any medical, nursing or home health care service for a person with a disability which is not specifically authorized by a provider of health care pursuant to subsection 1.
 - (c) Except if the services are provided in an educational setting, perform services for a person with a disability in the absence of the parent or guardian of, or any other person legally responsible for, the person with a disability, if the person with a disability is not able to direct his own services.
5. A provider of health care who determines in good faith that a personal assistant has complied with and meets the requirements of this section is not liable for civil damages as a result of any act or omission, not amounting to gross negligence, committed by him in making such a determination and is not liable for any act or omission of the personal assistant.
6. As used in this section:
 - (a) "Guardian" means a person who has qualified as the guardian of a minor or an adult pursuant to testamentary or judicial appointment, but does not include a guardian ad litem.
 - (b) "Parent" means a natural or adoptive parent whose paternal rights have not been terminated.
 - (c) "Personal assistant" means a person who, for compensation and under the direction of:
 - (1) A person with a disability;
 - (2) A parent or guardian of, or any other person legally responsible for, a person with a disability who is under the age of 18 years; or
 - (3) A parent, spouse, guardian or adult child of a person with a disability who suffers from a cognitive impairment, performs services for the person with a disability to help him maintain his independence, personal hygiene and safety.
 - (d) "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, a dentist, a registered nurse, a licensed practical nurse, a physical therapist or an occupational therapist.

(Added to NRS by 1995, 749; A 2005, 69)

The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received. This referral/authorization is not a guarantee of payment.

PCS Recipient Request for Provider Transfer – FA-24T

- This form is to be used when a recipient is requesting to transfer from one provider to another.
- Fill out the form in its entirety.
- Recipient, LRI or PCR must complete Section 1, indicate the reason for the transfer and initial where applicable.
- Section 2 is the new provider information.
 - The new provider must ensure that there will be no lapse in services when a recipient is transferring.
 - Start Date with New Requesting Provider: This is the date the authorization will begin. The agency must be in the home providing services on this date.

Nevada Medicaid and Check Up
Personal Care Services Recipient Request for Provider Transfer

Purpose: Use this form to verify a recipient's request to transfer to another provider. All fields, signatures and initials must be completed and are required for processing of this transfer request. Provider is required to submit verification of release of information. Incomplete forms will not be acted upon.
Upload this request through the Provider Web Portal. **Questions? Call:** (800) 525-2395

DATE OF REQUEST: ____/____/____

SECTION I: RECIPIENT INFORMATION	
<i>The Recipient, Legally Responsible Individual (LRI) or Personal Care Representative (PCR) must complete Section I. Indicate the reason for the transfer, initial the items below to indicate an understanding of the changes that may occur due to the transfer and sign the form.</i>	
Last Name:	First Name:
Medicaid ID:	Date of Birth:
Reason for transfer of service to new provider: _____	
Recipient/LRI/PCR must initial, complete the following and sign below:	
_____/LRI/PCR understand that services will be terminated with my current personal care services agency: (<i>agency name</i>) _____ and I have notified my current agency of my last date of service with them. I understand that I am authorized to receive service from only one agency at a time.	
_____/LRI/PCR understand that selecting a new agency may result in a new personal care assistant.	
_____/LRI/PCR understand that a request for transfer will not result in a change in my current personal care hours.	
_____/LRI/PCR have NOT been offered nor have I received financial incentives to authorize this transfer.	
_____/LRI/PCR for the Medicaid recipient identified above certify that I have completed this form and understand the actions that will take place upon my signature.	
Recipient/LRI/PCR: (<i>print name</i>) _____	
Relationship to Recipient: _____	
Recipient/LRI/PCR Signature: _____	Date: _____
SECTION II: NEW PROVIDER INFORMATION	
<i>The provider must complete Section II. Be sure to complete the effective dates and sign the form.</i>	
New Provider Name: _____	
New Provider Agency NPI: _____	New Provider Agency Phone Number: _____
Last Date with Current Provider: _____	
Start Date with New Requesting Provider (<i>the day after the last date with current provider</i>): _____	
Additional comments or contact information not specified above (<i>that would assist in the completion of this request</i>): _____ _____	

PCS Recipient Request for Provider Transfer – FA-24T, continued

- An individual representative from the new provider must initial and sign page 2.

The Individual Representative from the New Provider must initial the following and sign below:	
<input type="checkbox"/>	I have met with the recipient and provided the recipient with a copy of our agency's policies and procedures.
<input type="checkbox"/>	No information has been provided to the recipient implying that a failure to transfer will result in consequences such as a decrease in PCS hours, loss of Medicaid eligibility or that the current/existing agency is now unable to provide services.
<input type="checkbox"/>	No financial incentives have been made or offered in relation to this transfer request.
<input type="checkbox"/>	No assurances regarding an increase in PCS hours have been made to the recipient.
Individual Representative from New Provider (<i>print name</i>): _____	
Provider Signature:	Date:

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Submitting a Prior Authorization via the EVS Secure Provider Web Portal

Logging into the Provider Web Portal



Nevada Department of Health and Human Services

Division of Health Care Financing and Policy Provider Portal

Home

Home

Login ?

*User ID
hospizona1

Log In

[Forgot User ID?](#)

[Register Now](#)

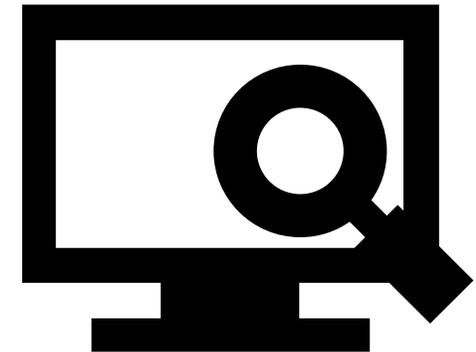
Broadcast Messages

Hours of Availability
The Nevada Provider Web Portal is unavailable between 12:25 AM PST on Sunday.

What can you do in the Provider Portal
Through this secure and easy to use internet portal, hea

Once registered, users may access their accounts from the PWP “Home” page by:

- Entering the **User ID**.
- Clicking the **Log In** button.



Logging in to the Provider Web Portal, continued

Computer and Challenge Question

Site Key

The HealthCare Portal uses a personalized site key to protect your privacy online. To use a site key, you are asked to respond to your Challenge question the first time you use a personal computer, or every time you use a public computer. When you type the correct answer to the Challenge question, your site key token displays which ensures that you have been correctly identified. Similarly, by displaying your personalized site key token, you can be sure that this is the actual HealthCare Portal and not an unauthorized site.

If this is your personal computer, you can register it now by selecting: **This is a personal computer. Register it now.**

Answer the challenge question to verify your identity.

Challenge Question In what city were you born?

*Your Answer

[Forgot answer to challenge question?](#)

Select This is a personal computer. Register it now.
 This is a public computer. Do not register it.

Once the user has clicked the **Log In** button, the user will need to provide identity verification as follows:

- Answer the **Challenge Question** to verify identity.
- Choose whether log in is on a **personal computer** or **public computer**.
- Click the **Continue** button.

Logging in to the Provider Web Portal, continued

[Home](#) > [Challenge Question](#) > Site Token Password

Confirm Site Key Token and Passphrase

Confirm that your site key token and passphrase are correct.

If you recognize your site key token and passphrase, you can be more comfortable that you are at the valid HealthCare Portal site and therefore is safe to enter your password.

Make sure your site key token and passphrase are correct.

If the site key token and passphrase are correct, type your password and click **Sign In**. If this is not your site key token or passphrase, do not type your password. Call the [customer help desk](#) to report the incident.

Site Key: 

Passphrase Answer

***Password**

[Sign In](#)

[Forgot Password?](#)

The user will continue providing identity verification as follows:

- Confirming that the **Site Key** and **Passphrase** are correct.
- Entering **Password**.
- Clicking the **Sign In** button.

NOTE: If this information is incorrect, users should not enter their password. Instead, they should contact the help desk by clicking the **customer help desk** link.

Welcome Screen

The screenshot shows the Nevada Department of Health and Human Services Provider Portal. At the top left is the state seal and the department name. A navigation bar contains links for My Home, Eligibility, Claims, Care Management, File Exchange, and Resources. A 'Provider' section displays user information and a 'Broadcast Messages' section with a 'Contact Us' link. A 'Provider Services' sidebar lists various actions like 'Member Focused Viewing' and 'Search Payment History'. A central banner reads 'Welcome Health Care Professional!' with a photo of healthcare workers and a paragraph of text. At the bottom, there are links to 'Prior Authorization Quick Reference Guide' and 'Provider Web Portal Quick Reference Guide'.

A: My Home, Eligibility, Claims, Care Management, File Exchange, Resources

B: Broadcast Messages

C: Contact Us, Secure Correspondence

D: My Profile, Manage Accounts

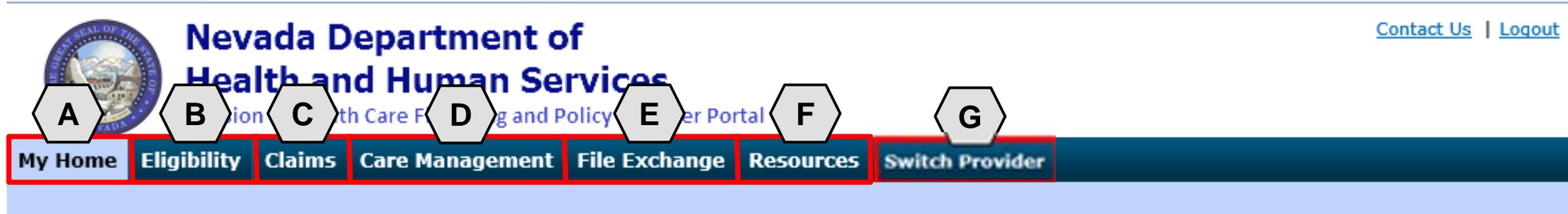
E: Member Focused Viewing, Search Payment History, Revalidate-Update Provider, Pharmacy PA, PASRR, EHR Incentive Program, EPSDT, Presumptive Eligibility

F: Prior Authorization Quick Reference Guide [Review], Provider Web Portal Quick Reference Guide [Review]

Once the provider information has been verified, the user may explore the features of the PWP, including:

- A. Additional tabs for users to research eligibility, submit claims and PAs, access additional resources, and more.
- B. Important broadcast messages.
- C. Links to contact customer support services.
- D. Links to manage user account settings, such as passwords and delegate access.
- E. Links to additional information regarding Medicaid programs and services.
- F. Links to additional PWP resources.

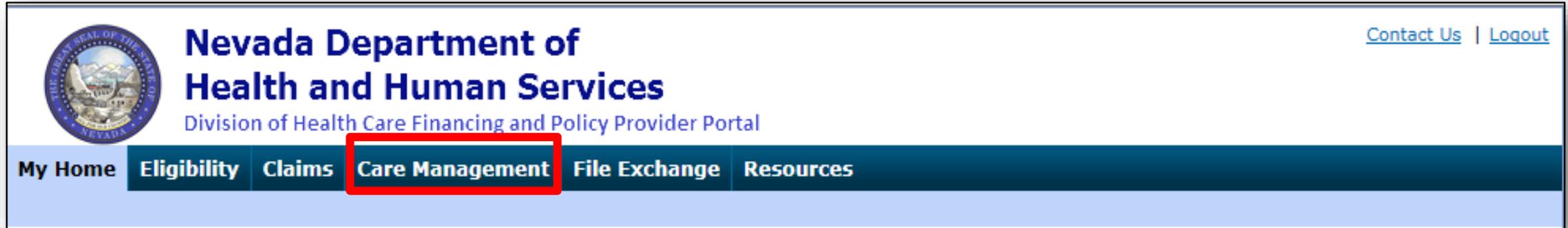
Navigating the Provider Web Portal



The tabs at the top of the page provide users quick access to helpful pages and information:

- A. My Home:** Confirm and update provider information and check messages.
- B. Eligibility:** Search for recipient eligibility information.
- C. Claims:** Submit claims, search claims, view claims and search payment history.
- D. Care Management:** Request PAs, view PA statuses and maintain favorite providers.
- E. File Exchange:** Upload forms online.
- F. Resources:** Download forms and documents.
- G. Switch Providers:** This is where **delegates** can switch between providers to whom they are assigned. The tab is only present when the user is logged in as a delegate.

Care Management Tab



The screenshot shows the header of the Nevada Department of Health and Human Services Provider Portal. On the left is the state seal of Nevada. To its right is the text "Nevada Department of Health and Human Services" and "Division of Health Care Financing and Policy Provider Portal". In the top right corner are links for "Contact Us" and "Logout". Below this is a dark blue navigation bar with white text for "My Home", "Eligibility", "Claims", "Care Management", "File Exchange", and "Resources". The "Care Management" tab is highlighted with a red rectangular box.

Create Authorization

- Create authorizations for eligible recipients

View Authorization Status

- Prospective authorizations that identify the requesting or servicing provider

Maintain Favorite Providers

- Create a list of frequently used providers
- Select the facility or servicing provider from the providers on the list when creating an authorization
- Maintain a favorites list of up to 20 providers



Before You Create a Web Portal Prior Authorization Request

Before Creating a Prior Authorization Request



Verify eligibility to ensure that the recipient is eligible on the date of service for the requested services.



Use the Provider Web Portal's PA search function to see if a request for the dates of service, units and service(s) already exists.



Review the coverage, limitations and PA requirements for the Nevada Medicaid Program before submitting PA requests.



Use the Provider Web Portal to check PAs in pending status for additional information.



Create a Prior Authorization Request

Key Information

Recipient Demographics

— First Name, Last Name and Birth Date will be auto-populated based on the recipient ID entered.

Diagnosis Codes

— All PAs will require at least one valid diagnosis code.

Searchable Diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS)

— Enter the first three letters or the first three numbers of the code to use the predictive search.

PA Attachments

— Attachments are required with all PA requests. Attachments can only be submitted electronically.

— PA requests received without an attachment will remain in pended status for 30 days.

— If no attachment is received within 30 days, the PA request will automatically be canceled.

Submitting a PA Request

The screenshot displays the Nevada Department of Health and Human Services Provider Portal. The header includes the state seal and the text "Nevada Department of Health and Human Services" and "Division of Health Care Financing and Policy Provider Portal". The main navigation bar contains tabs: "My Home", "Eligibility", "Claims", "Care Management", "Change", and "Resources". The "Care Management" tab is highlighted with a red box and a grey hexagon labeled "1". Below this, a sub-menu is visible with "Create Authorization" highlighted by a red box and a grey hexagon labeled "2". Other sub-menu items include "Authorization Status", "Maintain Favorite Providers", and "Authorization Criteria". The page content includes a "My Home" section, a "Provider" profile section with fields for Name, Provider ID, and Location ID, and a "Broadcast Messages" section with a message about system availability. A "Welcome Health Care Professional!" message is also present.

1. Hover over the **Care Management** tab.
2. Click **Create Authorization** from the sub-menu.

Submitting a PA Request, continued

Create Authorization ?

* Indicates a required field.

Medical Dental

*Process Type: Home Health Expand All | Collapse All

5 **Requesting Provider Information**

Provider ID	ID Type	Name
	NPI	

Recipient Information

*Recipient ID: 43827875678

Last Name: ABIEGUT First Name: ABYNNRYP

Birth Date: 04/10/1928

Referring Provider Information

Referring Provider same as Requesting Provider:

Select from Favorites: No favorite providers available.

Provider ID	ID Type	Name	Add to Favorites
			<input type="checkbox"/>

5. The **Requesting Provider Information** is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.

Submitting a PA Request, continued

Create Authorization ?

* Indicates a required field.

Medical **Dental**

***Process Type** Home Health Expand All | Collapse All

Requesting Provider Information

Provider ID	ID Type	NPI	Name
-------------	---------	-----	------

Recipient Information

6 ***Recipient ID** 43827875678

Last Name ABIEGUT **First Name** ABYNNRYP

Birth Date 04/10/1928

Referring Provider Information

Referring Provider same as Requesting Provider

Select from Favorites No favorite providers available.

Provider ID	ID Type	Name	Add to Favorites
-------------	---------	------	------------------

6. Enter the **Recipient ID**. The Last Name, First Name and Birth Date will populate automatically.

Submitting a PA Request, continued

Create Authorization ?

* Indicates a required field.

Medical Dental

*Process Type [Expand All](#) | [Collapse All](#)

Requesting Provider Information -

Provider ID	ID Type	NPI	Name
-------------	---------	-----	------

Recipient Information -

*Recipient ID

Last Name ABIEGUT First Name ABYNNRYP

Birth Date 04/10/1928

Referring Provider Information -

Referring Provider same as Requesting Provider

Select from Favorites

Provider ID	ID Type	Name	Add to Favorites
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

7. Enter Referring Provider Information using one of three ways.

7

Submitting a PA Request, continued

The screenshot shows a form titled "Referring Provider Information" with a minus sign in the top right corner. The form contains several fields and a checkbox, all highlighted with a red border. Annotation A points to a checkbox labeled "Referring Provider same as Requesting Provider". Annotation B points to a drop-down menu labeled "Select from Favorites". Annotation C points to two input fields: "Provider ID" and "ID Type". Annotation D points to a checkbox labeled "Add to Favorites".

- A. Check the **Referring Provider Same as Requesting Provider** box.
- B. Choose an option from the **Select from Favorites** drop-down. This drop-down displays a list of providers that the user has indicated as favorites.
- C. Enter the **Provider ID** and **ID Type**. Both fields must be completed when using this option.
- D. Click the **Add to Favorites** checkbox. Use this after entering a provider ID to add it to the **Select from Favorites** drop-down.

Submitting a PA Request, continued

Referring Provider Information

Referring Provider same as Requesting Provider

Select from Favorites

Provider ID ID Type Name Add to Favorites

Service Provider Information

Service Provider same as Requesting Provider

Select from Favorites

*Provider ID *ID Type Name Add to Favorites

Location

8. Enter **Service Provider Information**.

8

Submitting a PA Request, continued

Service Provider Information

Service Provider same as Requesting Provider

Select from Favorites: No favorite providers available.

*Provider ID: 1831573690 *ID Type: NPI Name: Add to Favorites

Location: FEDERALLY QUALIFIED HEALTH CENTER

Diagnosis Information

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code. Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
*Diagnosis Type: ICD-10-CM ICD-9-CM	*Diagnosis Code	

Click to collapse.

9 **10** **11** Add Cancel

Service Details

9. Select a **Diagnosis Type** from the drop-down list.
10. Enter the **Diagnosis Code**. Enter only one diagnosis code. Once the user begins typing, the field will automatically search for matching codes.
11. Click the **Add** button.

Submitting a PA Request, continued

Diagnosis Information

Error
Diagnosis Code not found.

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.
Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
Click to collapse.		
*Diagnosis Type ICD-10-CM	*Diagnosis Code 1234 Diagnosis Code not found.	

If you click the **Add** button with an invalid diagnosis code, an error will display. You must ensure the diagnosis code is correct, up-to-date with the selected **Diagnosis Type**, and does not include decimals.

Submitting a PA Request, continued

Diagnosis Information [-]

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.
Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	T7500XA-Unspecified effects of lightning, initia	Remove

Click to collapse.

*Diagnosis Type *Diagnosis Code

Once a diagnosis code has been entered accurately, and the **Add** button has been clicked, the diagnosis code will display under the **Diagnosis Information section**. If a code needs to be removed from the PA request, click **Remove** located in the **Action** column.

Submitting a PA Request, continued

Diagnosis Information

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code. Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter	Remove

Click to collapse.

*Diagnosis Type *Diagnosis Code

[Add](#) [Cancel](#)

- 12. Enter detail regarding the service(s) provided into the **Service Details** section.
- 13. Click the **Add Service** button.

Service Details

+ to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

Line #	From Date	To Date	Code	Modifiers	Units	Action
	01/01/2018	01/01/2019	CPT/HCPCS	A6413-Adhesive bandage, first-aid		

Click to collapse.

*From Date To Date Code Type *Code

Modifiers

*Units

*Medical Justification

[Add Service](#) [Cancel Service](#)

Submitting a PA Request, continued

Service Details

Click '+' to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

	Line #	From Date	To Date	Code	Modifiers	Units	Action
<input type="checkbox"/>	1	01/01/2018	01/01/2019	A6413-Adhesive bandage, first-aid		1	Copy Remove

Click to collapse.

***From Date** **To Date** **Code Type** CPT/HCPCS ***Code**

Modifiers

***Units**

***Medical Justification**

After clicking the **Add Service** button, the service details will display in the list.

NOTE: Manage additional details as needed. If a user wishes to copy a service detail, click **Copy** located in the **Action** column. To remove the detail, click **Remove**.

Submitting a PA Request, continued

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

Click the **Remove** link to remove the entire row.

Transmission Method	File	Action
Click to collapse.		
*Transmission Method	EL-Electronic Only	
*Upload File	Choose File No file chosen	
*Attachment Type		
<input type="button" value="Add"/> <input type="button" value="Cancel"/>		
<input type="button" value="Submit"/> <input type="button" value="Cancel"/>		

The **Transmission Method** will default to EL-Electronic Only as attachments must be sent via the Provider Web Portal.

Submitting a PA Request, continued

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type, and upload the file.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, select an appropriate Transmission Method.

Click the **Remove** link to remove an attachment.

Transmission Method	Attachment Type
<input type="checkbox"/> Click to collapse.	
*Transmission Method	
*Upload File	
*Attachment Type	
<input type="button" value="Add"/>	

- 59-Benefit Letter
- 03-Report Justifying Treatment Beyond Utilization Guidelines
- 11-Chemical Analysis
- 04-Drug Administered
- 05-Treatment Diagnosis
- 06-Initial Assessment
- 07-Functional Goals
- 08-Plan of Treatment
- 09-Progress Report
- 10-Continued Treatment
- 13-Certified Test Report
- 15-Justification for Admission
- 21-Recovery Plan
- 48-Social Security Benefit Letter
- 55-Rental Agreement
- 77-Support Data for Verification
- A3-Allergies/Sensitivities Document
- A4-Autopsy Report
- AM-Ambulance Certification
- AS-Admission Summary
- AT-Purchase Order Attachment
- B2-Prescription
- B3-Physician Order
- BR-Benchmark Testing Results
- BS-Baseline
- BT-Blanket Test Results
- CB-Chiropractic Justification
- CK-Consent Form(s)
- D2-Physician Order
- DA-Dental Models

14. Choose the type of attachment being submitted from the **Attachment Type** drop-down list.

Submitting a PA Request, continued

The screenshot shows a web application interface for submitting a PA request. The interface includes fields for *From Date, To Date, Code Type (CPT/HCPCS), and *Code. Below these are sections for Modifiers, *Units, and *Medical Justification. A blue button labeled "Add Service" is visible. The "Attachments" section contains instructions and a link for "Prior Authorization Forms". A "Transmission Method" dropdown is set to "EL-Electronic Only". The "Upload File" field is empty, and the "Attachment Type" is set to "NN-Nursing Notes". A "Browse..." button is highlighted with a red box and labeled "15". A "Choose File to Upload" dialog box is open, showing the Desktop folder. The file "Nurse Notes.docx" is selected and highlighted with a red box and labeled "16". The "Open" button in the dialog is highlighted with a red box and labeled "17".

15. Click the **Browse** button.

16. Select the desired attachment.

17. Click the **Open** button.

Allowable file types include:

.doc, .docx, .gif, .jpeg, .pdf, .txt, .xls, .xlsx, .bmp, .tif, and .tiff.

Submitting a PA Request, continued

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

Click the **Remove** link to remove the entire row.

Transmission Method	File	Action
Click to collapse.		
*Transmission Method: <input type="text" value="EE Electronic Only"/>	*Upload File: <input type="text" value="C:\Users\bargera\Desktop\Nurse Notes.docx"/> <input type="button" value="Browse..."/>	*Attachment Type: <input type="text" value=""/>
18 <input type="button" value="Add"/> <input type="button" value="Cancel"/>		

18. Click the **Add** button.

Submitting a PA Request, continued

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

Click the **Remove** link to remove the entire row.

	Transmission Method	File	Action
<input type="checkbox"/>	EL-Electronic Only	Nurse Notes.docx	Remove

Click to collapse.

*Transmission Method

*Upload File

*Attachment Type

The added attachment displays in the list.

To remove the attachment, click **Remove** in the **Action** column.

Add additional attachments by repeating steps 14-18.

NOTE: The total attachment file size limit before submitting a PA is 4 MB. When more attachments are needed beyond this capacity, the user will first submit the PA. Afterwards, go back into the PA using the View Authorization Response page, click the edit button to open the PA and then add more attachments.

Submitting a PA Request, continued

19. Click the **Submit** button.

Justification

[Add Service](#) [Cancel Service](#)

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

Click the **Remove** link to remove the entire row.

	Transmission Method	File	Action
<input type="checkbox"/>	EL-Electronic Only	Nurse Notes.docx	Remove

Click to collapse.

*Transmission Method

*Upload File

*Attachment Type

[Add](#) [Cancel](#)

19 [Submit](#) [Cancel](#)

Submitting a PA Request, continued

20

Confirm Authorization ?

[Expand All](#) | [Collapse All](#)

Requesting Provider Information -

Provider ID 1831573690	ID Type NPI	Name HOSPITALIST SERVICES OF NEVADA-MANDAVIA
------------------------	-------------	----------------------------------------------

Recipient Information and Process Type -

Recipient ID 43827875678	Gender Female	
Recipient ABYNNRYP ABIEGUT		
Birth Date 04/10/1928		
Process Type Home Health		

Referring Provider Information -

Provider ID 1831573690	ID Type NPI	Name HOSPITALIST SERVICES OF NEVADA-MANDAVIA
------------------------	-------------	----------------------------------------------

Service Provider Information -

Provider ID 1831573690	ID Type NPI	Name HOSPITALIST SERVICES OF NEVADA-MANDAVIA
Location _		

[Expand All](#) | [Collapse All](#)

Diagnosis Information -

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

Diagnosis Type	Diagnosis Code
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter

Service Details -

Line #	From Date	To Date	Code	Modifiers	Units
1	01/01/2018	01/01/2019	CPT/HCPCS A6413-Adhesive bandage, first-aid		1

Attachments -

Transmission Method	File	Attachment Type
EL-Electronic Only	Nurse Notes.docx	NN-Nursing Notes

Back

21 Confirm

Cancel

20. Review the information on the PA request.
21. Click the **Confirm** button to submit the PA for processing. Only click the Confirm button once. If a user clicks Confirm multiple times, multiple PA's will be submitted and denied due to multiple submissions.

NOTE: If updates are needed prior to clicking the **Confirm** button, click the **Back** button to return to the "Create Authorization" page.

Submitting a PA Request, continued

My Home | **Eligibility** | **Claims** | **Care Management** | **File Exchange** | **Resources**

Create Authorization | View Authorization Status | Maintain Favorite Providers | Authorization Criteria

[Care Management](#) > Authorization Receipt

Authorization Receipt ?

Your Authorization Tracking Number **45180650011** was successfully submitted.

Click **Print Preview** to view authorization details and receipt.
Click **Copy** to copy member data or authorization data.
Click **New** to create a new authorization for a different member.

General Authorization Receipt Instructions

[Print Preview](#) | [Copy](#) | [New](#)

After the **Confirm** button has clicked, an “Authorization Tracking Number” will be created. This message signifies that the PA request has been successfully submitted.

Submitting a PA Request, continued

The screenshot shows a web application interface for 'Authorization Receipt'. At the top, there is a navigation bar with tabs: 'My Home', 'Eligibility', 'Claims', 'Care Management', 'File Exchange', and 'Resources'. Below this is a sub-navigation bar with links: 'Create Authorization', 'View Authorization Status', 'Maintain Favorite Providers', and 'Authorization Criteria'. The main content area has a breadcrumb trail: 'Care Management > Authorization Receipt'. A dark blue header for the section reads 'Authorization Receipt' with a help icon. The main message states: 'Your Authorization Tracking Number 45180650011 was successfully submitted.' Below this, instructions are provided: 'Click **Print Preview** to view authorization details and receipt. Click **Copy** to copy member data or authorization data. Click **New** to create a new authorization for a different member.' Underneath the instructions, there is a link for 'General Authorization Receipt Instructions'. At the bottom, three buttons are displayed: 'Print Preview' (labeled A), 'Copy' (labeled B), and 'New' (labeled C). A red rectangular box highlights these three buttons.

- A. **Print Preview:** Allows a user to view the PA details and receipt for printing.
- B. **Copy:** Allows a user to copy member or authorization data for another authorization.
- C. **New:** Allows a user to begin a new PA request for a different member.



Viewing Status

Viewing the Status of PAs

The screenshot displays the top navigation bar of the Nevada Medicaid Provider Portal. The 'Care Management' tab is highlighted with a red box and a callout '1'. Below it, the 'View Authorization Status' link is also highlighted with a red box and a callout '2'. The main content area includes a 'Provider' section with fields for Name, Provider ID, and Location ID, and a 'Broadcast Messages' section with a message about the portal's availability. A 'Welcome Health Care Professional' banner is visible at the bottom.

1. Hover over the **Care Management** tab.
2. Click **View Authorization Status**.

Viewing the Status of PAs, continued

My Home | Eligibility | Claims | Care Management | File Exchange | Resources

Create Authorization | **View Authorization Status** | Maintain Favorite Providers | Authorization Criteria

Care Management > View Authorization Status

View Authorization Status

Prospective Authorizations

Prospective authorizations identifying you as the Requesting or Servicing Provider are listed below. These results include beginning Services Date of today or greater. Click the Authorization Tracking Number to view the authorization response search for a different authorization.

Prospective Authorizations

Authorization Tracking Number	Service Date ▲	Recipient Name	Recipient ID	Process Type	Requesting P
45181270003	01/01/2018 - 01/01/2019	ABIEGUT, ABYNNRYP	43827875678	Home Health	HOSPITALIST SERV NEVADA-MANDAVIA
43180110001	01/11/2018 - 01/11/2019	QROTB, FENKTPVI	54409179444	Outpt M/S	HOSPITALIST SERV NEVADA-MANDAVIA
41180120002	01/12/2018 - 01/12/2019	KWLVDTYRXW, AOWPEW H	80335695037	Outpt M/S	HOSPITALIST SERV NEVADA-MANDAVIA

3. Click the **ATN** hyperlink of the PA to be viewed.

3

Viewing the Status of PAs, continued

View Authorization Response for AOWPEW KWLVDTYRXW [Back to View Authorization Status](#) ?

Authorization Tracking # 41180120002 Process Type Outpt M/S [Expand All](#) | [Collapse All](#)

Requesting Provider Information

Recipient Information

Referring Provider Information

Diagnosis Information

Service Provider / Service Details Information

5

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/12/2018	01/12/2019	10	10	-	CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING	-	Certified In Total 01/12/2018	-

4. Click the **plus** symbol to the right of a section to display its information.
5. Review the information as needed.

Viewing the Status of PAs, continued

View Authorization Response for AOWPEW KWLVDTYRXW [Back to View Authorization Status](#) ?

Authorization Tracking # 41180120002 **Process Type** Outpt M/S [Expand All](#) | [Collapse All](#)

Requesting Provider Information +

Recipient Information +

Referring Provider Information +

Diagnosis Information +

Service Provider / Service Details Information -

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/12/2018	01/12/2019	10	10	-	CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING	6	Certified In Total 01/12/2018	-

[Edit](#) [View Provider Request](#) [Print Preview](#)

- Review the details listed in the **Decision / Date** and **Reason** columns.

Viewing the Status of PAs, continued

Service Provider / Service Details Information								
Provider ID			ID Type	NPI	Name			
From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/12/2018	01/12/2019	10	10	-	CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING	-	Certified In Total 01/12/2018	-

In the **Decision / Date** column, you may see one of the following decisions:

- **Certified in Total:** The PA request is approved for exactly as requested.
- **Certified Partial:** The PA request has been approved, but not as requested.
- **Not Certified:** The PA request is not approved.
- **Pended:** The PA request is pending approval.
- **Cancel:** The PA request has been canceled.

Viewing the Status of PAs, continued

Service Provider / Service Details Information								
Provider ID			ID Type	NPI	Name			
From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
08/29/2017	08/29/2017	1	1	\$125.00	CPT/HCPCS 80061-Lipid panel	View	Certified Partial 06/11/2018	Product/service/procedure delivery pattern (e.g., units, days, visits, weeks, hours, months)
08/30/2017	08/30/2017	1	0	-	CPT/HCPCS 36415-Routine venipuncture	View	Not Certified 06/11/2018	Non-covered Service

When the **Decision / Date** column is not “Certified in Total” information will be provided in the **Reason** column. For example, if a PA is not certified (A), the reason why it was not certified displays (B).

Viewing the Status of PAs, continued

Service Provider / Service Details Information								
Provider C 1573690 D		ID Type NPI E		Name HOSPITAL SERVICES OF NEVADA- F MANDATE G				
From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/12/2018	01/12/2019	10	10	-	CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING	-	Certified In Total 01/12/2018	-

- C. **From Date** and **To Date**: Display the start and end dates for the PA.
- D. **Units**: Displays the number of units originally on the PA.
- E. **Remaining Units** or **Amount**: Display the units or amount left on the PA as claims are processed.
- F. **Code**: Displays the CPT/HCPCS code on the PA.
- G. **Medical Citation**: Indicates when additional information is needed for authorizations (including denied).

Viewing the Status of PAs, continued

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
02/17/2013	02/17/2013	3	0	–	Revenue 0121-R&B-2 BED-MED-SURG-GYN	Hide	Not Certified 02/21/2013	–
<p>Medical Citation 7002 - Information provided does not support medical necessity as defined by Nevada Medicaid.</p> <p>Notes To Provider Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted. Inpatient admission criteria not met. Intensity of service was not supported in the documentation submitted.</p>								
02/20/2031	02/20/2031	2	0	–	Revenue 0121-R&B-2 BED-MED-SURG-GYN	View	Not Certified 02/22/2013	–
02/17/2013	02/20/2013	3	3	–	Revenue 0121-R&B-2 BED-MED-SURG-GYN	–	Certified In Total 02/24/2013	–

[Edit](#)

[View Provider Request](#)

[Print Preview](#)

The Medical Citation field indicates if additional information is needed for all authorizations (including denied). Click “View” to see the details and clinical notes provided by Nevada Medicaid or click “Hide” to collapse the information panel.

Viewing the Status of PAs, continued

Print Preview

View Authorization Response for AOWPEW KWLVDTYRXW [Back to View Authorization Status](#) ?

Authorization Tracking # 41180120002 Process Type Outpt M/S [Expand All](#) | [Collapse All](#)

Requesting Provider Information +

Recipient Information +

Referring Provider Information +

Diagnosis Information +

Service Provider / Service Details Information -

Provider ID 1831573690 ID Type NPI Name HOSPITALIST SERVICES OF NEVADA-
MANDAVIA

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/12/2018	01/12/2019	10	10	-	CPT/HCPCS 0003F-INACTIVE TOBACCO USE, NON-SMOKING	-	Certified In Total 01/12/2018	-

H **I** **J**

Edit **View Provider Request** **Print Preview**

- H. **Edit:** Edit the PA.
- I. **View Provider Request:** Expand all sections to view the information.
- J. **Print Preview:** Display a printable version of the PA with options to print.



Searching for PAs

Searching for PAs

Prospective Authorizations Search Options **1**

Enter at least one of the following fields to search for an authorization.

2 **Authorization Information**

Authorization Tracking Number

Select a Day Range or specify a Service Date

Day Range OR Service Date

Status Information

Select status to return authorization service lines with the chosen status.

Status

Recipient Information

Recipient information is not mandatory. You can either enter the Recipient ID; or the Last Name, First Name, and Birth Date.

Recipient ID Birth Date

Last Name First Name

Provider Information

Provider ID ID Type

This Provider is the Servicing Provider on the Authorization
 Requesting Provider on the Authorization

1. Click the **Search Options** tab.
2. Enter search criteria into the search fields.

Searching for PAs, continued

Authorization Information

A Authorization Tracking Number

Select a Day Range or specify a Service Date

B Day Range **OR** **C** Service Date 

- A. **Authorization Tracking Number:** Enter the ATN to locate a specific PA.
- B. **Day Range:** Select an option from this list to view PA results within the selected time period.
- C. **Service Date:** Enter the date of service to display PA with that service date.

NOTE: Without an ATN, a **Day Range** or a **Service Date** must be entered. If the PA start date is more than 60 days ago, a **Service Date** must be entered.

Searching for PAs, continued

Status Information	
Select status to return authorization service lines with the chosen status.	
 Status	<ul style="list-style-type: none">CancelCertified In TotalCertified PartialNot CertifiedPended
Recipient Information	
Recipient information is not mandatory. You can either enter the Recipient ID; or the Last Name, First Name, and Birth Date.	

D. **Status:** Select a status from this list to narrow search results to include only the selected status.

Searching for PAs, continued

Recipient Information

Member information is not mandatory. You can either enter the Member ID; or the Last Name, First Name, and Birth Date.

E	Recipient ID	<input type="text"/>	F	Birth Date	<input type="text"/>	
G	Last Name	<input type="text"/>	First Name	<input type="text"/>		

E. **Recipient ID:** Enter the unique Medicaid ID of the client.

F. **Birth Date:** Enter the date of birth for the client.

G. **Last Name** and **First Name:** Enter the client's first and last name.

NOTE: Enter only the **Recipient ID** number **or** the client's last name, first name and date of birth.

Searching for PAs, continued

Provider Information

H Provider ID 

I ID Type

J This Provider is the Servicing Provider on the Authorization
 Referring Provider on the Authorization

H. Provider ID: Enter the provider's unique National Provider Identifier (NPI).

I. ID Type: Select the provider's ID type from the drop-down list.

J. This Provider is the: Select whether the provider is the servicing or referring provider on the PA request.

Searching for PAs, continued

Recipient Information

Recipient information is not mandatory. You can either enter the Recipient ID; or the Last Name, First Name, and Birth

Recipient ID Birth Date

Last Name First Name

Provider Information

Provider ID ID Type

This Provider is the Servicing Provider on the Authorization
 Requesting Provider on the Authorization

3

Search Results

<u>Authorization Tracking Number</u>	<u>Service Date</u> ▼	<u>Recipient Name</u>	<u>Recipient ID</u>	<u>Process Type</u>	<u>Requesting Provider</u>
43180110001	01/11/2018 - 01/11/2019	QROT, FENKTPVI	54409179444	Outpt M/S	HOSPITALIST SERVICES NEVADA-MANDAVIA

3. Click the **Search** button.
4. Select an **ATN** hyperlink to review the PA.



Submitting Additional Information

Submitting Additional Information

View Authorization Response for ABYNNRYP ABIEGUT [Back to View Authorization Status](#)

Authorization Tracking # 45181270003 Process Type Home Health [Expand All](#) | [Collapse All](#)

Requesting Provider Information

Recipient Information

Referring Provider Information

Diagnosis Information

Service Provider / Service Details Information

Provider ID 1831573690 ID Type NPI Name HOSPITALIST SERVICES OF NEVADA-MANDAVIA

From Date	To Date	Units	Remaining Units	Amount	Code	Medical Citation	Decision / Date	Reason
01/01/2018	01/01/2019	1	0	-	CPT/HCPCS A6413-Adhesive bandage, first-aid	-	Pended	-

  [Edit](#) [Provider Request](#) [Print Preview](#)

1. Click the **Edit** button to edit a submitted PA request.

Additional information may include:

- Requests for additional services
- Attachments
- “FA-29 Prior Authorization Data Correction” form
- “FA-29A Request for Termination of Service” form

Submitting Additional Information, continued

2. Add additional diagnosis codes, service details and/or attachments.

Diagnosis Information

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code. Insert decimals as needed.
Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	T7500XA-Unspecified effects of lightning, initial encounter	

Click to collapse.

*Diagnosis Type *Diagnosis Code

Service Details

Click '+' to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

Line #	From Date	To Date	Decision	Code	Modifiers	Units	Action
1	01/01/2018	01/01/2019	Pended	A6413-Adhesive bandage, first-aid		1	Copy

Click to collapse.

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

Click the **Remove** link to remove the entire row.

Transmission Method	File	Attachment Type	Action
---------------------	------	-----------------	--------

Click to collapse.

2

Submitting Additional Information, continued

Attachments

To include an attachment electronically with the prior authorization request, browse and select the attachment, select an Attachment Type and then click on the Add button.

[Prior Authorization Forms](#)

If you will not be sending an attachment electronically, but you have information about files that were sent using another method, such as by fax or by mail, select the appropriate Transmission Method and Attachment Type.

Click the **Remove** link to remove the entire row.

Transmission Method	File	Attachment Type	Action
EL-Electronic Only	Nurse Notes.docx	NN-Nursing Notes	Remove
EL-Electronic Only	Benefit Letter.docx	59-Benefit Letter	Remove

Click to collapse.

*Transmission Method

*Upload File

*Attachment Type

3

3. Click the **Resubmit** button to review the PA information.

Submitting Additional Information, continued

The screenshot shows a web form with several sections: Referring Provider Information, Service Provider Information, Diagnosis Information, Service Details, and Attachments. A red border highlights the entire form area. A callout box with the number '4' points to the Service Provider Information section. A callout box with the number '5' points to the Confirm button at the bottom right of the form.

Referring Provider Information

Provider ID	1831573690	ID Type	NPI	Name	HOSPITALIST SERVICES OF NEVADA-MANDAVIA
-------------	------------	---------	-----	------	-----------------------------------------

Service Provider Information

Provider ID	1831573690	ID Type	NPI	Name	HOSPITALIST SERVICES OF NEVADA-MANDAVIA
Location	_				

[Expand All](#) | [Collapse All](#)

Diagnosis Information

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

Diagnosis Type	Diagnosis Code
ICD-10-CM	T750XA-Unspecified effects of lightning, initial encounter

Service Details

Line #	From Date	To Date	Code	Modifiers	Units
1	01/01/2018	01/01/2019	CPT/HCPCS A6413-Adhesive bandage, first-aid		1

Attachments

Transmission Method	File	Attachment Type
EL-Electronic Only	Nurse Notes.docx	NN-Nursing Notes
EL-Electronic Only	Benefit Letter.docx	59-Benefit Letter

[Back](#) [Confirm](#) [Cancel](#)

4. Review the information.
5. Click the **Confirm** button.

NOTE: The PA number remains the same as the original PA request when resubmitting the PA request.

How to Submit Additional Information, continued

FA-29	Prior Authorization Data Correction Form
FA-29A	Request for Termination of Service
FA-29B	Prior Authorization Reconsideration Request

- Locate necessary forms on the Forms Page after the completion of a PA.
- Once the new information has been added to the PA request, click “Resubmit” to review the PA information.
- Click “Confirm” to resubmit the PA.
- The ATN will remain the same.

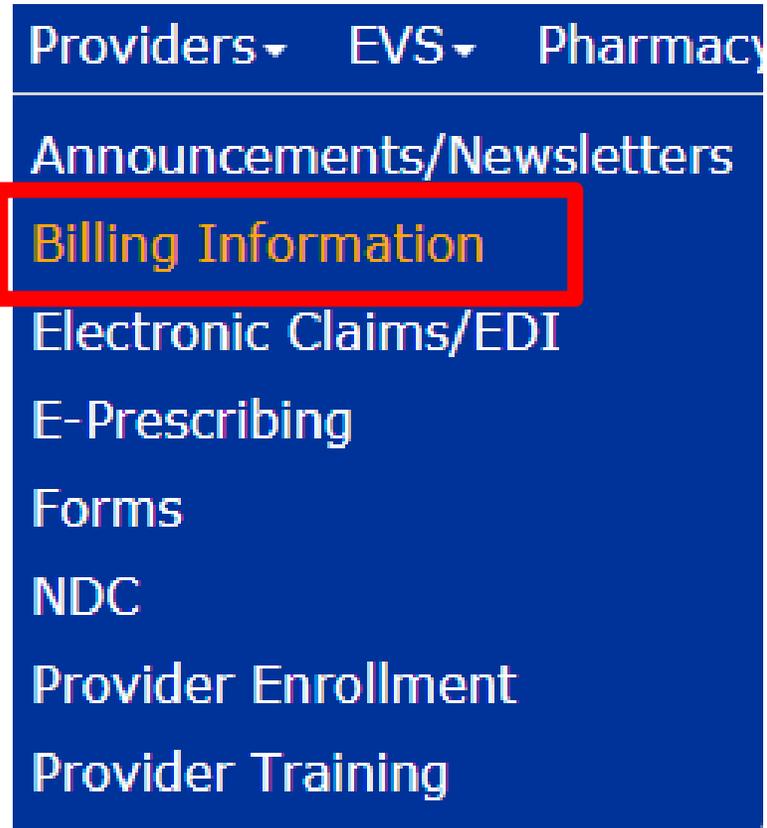


PA requests with a status of Not Certified or Cancel cannot be resubmitted. The **Edit** button will not appear on the View Authorization Response page.



Medicaid Billing Information

Locating Medicaid Billing Information



- Step 1: Highlight **Providers** from top blue tool bar.
- Step 2: Select **Billing Information** from the drop-down menu.

Locating Medicaid Billing Information, continued

Billing Information

Effective February 1, 2019, all providers will be required to submit their claims electronically (using Trading Partners or Direct Data Entry [DDE]), as paper claims submission will no longer be accepted with the go-live of the new modernized Medicaid Management Information System (MMIS). Please continue to review the modernization-related web announcements at <https://www.medicaid.nv.gov/providers/Modernization.aspx> for further details.

Attention All Providers: Requirements on When to Use the National Provider Identifier (NPI) of an Ordering, Prescribing or Referring (OPR) Provider on Claims [[Web Announcement 1711](#)]

FAQs: National Correct Coding Initiative (NCCI) Claim Review Edits [[Review Now](#)]

Clinical Claim Editor FAQs Updated December 5, 2011 [[Review Now](#)]

Third Party Liability Frequently Asked Questions [[Review Now](#)]

Billing Manual

For Archives [Click here](#)

Title	File Size	Last Update
Billing Manual	1 MB	02/01/2019

Review the Billing Manual for more information regarding:

- Introduction to Medicaid
- Contact Information
- Recipient Eligibility
- PA
- Third Party Liability (TPL)
- Electronic Billing
- Frequently Asked Questions
- Claims Processing and Beyond

Locating Medicaid Billing Information, continued

Billing Information

Effective February 1, 2019, all providers will be required to submit their claims electronically (using Trading Partners or Direct Data Entry [DDE]), as paper claims submission will no longer be accepted with the go-live of the new modernized Medicaid Management Information System (MMIS). Please continue to review the modernization-related web announcements at <https://www.medicaid.nv.gov/providers/Modernization.aspx> for further details.

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Clinical Claim Editor FAQs Updated December 5, 2011 [[Review Now](#)]
Third Party Liability Frequently Asked Questions [[Review Now](#)]

Billing Manual

For Archives [Click here](#)

Title	File Size	Last Update
Billing Manual	2 MB	03/18/2019

[Billing Guidelines \(by Provider Type\)](#)

30

[Personal Care Services - Provider Agency](#)

83

[Personal Care Services - Intermediary Service Organization](#)

- Locate the section header “Billing Guidelines (by Provider Type)”
- Select appropriate provider type guideline



Search Fee Schedule and DHCFP Rates Unit

Fee Schedule

Featured Links

[Authorization Criteria](#)

[DHCFP Home](#)

[EDI Information](#)

[EVS User Manual](#)

[Modernization Project](#)

[Online Provider Enrollment](#)

[Provider Login \(EVS\)](#)

[Prior Authorization](#)

[Search Fee Schedule](#)

[Search Providers](#)

[Claims](#)

[Trading Partner](#)

- Utilize the Search Fee Schedule to determine the Rate of Reimbursement for a procedure code.

Fee Schedule, continued



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

[Contact Us](#) | [Login](#)

Home

[Resources](#) > Search Fee Schedule

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AMA Disclaimer of Warranties and Liabilities

* I accept I have read and agree to the Terms of Agreement

Submit

Cancel

- Step 1: Click "I Accept"
- Step 2: Click "Submit"

Fee Schedule, continued

Search Fee Schedule ?

* Indicates a required field.
Select a code type, then enter the procedure code or description and provider type.

- This page is used only for Nevada Fee For Service (FFS) rates.
- The fee displayed to the user as a result of the search may not be the amount the provider receives; Information on the claim may affect actual fee amount. The information contained in the schedule is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein. For example, coverage as well as an actual rate may have been revised or updated and may no longer be the same as posted on the website.
- Revenue code pricing for inpatient and nursing home provider types 011, 013, 019, 051, 056, 063, 065, 075, and 078 that is specific to a provider is not available through the Fee Schedule. Provider specific rates override the fee schedule. In addition, fees are not currently available for PT 064.
- Modifier and specialty do not affect ASC and ESRD bundled rates, so the modifier and specialty will not be used or displayed in the search results for these rates.

Financial Payer and Benefit Nevada Medicaid Title XIX Fee For Service

*Code Type

*Procedure Code or Description

*Service Category

- Step 1: Select Code Type from drop-down menu.
- Step 2: Input Procedure Code or Description.
- Step 3: Select Service Category from drop-down menu.
- Step 4: Click “Search” to populate results.

Fee Schedule, continued

Search Fee Schedule ?

* Indicates a required field.
Select a code type, then enter the procedure code or description and provider type.

- This page is used only for Nevada Fee For Service (FFS) rates.
- The fee displayed to the user as a result of the search may not be the amount the provider receives; Information on the claim may affect actual fee amount. The information contained in the schedule is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein. For example, coverage as well as an actual rate may have been revised or updated and may no longer be the same as posted on the website.
- Revenue code pricing for inpatient and nursing home provider types 011, 013, 019, 051, 056, 063, 065, 075, and 078 that is specific to a provider is not available through the Fee Schedule. Provider specific rates override the fee schedule. In addition, fees are not currently available for PT 064.
- Modifier and specialty do not affect ASC and ESRD bundled rates, so the modifier and specialty will not be used or displayed in the search results for these rates.

Financial Payer and Benefit Nevada Medicaid Title XIX Fee For Service

***Code Type** Procedure ▼

***Procedure Code or Description** 0362T-BHV ID SUPRT ASSMT EA 15 MIN

***Service Category** Behavioral Treatment ▼

Search **Reset**

Note: Make sure that the Effective Date ends in 2299.

Search Results Total Records: 6

Procedure	Provider Type	Provider Specialty	Modifier	Fee Amount	Age Restrictions	Effective Date ▼
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	312-Lic. Board Certified Assist Behavior Analyst			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	312-Lic. Board Certified Assist Behavior Analyst	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	310-Lic. Board Certified Behavior Analyst			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	310-Lic. Board Certified Behavior Analyst	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	311-Psychologist			REGULAR	1/1/2019 - 12/31/2299
0362T-BHV ID SUPRT ASSMT EA 15 MIN	85-Applied Behavior Analysis (ABA)	311-Psychologist	UD-M/caid care lev 13 state		REGULAR	1/1/2019 - 12/31/2299

DHCFP Rates Unit

Quick Links ▾ Calendar

PASRR
Medicaid Services Manual
Rates Unit
Get Adobe Reader

- Step 1: Highlight **Quick Links** from tool bar at www.medicaid.nv.gov.
- Step 2: Select **Rates Unit**.
- Step 3: From new window, select **Accept**.



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

NV.gov Agencies Jobs About Nevada

Google

ADA Americans with Disabilities Act

HOME ABOUT PROGRAMS PROVIDERS MEMBERS PUBLIC NOTICES RESOURCES BOARDS/COMMITTEES CONTACT

▶ POINT AND CLICK LICENSE AGREEMENT FOR AMA/CPT AND ADA/CDT

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End User Point and Click Agreement

ACCEPT

DECLINE

DHCFP Rates Unit, continued

▶ RATE ANALYSIS & DEVELOPMENT

Nevada Medicaid

The Rate Analysis & Development Unit is responsible for: rate development; rate study/review; rate appeals; annual and quarterly updates; and nursing facility rates.

Nevada Medicaid administers the program with provisions of the Nevada Medicaid State Plan, Titles XI and XIX for the Social Security Act, all applicable Federal regulations and other official issuance of the Department. Methods and standards used to determine rates for inpatient and outpatient services are located in the State Plan under Attachments 4.19 A through E.

- [How Medicaid Financing and Reimbursement Work](#)

New Codes for 2019

- [Annual New Code Update Process](#) &
- [2019 Annual Update](#) &
- [Update on the 2019 New Codes](#) &
- [2019 Covered Codes](#) &
- [2019 ASC Covered Codes](#) &

Fee Schedule Search

Nevada Medicaid has a new feature on the Medicaid.nv.gov website under the Provider "Home" page (EVS). The new feature will allow Providers to not only view fee schedules, but also the ability to verify member eligibility, search for claims, payment information and Remittance Advices. For modifier or anesthesia base units, see the appropriate links below. Please refer to the appropriate Medicaid policy to fully determine coverage as well as any coverage limitations. Medicaid policy takes precedence over any code and rate listed here for a particular provider type.

- [Fee Schedule Search](#)
- [Web Portal User Manual](#)
- [Anesthesiology Unit Values](#) &
- [Nevada Medicaid Modifier Listing](#) &

Fee Schedules

The fee schedules found here are updated on an annual basis, sometimes more frequently. Information regarding the [annual new code update](#) & may be found on this website.

The information contained in these schedules is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein.

- [Managed Care Capitation Rates](#) & - Pending CMS Approval
- [Fee-for-Service PDF Fee Schedules](#)

Contact

rates@dhcfp.nv.gov

Rate Recycles

Rate Recycle Reports will be posted here weekly. Please check this section regularly to stay informed.

[Pending Recycles](#) &

— Locate the “Fee-for-Service PDF Fee Schedules” from the Fee Schedules section.

DHCFP Rates Unit, continued

FEE SCHEDULES

The information contained in these schedules is made available to provide information and is not a guarantee by the State or the Department or its employees as to the present accuracy of the information contained herein.

- [Provider Type 30 and 83 Personal Care Services](#) 

- Select Appropriate Title to open the PDF pertaining to the reimbursement schedule.



Submitting a Professional Claim via the EVS Secure Provider Web Portal (DDE)



Understanding Claim Sub Menus

Understanding Claims Sub Menus

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

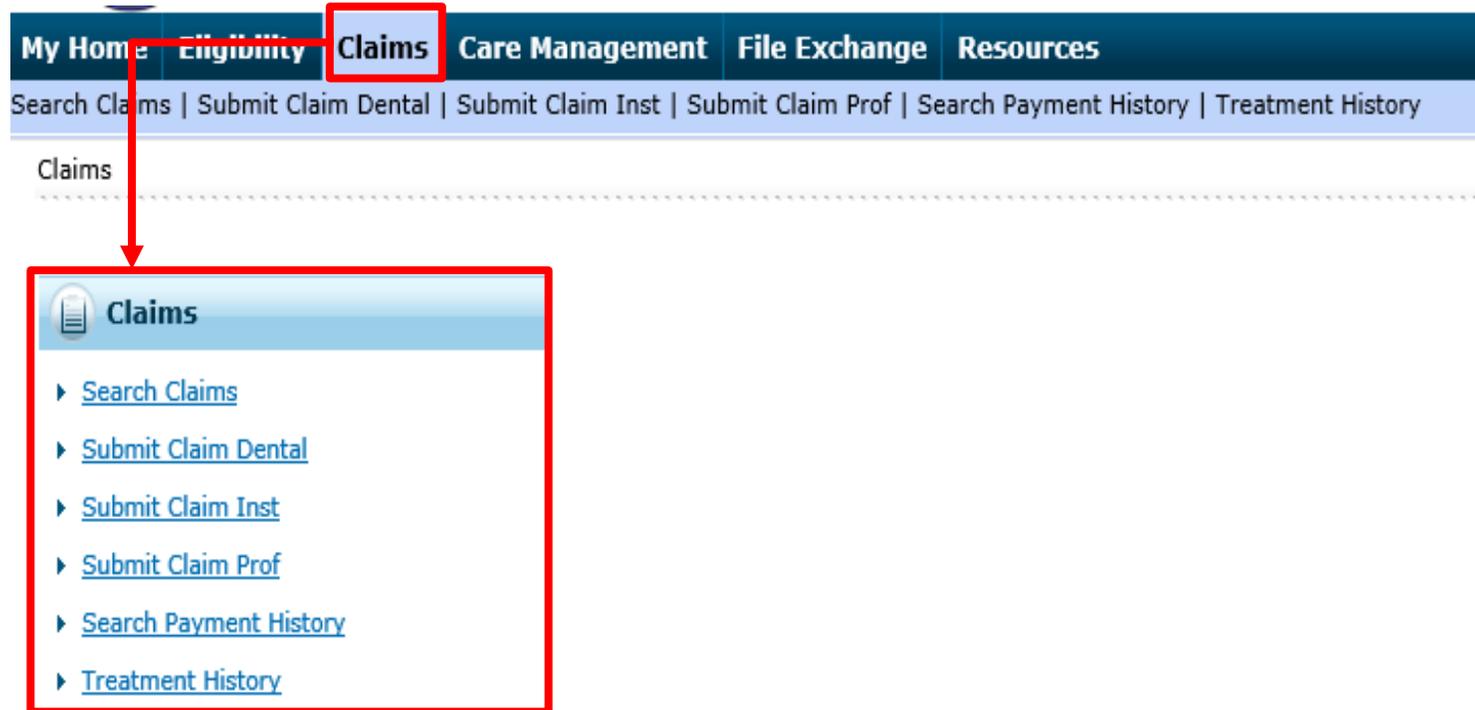
My Home Eligibility **Claims** Care Management File Exchange Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Treatment History

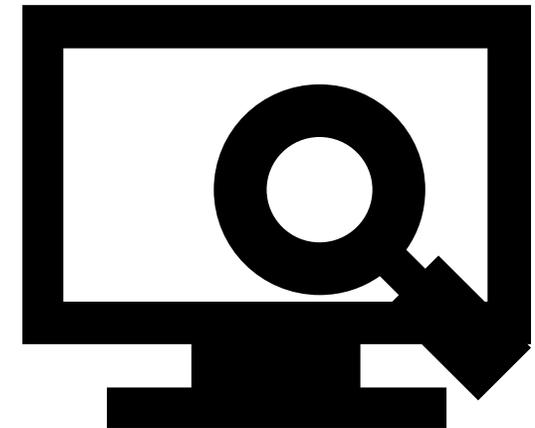
Provider Broadcast Messages [Contact Us](#)

1. Hover over **Claims**.
2. Select the appropriate sub menu from the options.

Understanding Claims Sub Menus, continued



The page will display a list of Claims activities for the user to choose from.





Submitting a Professional Claim

Submitting a Claim

The Professional Claim submission process is broken out into three main steps:

- **Step 1** - Provider, Patient, and Claim Information
- **Step 2** - Diagnosis Codes
- **Step 3** - Service Details and Attachments

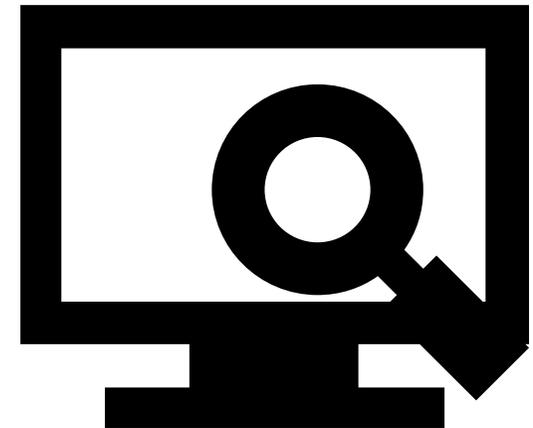


Submitting a Claim: Step 1



The screenshot shows the Nevada Department of Health and Human Services website. The header includes the state seal and the text "Nevada Department of Health and Human Services" and "Division of Health Care Financing and Policy Provider Portal". A navigation bar contains tabs: "My Home", "Eligibility", "Claims", "Care Management", "File Exchange", and "Resources". The "Claims" tab is highlighted with a red box and a callout box labeled "1". Below the navigation bar, a secondary menu contains links: "Search Claims", "Submit Claim Dental", "Submit Claim Inst", "Submit Claim Prof", and "Search Payment His". The "Submit Claim Prof" link is highlighted with a red box and a callout box labeled "2". Below this, a "Claims" section is visible, containing a "Claims" header and a list of links: "Search Claims", "Submit Claim Dental", "Submit Claim Inst", "Submit Claim Prof", "Search Payment History", and "Treatment History".

1. Hover over the **Claims** tab.
2. Select **Submit Claim Prof.**



Submitting a Claim: Step 1

My Home Eligibility **Claims** Care Management File Exchange Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | **Submit Claim Prof** | Search Payment History | Treatment History

Claims > Submit Claim Prof

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type Professional

Provider Information

Billing Provider ID 1578564860 ID Type NPI

*Billing Provider Service Location 20-HOSPITALISTS OF ARIZONA-2510 W DUNLAP AVE STE 290,PHOENIX,ARIZONA,850212759

Rendering Provider ID [] ID Type []

Rendering Provider Service Location -

Referring Provider ID [] ID Type []

Supervising Provider ID [] ID Type []

Service Facility Location ID [] ID Type []

Patient Information

*Recipient ID []

Last Name [] First Name []

Birth Date []

Claim Information

Date Type [] Date of Current []

Accident Related [] Admission Date []

*Patient Number [] Authorization Number []

*Transport Certification Yes No

*Does the provider have a signature on file? Yes No

Include Other Insurance

Total Charged Amount \$0.00

A

B

C

“Submit Professional Claim: Step 1” page sub-sections to complete:

- A. Provider Information
- B. Patient Information
- C. Claim Information

Submitting a Claim: Step 1, continued

Provider Information

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Provider Information

Billing Provider ID	<input type="text" value="1578564860"/>	ID Type	<input type="text" value="NPI"/>
*Billing Provider Service Location	<input type="text" value="20-HOSPITALISTS OF ARIZONA-2510 W DUNLAP AVE STE 290,PHOENIX,ARIZONA,850212759"/>		<input type="text" value="v"/>
Rendering Provider ID	<input type="text"/>	ID Type	<input type="text" value="v"/>
Rendering Provider Service Location	<input type="text" value="-"/>		
Referring Provider ID	<input type="text"/>	ID Type	<input type="text" value="v"/>
Supervising Provider ID	<input type="text"/>	ID Type	<input type="text" value="v"/>
Service Facility Location ID	<input type="text"/>	ID Type	<input type="text" value="v"/>

Patient Information

*Recipient ID	<input type="text"/>
Last Name	<input type="text"/>
First Name	<input type="text"/>

3. Select the appropriate provider type/service location being billed from the **Billing Provider Service Location** drop-down option.
4. Enter the Rendering ID and ID Type. If the Rendering ID is unknown, click the  button adjacent to the **Rendering Provider ID** field.

NOTE: If the Billing Provider has multiple locations, the user will use the drop-down option to locate and select the correct location for the claim.

Submitting a Claim: Step 1, continued

Provider Information

Provider ID Search [Back to Claims](#) ?

5

* Indicates a required field.

*Last Name First Name

6

7

5. Select the desired search method.
6. Enter the provider's last name.
7. Click the **Search** button, and the search results populate at the bottom.
8. Click the [blue](#) link in the **Provider ID** column with correct Provider ID.

Search Results: Smith ?

Duplicate providers may appear in the results since a unique row is created for each specialty. Total Records: 174

Provider ID ▲	Provider Name	Provider Type	Address	City	State	Zip Code
1003195538 (NPI) 8	CHAE A SMITH	Mental Health Outpatient Services	6130 ELTON AVE	LAS VEGAS	NEVADA	89107-2538
1013228659 (NPI)	GWEN M SMITHSON	Mental Health Outpatient Services	224 E WINNIE LN STE 222	CARSON CITY	NEVADA	89706-2251
1013901529 (NPI)	WILLIAM R SMITH	Nurse, Anesthetist	1050 E SOUTH TEMPLE	SALT LAKE CITY	UTAH	84102-1507
1013905793 (NPI)	JEFFERY D SMITH	Physician Assistant	520 S EAGLE RD STE 2209	MERIDIAN	IDAHO	83642-6354
1013907096 (NPI)	AMY P SMITH	Nurse, APRN	2201 SOUTH AVE	S LAKE TAHOE	CALIFORNIA	96150-7025
1023298254 (NPI)	COURTNEY M SMITH	Audiologist	3150 N TENAYA WAY STE 112	LAS VEGAS	NEVADA	89128-0446

NOTE: The user can also search by the **Search By ID** or **Search By Organization** tabs.

Submitting a Claim: Step 1, continued

Provider Information

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Provider Information

Billing Provider ID	1578564860	ID Type	NPI
*Billing Provider Service Location	<input type="text" value="20-HOSPITALISTS OF ARIZONA-2510 W DUNLAP AVE STE 290,PHOENIX,ARIZONA,850212759"/>		
Rendering Provider ID	<input type="text" value="1003195538"/> 🔍	ID Type	<input type="text" value="NPI"/>
Rendering Provider Service Location	<input type="text" value="14-SMITH, MICHAEL A-6130 ELTON AVE,LAS VEGAS,NEVADA,891072538"/>		
Referring Provider ID	<input type="text"/> 🔍	ID Type	<input type="text"/>
Supervising Provider ID	<input type="text"/> 🔍	ID Type	<input type="text"/>
Service Facility Location ID	<input type="text"/> 🔍	ID Type	<input type="text"/>

Patient Information

*Resident ID

9. Select a **Rendering Provider Service Location** from the drop-down.

NOTE: If needed, the user may enter a **Referring Provider**, **Supervising Provider**, or **Service Facility Location ID** the same way the **Rendering Provider ID** was entered.

Submitting a Claim: Step 1, continued

Patient Information

Service Facility Location ID ID Type

Patient Information

*Recipient ID **10**

Last Name TRNXEUK First Name UGNWLA

Birth Date 02/11/1985

Claim Information

Date Type Date of Current

Accident Related Admission Date

*Patient Number Authorization Number

*Transport Certification Yes No

*Does the provider have a signature on file? Yes No

Include Other Insurance Total Charged Amount \$0.00

10. Enter the 11-digit **Recipient ID** and click outside of the field to populate **Last Name, First Name** and **Birth Date**.

Submitting a Claim: Step 1, continued

Claim Information

Birth Date 02/11/1985

Claim Information

Date Type

Accident Related

***Patient Number** 123456789

***Transport Certification** Yes No

***Does the provider have a signature on file?** Yes No

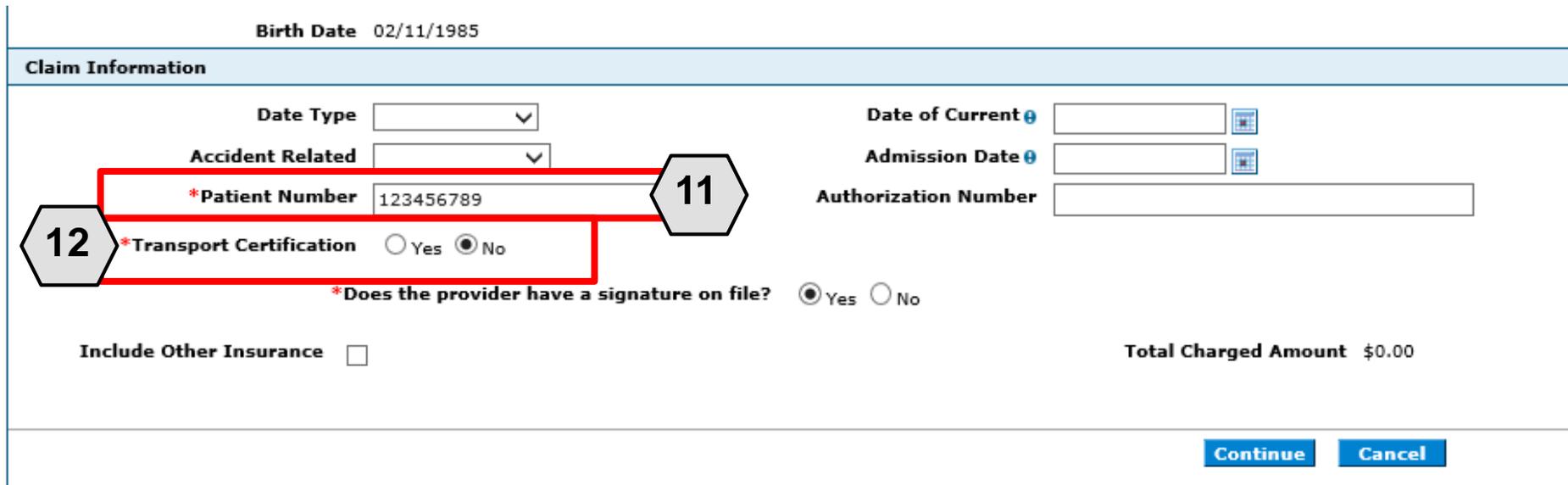
Include Other Insurance

Date of Current

Admission Date

Authorization Number

Total Charged Amount \$0.00



NOTE: Other fields can be completed based on additional details known about the claim.

The following fields with an (*) must be completed as follows:

11. Enter the **Patient Number**.
12. Choose “Yes” or “No” to indicate a **Transport Certification** (If “Yes,” additional details will be required. These are illustrated on the next slide).

Submitting a Claim: Step 1, continued

Claim Information

Claim Information

Date Type Date of Current

Accident Related Admission Date

*Patient Number 123456789 Authorization Number

*Transport Certification Yes No

13 *Certification Condition Indicator Yes No

*Condition Indicator Patient was admitted to a hospital

14

15 *Transport Distance 1.00

*Ambulance Transport Reason Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transported to a facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transported to a facility for care of symptoms, complaints, or both.

*Does the provider have a signature on file? Yes No

Include Other Insurance Total Charged Amount \$0.00

16

If the user selects “Yes” in the **Transport Certification** field, additional details must be entered.

13. Choose “Yes” or “No” as the **Certification Condition Indicator**.

14. Indicate the patient’s condition from the **Condition Indicator** drop-downs (up to five options may be selected).

15. Enter the distance (in miles) that the patient traveled into the **Transport Distance** field.

16. Select the **Ambulance Transport Reason**.

Submitting a Claim: Step 2

Diagnosis Codes

Submit Professional Claim: Step 2 ?

* Indicates a required field.

Claim Type Professional

Provider Information

Billing Provider ID 1578564860 **ID Type** NPI

Patient and Claim Information

Recipient ID 67770816236 **Gender** Male
Recipient UGNWLA TRNXEUK
Birth Date 02/11/1985 **Total Charged Amount** \$0.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes ☰

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
<u>1</u>			
1	*Diagnosis Type <input type="text" value="ICD-10-CM"/>	*Diagnosis Code <input type="text"/>	

[Add](#) [Reset](#)

[Back to Step 1](#) [Continue](#) [Cancel](#)

Once the user clicks the **Continue** button, the “Submit Professional Claim: Step 2” page is displayed with all the panels expanded.

Submitting a Claim: Step 2, continued

Diagnosis Codes

Submit Professional Claim: Step 2 ?

* Indicates a required field.

Claim Type Professional

Provider Information

Billing Provider ID 1578564860 ID Type NPI

Patient and Claim Information

Recipient ID 67770816236 Gender Male
Recipient UGNWLA TRNXEUK
Birth Date 02/11/1985 Total Charged Amount \$0.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes [-]

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1	*Diagnosis Type ICD-10-CM ▼	*Diagnosis Code R40 R400-Somnolence R401-Stupor R4020-Unspecified coma R402110-Coma scale, eyes open, never, unspecified time R402111-Coma scale, eyes open, never, in the field R402112-Coma scale, eyes open, never, EMR R402113-Coma scale, eyes open, never, at hospital admission R402114-Coma scale, eyes open, never, 24+hrs R402120-Coma scale, eyes open, to pain, unspecified time R402121-Coma scale, eyes open, to pain, in the field ** 104 matches found. Select entry or refine search text. **	

1 **3** **2**

[Add](#) [Reset](#)

[Back to Step 1](#)

Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes, descriptions and American Dental Association (ADA) respectively. All rights reserved. AMA and ADA assume no liability for data contained or not contained on this website and on documents.

1. Choose a **Diagnosis Type**.
2. Enter the **Diagnosis Code**.
3. Click the **Add** button.

NOTE: The **Diagnosis Code** field contains a predictive search feature using the first three characters of the code or code description.

Submitting a Claim: Step 2, continued

Diagnosis Codes

Submit Professional Claim: Step 2 ?

* Indicates a required field.

Claim Type Professional

Provider Information

Billing Provider ID 1578564860 **ID Type** NPI

Patient and Claim Information

Recipient ID 67770816236 **Gender** Male
Recipient UGNWLA TRNXEUK
Birth Date 02/11/1985 **Total Charged Amount** \$0.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes [-]

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1	ICD-10-CM	R401-Stupor	Remove
2			

2 *Diagnosis Type *Diagnosis Code

[Add](#) [Reset](#)

[Back to Step 1](#) **4** [Continue](#) [Cancel](#)

Click the **Remove** link to remove a diagnosis code from the claim.

Once all the diagnosis codes have been entered, the user will:

4. Click the **Continue** button.

Submitting a Claim: Step 3

Service Details

Submit Professional Claim: Step 3 ?

* Indicates a required field.

Claim Type Professional

Provider Information

Billing Provider ID 1578564860 ID Type NPI

Patient and Claim Information

Recipient ID 67770816236
 Recipient UGNWLA TRNXEUK Gender Male
 Birth Date 02/11/1985 Total Charged Amount \$0.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes +

Service Details -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1						0.000	

1 *From Date 09/12/2018 To Date 09/12/2018

*Place of Service

01-Pharmacy
 02-Telehealth
 03-School
 04-Homeless Shelter
 05-Indian Health Service Free-standing Facility
 06-Indian Health Service Provider-based Facility
 07-Tribal 638 Free-standing Facility
 08-Tribal 638 Provider-based Facility
 09-Prison-Correctional Facility
 11-Office
 12-Home
 13-Assisted Living Facility
 14-Group Home *
 15-Mobile Unit
 16-Temporary Lodging
 17-Walk-in Retail Health Clinic

Procedure Code
 Modifiers
 *Charge Amount
 *Units 0.000
 *Unit T
 Clia Number
 Rendering Provider ID
 Rendering Provider Service Location
 Referring ID Type

Enter the following service details for the claim:

1. Enter the **From Date** and **To Date** that services were rendered.
2. Select the **Place of Service** from the drop-down.

Submitting a Claim: Step 3, continued

Service Details

Diagnosis Codes

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1						0.000	

1 *From Date 09/12/2018 To Date 09/12/2018 *Place of Service 11-Office EMG

*Procedure Code 201 Modifiers

20100-Explore wound neck
20101-Explore wound chest
20102-Explore wound abdomen
20103-Explore wound extremity
2010F-Vital signs recorded
2014F-Mental status assess
20150-Excise epiphyseal bar
2015F-Asthma impairment assessed
2016F-Asthma risk assessed
2018F-Hydration status assess
** 11 matches found. Select entry or refine search text. **

*Diagnosis Pointers 1

EPSDT Family Plan

NDCs for Svc. # 1

Add Reset

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

3. Enter the **Procedure Code**, which is searchable by entering at least the first three letters or numbers of the code description.

4. Enter at least one **Diagnosis Pointer**.

NOTE: **Diagnosis Pointers** are used to show what diagnosis is applicable to a service detail.

Submitting a Claim: Step 3

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
<u>1</u>						0.000	

1 *From Date 09/12/2018 To Date 09/12/2018 *Place of Service 11-Office EMG

*Procedure Code 2018F-Hydration st Modifiers *Diagnosis Pointers 1

*Charge Amount 100.00 *Units 1.000 *Unit Type Unit Minutes EPSDT Family Plan

5 6 7

NDCs for Svc. # 1

8 Add Reset

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

Back to Step 1 Back to Step 2 Submit Cancel

With the **Procedure Code** and **Diagnosis Pointers** entered, the user will need to:

5. Enter a **Charge Amount**.
6. Enter the number of **Units**.
7. Select a **Unit Type** from the drop-down.
8. Click the **Add** button to add the procedure to the claim.

NOTE: The user may enter any additional details, such as **Modifiers**, prior to clicking **Add**. Repeat Steps 1-8 in this section for each additional procedure.

Submitting a Claim: Step 3, continued

Service Details

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/12/2018	09/12/2018	11-Office	2018F-Hydration status assess	\$100.00	1.000 Unit	Remove

1 *From Date 09/12/2018 To Date 09/12/2018 *Place of Service 11-Office EMG

*Procedure Code 2018F-Hydration st Modifiers *Diagnosis Pointers 1

*Charge Amount 100.00 *Units 1.000 *Unit Type Unit EPSDT Family Plan

Clia Number

Rendering Provider ID ID Type

Rendering Provider Service Location

Referring Provider ID ID Type

NDCs for Svc. # 1								
Save Reset Cancel								
2	01/12/2018	01/12/2018	11-Office	96361-Hydrate iv infusion add-on	\$200.00	1.000 Unit	Remove	
3						0.000		
3	*From Date	To Date	*Place of Service					EMG

When editing a Service Detail, three buttons are available:

- Save:** Saves any changes made to the detail.
- Reset:** Clears all fields in the selected service detail.
- Cancel:** Cancels any updates and closes the service detail.

Submitting a Claim: Step 3, continued

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/12/2018	09/12/2018	11-Office	2018F-Hydration status assess	\$100.00	1.000 Unit	Remove

1 *From Date 09/12/2018 To Date 09/12/2018 *Place of Service 11-Office EMG

*Procedure Code 2018F-Hydration st Modifiers *Diagnosis Pointers 1

*Charge Amount 100.00 *Units 1.000 *Unit Type Unit EPSDT Family Plan

Clia Number

Rendering Provider ID ID Type

Rendering Provider Service Location Referring Provider ID ID Type

NDCs for Svc. # 1

If applicable, only one NDC/UPN is allowed per service detail line. When adding an NDC/UPN, the Code Type, Quantity and Unit of Measure fields are required. Additionally, NDC/UPN information is required when adding or saving NDC/UPN with prescription information (Prescription Number, Prescription Type, Prescription Date).

Code Type HIBC

NDC/UPN 123456789

Quantity 1.000 Unit of Measure Milliliter

Save Reset Cancel

Optionally, if the user needs to enter a National Drug Code for a Service Detail, the user will click the  symbol to expand the **NDC for Svc.** panel.

From here, the user may enter and save NDC information to the service detail. To close this panel, the user will click the  symbol.

Submitting a Claim: Step 3, continued

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/12/2018	09/12/2018	11-Office	2018F-Hydration status assess	\$100.00	1.000 Unit	Remove
2	01/12/2018	01/12/2018	11-Office	96361-Hydrate iv infusion add-on	\$200.00	1.000 Unit	Remove
3						0.000	

3 *From Date To Date *Place of Service EMG

*Procedure Code Modifiers *Diagnosis Pointers

*Charge Amount *Units *Unit Type EPSDT Family Plan

Clia Number

Rendering Provider ID ID Type

Rendering Provider Service Location

Referring Provider ID ID Type

NDCs for Svc. # 3

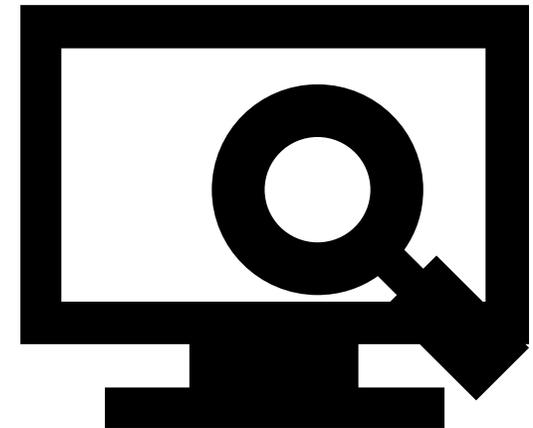
Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

9

9. Click the **Submit** button.



Submitting a Claim: Step 3, continued

Date Type Accident Related Patient Number 123456789
 Date of Current Admission Date Authorization Number

Transport Certification Yes
 Certification Condition Indicator Yes
 Condition Indicator Patient was admitted to a hospital
 Transport Distance 1.00
 Ambulance Transport Reason Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transferred to a residential facility.
 Previous Claim ICN
 Note
 Does the provider have a signature on file? Yes

Total Charged Amount \$300.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes +

Service Details -

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
<u>1</u>	09/12/2018	09/12/2018	11		2018F		1	1.000 Unit	<input type="checkbox"/>	<input type="checkbox"/>	\$100.00
<u>2</u>	01/12/2018	01/12/2018	11		96361		1	1.000 Unit	<input type="checkbox"/>	<input type="checkbox"/>	\$200.00

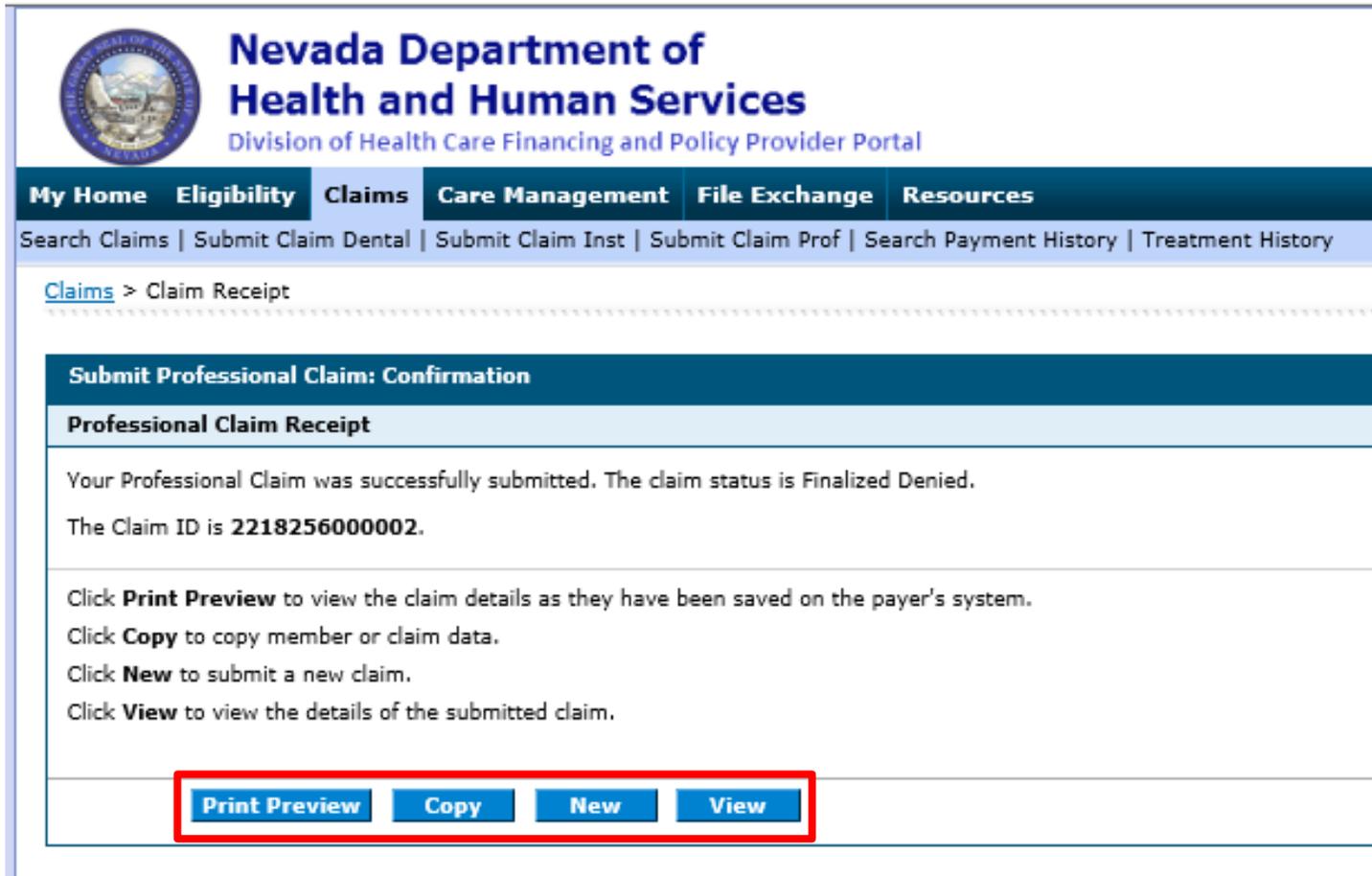
No Other Insurance Details exist for this claim

No Attachments exist for this claim

Back to Step 1
Back to Step 2
Back to Step 3
Print Preview
10
Confirm
Cancel

10. Click the **Confirm** button.

Submitting a Claim: Step 3, continued



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

My Home | **Eligibility** | **Claims** | **Care Management** | **File Exchange** | **Resources**

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Treatment History

[Claims](#) > Claim Receipt

Submit Professional Claim: Confirmation

Professional Claim Receipt

Your Professional Claim was successfully submitted. The claim status is Finalized Denied.
The Claim ID is **2218256000002**.

Click **Print Preview** to view the claim details as they have been saved on the payer's system.
Click **Copy** to copy member or claim data.
Click **New** to submit a new claim.
Click **View** to view the details of the submitted claim.

Print Preview | **Copy** | **New** | **View**

The **Submit Professional Claim: Confirmation** will appear after the claim has been submitted. It will display the claim status and **Claim ID**.

The user may then:

- Click the **Print Preview** button to view the claim details.
- Click the **Copy** button to copy claim data.
- Click the **New** button to submit a new claim.
- Click the **View** button to view the details of the submitted claim, including adjudication errors.



Submitting a Claim: Attachments

Submitting a Claim: Attachments

1	09/12/2018	09/12/2018	11-Office	2018F-Hydration status assess	\$100.00	1.000 Unit	Remove
2	01/12/2018	01/12/2018	11-Office	96361-Hydrate iv infusion add-on	\$200.00	1.000 Unit	Remove
3						0.000	

3 *From Date To Date *Place of Service EMG

*Procedure Code Modifiers *Diagnosis Pointers

*Charge Amount *Units *Unit Type EPSDT Family Plan

Clia Number

Rendering Provider ID ID Type

Rendering Provider Service Location

Referring Provider ID ID Type

NDCs for Svc. # 3

[Add](#) [Reset](#)

Attachments

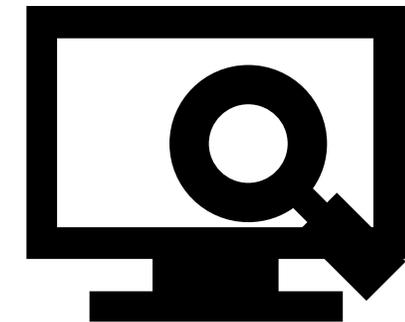
Click the **Remove** link to remove the entire row.

#	Transmission Message	File	Control #	Attachment Type	Action
+	Click to add attachment.				

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Cancel](#)

To upload attachments to a professional claim:

1. Click the (+) sign on the **Attachments** panel.



Submitting a Claim: Attachments, continued

The screenshot shows a web application interface for submitting a claim attachment. A "Choose File to Upload" dialog box is open, displaying the Desktop folder. The file "Test doc.pdf" is selected, and the "Open" button is highlighted. The background interface includes a form with the following fields:

- *Transmission Method: FT-File Transfer
- *Upload File: Browse...
- *Attachment Type: [Dropdown]
- Description: [Text Field]

Below the form are "Add" and "Cancel" buttons. At the bottom of the page are "Back to Step 1", "Back to Step 2", "Submit", and "Cancel" buttons. A table with columns "Control #", "Attachment Type", and "Action" is partially visible.

2. Click **Browse** button and locate the file on your computer to be attached.

A window will then pop up. From there:

3. Locate and select the file.

4. Click the **Open** button.

NOTE: The **Transmission Method** field will populate with "FT - File Transfer" by default and does not need to be changed.

Submitting a Claim: Attachments, continued

Charge Amount Units 0.000 Unit type Unit EPSP Family Plan

Clia Number

Rendering Provider ID ID Type

Rendering Provider Service Location

Referring Provider ID ID Type

NDCs for Svc. # 3

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method	FT-File Transfer			
	*Upload File	C:\Users\abarger\Desktop\Test doc.pdf	Browse...		
	*Attachment Type	NN-Nursing Notes			
	Description	<input type="text"/>			

5. Select the type of attachment from the **Attachment Type** drop-down list.
6. Click the **Add** button to attach the file OR click on the **Cancel** button to cancel and close the attachment line.

NOTE: A description of the attachment may be entered into the **Description** field, but it is not required.

Submitting a Claim: Attachments, continued

3 0.000

3 *From Date To Date *Place of Service EMG

*Procedure Code Modifiers *Diagnosis Pointers

*Charge Amount *Units 0.000 *Unit Type Unit EPSDT Family Plan

Clia Number

Rendering Provider ID ID Type

Rendering Provider Service Location

Referring Provider ID ID Type

NDCs for Svc. # 3

[Add](#) [Reset](#)

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
1	FT-File Transfer	Test doc.pdf (39K)	20180918859657	NN-Nursing Notes	Remove

Click to add attachment.

[Back to Step 1](#) [Back to Step 2](#) **7** [Submit](#) [Cancel](#)

7. Click the **Submit** button to proceed.

NOTE: To remove any attachments, click the **Remove** link.



Submitting a Crossover Claim

Submitting a Crossover Claim

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type Crossover Professional 1

Provider Information

Billing Provider ID	1952455032	ID Type	NPI
*Billing Provider Service Location	20-LESTER, LINDA B-1664 N VIRGINIA ST MAIL STOP 1,RENO,NEVADA,89557777		
Rendering Provider ID	<input type="text"/>	ID Type	<input type="text"/>
Rendering Provider Service Location	-		
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>
Supervising Provider ID	<input type="text"/>	ID Type	<input type="text"/>
Service Facility Location ID	<input type="text"/>	ID Type	<input type="text"/>

Patient Information

*Recipient ID	<input type="text" value="80733203496"/>		
Last Name	FICDTF	First Name	FERADRF
Birth Date	01/26/1943		

Claim Information

Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text"/>	Admission Date	<input type="text"/>
*Patient Number	<input type="text" value="12345"/>	Authorization Number	<input type="text"/>
*Transport Certification	<input type="radio"/> Yes <input checked="" type="radio"/> No		
*Does the provider have a signature on file?	<input checked="" type="radio"/> Yes <input type="radio"/> No		
Include Other Insurance	<input type="checkbox"/>		
Total Charged Amount	\$0.00		

Medicare Crossover Details

Allowed Medicare Amount	<input type="text" value="5,000.00"/>	Co-insurance Amount	<input type="text" value="950.00"/>
Deductible Amount	<input type="text" value="250.00"/>	Psychiatric Services Amount	<input type="text" value="0.00"/>
Medicare Payment Amount	<input type="text" value="3,800.00"/>	Medicare Payment Date	<input type="text" value="10/12/2018"/>

1. Select the **Claim Type: Crossover Professional**.

NOTE: The user will follow the same steps as previously shown in the “Submitting a Professional Claim” section.

Submitting a Crossover Claim, continued

Medicare Crossover Details

Allowed Medicare Amount	<input type="text" value="5,000.00"/>	2	Co-insurance Amount	<input type="text" value="950.00"/>
Deductible Amount	<input type="text" value="250.00"/>		Psychiatric Services Amount	<input type="text" value="0.00"/>
Medicare Payment Amount	<input type="text" value="3,800.00"/>		Medicare Payment Date	<input type="text" value="10/12/2018"/>

3

2. Enter the **Medicare Crossover Details:**

- **Allowed Medicare Amount**
- **Deductible Amount**
- **Medicare Payment Amount**
- **Medicare Payment Date**

3. Click the **Continue** button.

Submitting a Crossover Claim, continued

Diagnosis Codes +

Service Details -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1						0.000	

1 *From Date To Date *Place of Service EMG

*Procedure Code Modifiers *Diagnosis Pointers

*Charge Amount *Units *Unit Type EPSDT Family Plan

Clia Number

Rendering Provider ID ID Type **4**

Rendering Provider Service Location

Referring Provider ID ID Type

Medicare Crossover Details

Allowed Medicare Amount	<input type="text" value="5,000.00"/>	Co-insurance Amount	<input type="text" value="950.00"/>
Deductible Amount	<input type="text" value="250.00"/>	Psychiatric Services Amount	<input type="text" value="0.00"/>
Medicare Payment Amount	<input type="text" value="3,800.00"/>	Medicare Payment Date	<input type="text" value="10/12/2018"/>

NDCs for Svc. # 1 +

5

4. Enter applicable service detail information. Required fields are marked with a red asterisk (*).
5. Click the **Add** button.

Submitting a Crossover Claim, continued

Medicare Crossover Details							
Allowed Medicare Amount	\$5,000.00	Co-insurance Amount	\$950.00				
Deductible Amount	\$250.00	Psychiatric Services Amount	\$0.00				
Medicare Payment Amount	\$3,800.00	Medicare Payment Date	10/12/2018				
Expand All Collapse All							
Diagnosis Codes							
Service Details							
Select the row number to edit the row. Click the Remove link to remove the entire row.							
Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	09/20/2018	09/20/2018	21-Inpatient Hospital	01210-Anesth hip joint surgery	\$6,500.00	120.000 Unit	Remove
2						0.000	
Attachments							
Back to Step 1 Back to Step 2 6 Submit Cancel							

6. Click the **Submit** button.

Submitting a Crossover Claim, continued

Medicare Crossover Details												
Allowed Medicare Amount \$5,000.00				Co-insurance Amount \$950.00								
Deductible Amount \$250.00				Psychiatric Services Amount \$0.00								
Medicare Payment Amount \$3,800.00				Medicare Payment Date 10/12/2018								
Expand All Collapse All												
Diagnosis Codes												+
Service Details												-
#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount	
1	09/20/2018	09/20/2018	21		01210		1	120.000 Unit	<input type="checkbox"/>	<input type="checkbox"/>	\$6,500.00	
No Other Insurance Details exist for this claim												
No Attachments exist for this claim												
Back to Step 1				Back to Step 2		Back to Step 3		Print Preview		<div style="display: inline-block; border: 1px solid gray; padding: 5px; margin: 0 10px;">7</div> <div style="display: inline-block; border: 2px solid red; padding: 5px; margin: 0 10px;">Confirm</div> <div style="display: inline-block; padding: 5px; margin: 0 10px;">Cancel</div>		

7. Click the **Confirm** button.

Submitting a Crossover Claim, continued

Submit Crossover Professional Claim: Confirmation ?

Crossover Professional Claim Receipt

Your Crossover Professional Claim was successfully submitted. The claim status is Finalized Payment.

The Claim ID is 2218297000010.

Click **Print Preview** to view the claim details as they have been saved on the payer's system.
Click **Copy** to copy member or claim data.
Click **Adjust** to resubmit the claim.
Click **New** to submit a new claim.
Click **View** to view the details of the submitted claim.

[Print Preview](#) [Copy](#) [Adjust](#) [New](#) [View](#)

The user will receive a **Confirmation** with the **Professional Claim Receipt**.



Searching for a Professional Claim

Searching for a Claim

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

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My Home | **Eligibility** | **Claims** | **Management** | **File Exchange** | **Resources**

Search Claims | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Search Payment History](#) | [Treatment History](#)

Search Claims

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.

Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID

Recipient Information

Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type

Service From To Claim Status

Search **Reset**

To search for a claim the user will need to:

1. Hover over **Claims**.
2. Select **Search Claims**.

Searching for a Claim, continued

Search Claims

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.
Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID

Recipient Information

3 Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type

Service From To Claim Status

4

The fastest way to locate a claim is by entering the **Claim ID**.

To search without using the **Claim ID**:

3. Enter the search parameters.
4. Click the **Search** button.

NOTE: When searching for a claim without using the **Claim ID**, the user must enter the **Recipient ID** along with the **Service From** and **To** date range as shown in this example.

Searching for a Claim, continued

Search Claims ?

Medical/Dental

A minimum one field is required.
 Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.

Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID

Recipient Information

Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type

Service From To Claim Status

Once the user has clicked the **Search** button, the results will display below. From there, the user may:

5. Click the **(+)** symbol to expand the claim details.

Search Results

To see service line information, or to view the remittance advice, click on the '+' next to the claims ID.

Total Records: 1

	Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
5	2218256000002		Professional	Finalized Denied	09/12/2018	67770816236	1003195538	\$0.00	09/14/2018	

Searching for a Claim, continued

Search Results

To see service line information, or to view the remittance advice, click on the '+' next to the claims ID. Total Records: 1

Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
2218256000002		Professional	Finalized Denied	09/12/2018	67770816236	1003195538	\$0.00	09/14/2018	

Professional Claim Information

Recipient UGNWLA TRNXEUK	Total Charge Amount \$300.00
Birth Date 02/11/1985	Total Paid Amount \$0.00
Rendering Provider MICHAEL A SMITH	Paid Date 09/14/2018
Claim Status Finalized Denied	Reason Code Finalized/Denial-The claim/line has been denied.

Service Information

Service	Service Date	Line Status	Reason Code	Units	Procedure/Modifiers	Charge	Paid
1	09/12/2018	Finalized Denied	Finalized/Denial-The claim/line has been denied.	1	2018F	\$100.00	\$0.00
2	01/12/2018	Finalized Denied	Finalized/Denial-The claim/line has been denied.	1	96361	\$200.00	\$0.00

[RA Copy \(PDF\)](#)

- Click the [blue Claim ID](#) link to open a specific claim

NOTE: The user may view the RA by clicking the **RA Copy (PDF)** button. Searching for RAs will be covered later in the training.

Searching for a Claim, continued

[Claims](#) > [Search Claims](#) > View Dental Claim

[Print Preview](#)

View Dental Claim - ID 2218235000007

[Back to Search Results](#) ?

Provider Information

Billing Provider ID	1407146111	ID Type	NPI
Billing Provider Service Location	22-SMILES TODAY DENTAL GROUP LLC-1580 E DESERT INN RD, LAS VEGAS, NEVADA, 89169		
Rendering Provider ID	1407146111	ID Type	NPI
Rendering Provider Service Location	22-SMILES TODAY DENTAL GROUP LLC-1580 E DESERT INN RD, LAS VEGAS, NEVADA, 89169		
Referring Provider ID	_	ID Type	_
Service Facility Location ID	_	ID Type	_

Patient Information

Claim Status	Finalized Denied		
Recipient ID	97338188081		
Recipient	WXEBVG MUZAE	Gender	Female
Birth Date	05/02/1967		

Claim Information

Accident Related	_	Accident Date	_
Place of Treatment	11-Physician's Office		
Patient Number	12345		
Authorization Number	_		
Related Claim ICN	_		
Previous Claim ICN	_		
Note	_		
Total Allowed Amount	\$0.00	Total Co-pay Amount	\$0.00
		Total Charged Amount	\$725.25
		Total Paid Amount	\$0.00

[Expand All](#) All

Adjudication Errors

7

Diagnosis Codes

If the claim is denied, the user may review the errors as follows:

7. Click the (+) symbol adjacent to the **Adjudication Errors** panel.

Searching for a Claim, continued

Certification Condition Indicator Yes

Condition Indicator Patient was admitted to a hospital

—

—

—

Transport Distance 1.00

Ambulance Transport Reason Patient was transported to nearest facility for care of symptoms, complaints, or both. Can be used to indicate that the patient was transferred to a residential facility.

Previous Claim ICN —

Note —

Does the provider have a signature on file? Yes

Total Charged Amount \$300.00

Total Allowed Amount \$0.00 **Total Co-pay Amount** \$0.00 **Total Paid Amount** \$0.00

[Expand All](#) | [Collapse All](#)

Adjudication Errors -

Claim / Service #	HIPAA Adj	Description	EOB
Service # 1	1010	RENDERING PROV NOT MEMBER OF BILLING PROV GROUP	3110
Service # 2	1010	RENDERING PROV NOT MEMBER OF BILLING PROV GROUP	3110

Diagnosis Codes +

Service Details -

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
<u>1</u>	09/12/2018	09/12/2018	11	N	2018F		1	1.000 Unit	\$100.00	\$0.00	\$0.00	\$0.00
<u>2</u>	01/12/2018	01/12/2018	11	N	96361		1	1.000 Unit	\$200.00	\$0.00	\$0.00	\$0.00

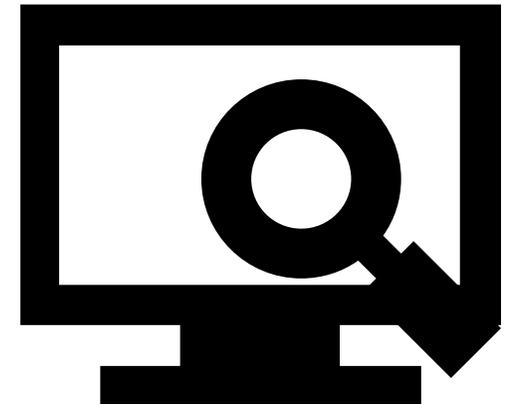
No Other Insurance Details exist for this claim

No Attachments exist for this claim

[Copy](#) [Print Preview](#) [RA Copy \(PDF\)](#)

With the **Adjudication Errors** panel expanded, the user may review the errors associated with the claim's denial.

NOTE: User will be shown how to adjust a claim later in the training.



Viewing a Remittance Advice (RA)

Viewing a Remittance Advice

The screenshot shows the Provider Web Portal interface. The navigation menu at the top includes 'My Home', 'Eligibility', 'Claims', 'Care Management', 'File Exchange', 'Resources', and 'My Provider'. The 'Claims' menu item is highlighted with a red box and a callout '1'. Below the navigation menu, the 'Search Payment History' link is highlighted with a red box and a callout '2'. The main content area shows the 'Search Payment History' form. The form includes a 'Provider Information' section with the following details: Provider ID 1205806429, ID Type NPI, Name KAREN S GONZALEZ, and Location ID 100506939. Below this, there is a search criteria section with the following fields: Payment Method (All), Payment Type (All), Check # / RA # (empty), Issue Date (From 06/22/2018, To 09/20/2018). A red box highlights the search criteria section, with a callout '3' pointing to it. At the bottom of the form, there is a 'Search' button highlighted with a red box and a callout '4', and a 'Reset' button next to it.

To begin locating an RA, the user will:

1. Hover over **Claims**.
2. Select **Search Payment History**.
3. Enter search criteria to refine the search results.
4. Click the **Search** button.

NOTE: Users can only search for RAs on the Provider Web Portal for the past 6 months. The default search range is for the past 90 days.

Viewing a Remittance Advice, continued

Search Results						
To access a copy of the Remittance Advice, select the 'RA' icon. Access to the RA will require PDF software.						
If the RA is too large to display, you will get an error message instead of downloaded RA. You will need to contact Customer Service for assistance.						
					5	Total Records: 11
Issue Date	Payment Method	Payment Type	Check # / RA #	Total Paid Amount	RA Copy (PDF)	
09/14/2018	CHK	C	000000000/100005447	\$0.00		
09/07/2018	CHK	C	000012397/100005394	\$30.00		
09/07/2018	ACH	E	000930866/100005361	\$130.00		
08/31/2018	CHK	C	000000000/100005323	\$0.00		
08/17/2018	CHK	C	000000000/100005263	\$0.00		
08/10/2018	ACH	E	000930835/100005216	\$300.00		
08/10/2018	ACH	E	000930819/100005155	\$610.00		
07/13/2018	ACH	E	000930802/100004985	\$50.00		
07/06/2018	ACH	E	000930797/100004953	\$20.00		
06/29/2018	ACH	E	000930789/100004925	\$10.00		

5. Click on the RA Copy (PDF) icon.

Viewing a Remittance Advice, continued

Search Results

To access a copy of the Remittance Advice, select the 'RA' icon. Access to the RA will require PDF software.

If the RA is too large to display, you will get an error message instead of downloaded RA. You will need to contact Customer Service for assistance.

Total Records: 11

Issue Date	Payment Method	Payment Type	Check # / RA #	Total Paid Amount	RA Copy (PDF)
09/14/2018	CHK	C	000000000/100005447	\$0.00	
09/07/2018	CHK	C	000012397/100005394	\$30.00	
09/07/2018	ACH	E	000930866/100005361	\$130.00	
08/31/2018	CHK	C	000000000/100005323	\$0.00	
08/17/2018	CHK	C	000000000/100005263	\$0.00	
08/10/2018	ACH	E	000930835/100005216	\$300.00	
08/10/2018	ACH	E	000930819/100005155	\$610.00	
07/13/2018	ACH	E	000930802/100004985	\$50.00	
07/06/2018	ACH	E	000930797/100004953	\$20.00	
06/29/2018	ACH	E	000930789/100004925	\$10.00	

1 2

PDF Files require [Adobe Acrobat Reader](#)

Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes, descriptions and data are copyrighted by the American Medical Association (AMA) and the American Dental Association (ADA), respectively, all rights reserved. AMA and ADA assume no liability for data contained or not contained on this website and on documents posted herein.

CPT is a registered trademark ® of the AMA. CDT is a registered trademark ® of the ADA. Applicable FARS/DFARS apply.

6. User will click the **Open** button.

Do you want to open or save **RA 100005447.pdf** (4.10 KB) from **portalmod.nvad.xnv.dcs-usps.com**?

6

Open

Save

Cancel

×

Viewing a Remittance Advice, continued

REPORT: CRA-HCDN-R	NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY				DATE: 09/13/2018	
RA#: 100005447	NEVADA MEDICAID (TXIX)				PAGE: 2	
PAYER: TXIX	PROVIDER REMITTANCE ADVICE					
	PROFESSIONAL SERVICES CLAIMS DENIED					
GONZALEZ KAREN S				PAYEE ID 100506939	MCD	
PO BOX 748356				NPI 1205806429		
LOS ANGELES, CA 90074-4444				CHECK/EPT NUMBER 000000000		
				PAYMENT DATE 09/14/2018		
--ICN--	PCN	MRN	SERVICE DATES	BILLED	OTH INS	SPENDDOWN
			FROM TO	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: ARS EAUNSXK			MEMBER NO.: 97131704238			
218256000001 UNLINK			091318 091318	10.00	0.00	0.00
			SERVICE DATES	PA NUMBER		
PROC CD MODIFIERS ALLW UNITS	FROM TO	RENDERING PROVIDER	BILLED AMT	DETAIL	ROBS	
65436	0.00	091318 091318	MCD 100506939		3006	
NCPDP REJ:				10.00		
TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:				10.00	0.00	0.00
TOTAL NO. DENIED:	1					

After clicking **Open**, the user can review the RA.



Copying Claims

Copying a Claim

My Home Eligibility Claims Care Management File Exchange Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Treatment History

1 Search Claims Wednesday 09/19/2018 03:25 PM PST

Search Claims

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.
Claim searches are limited to a maximum range of 45 days.

Claim Information 2

Claim ID

Recipient Information

Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type

Service From To Claim Status

3

Search Results

To see service line information, or to view the remittance advice, click on the '+' next to the claims ID. Total Records: 1

	Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
+ 4	2218262000035		Professional	Finalized Payment	09/18/2018	67032685329	1841251725	\$44.62	-	

To copy a claim, the user will:

1. Return to the “Search Claims” page.
2. Enter the search criteria.
3. Click the **Search** button.

Search results will populate at the bottom of the screen.

From the search results:

4. Click the [blue Claim ID](#) link.

Copying a Claim, continued

Recipient: FROBNEY, V. SHARON
Birth Date: 05/01/2002

Claim Information

Claim Status: Finalized Payment
Date Type: _
Accident Related: _
Patient Number: 053036404FKE
Related Claim ICN: _
Transport Certification: No
Previous Claim ICN: _
Note: _
Date of Current: _
Admission Date: 09/18/2018
Authorization Number: _
Does the provider have a signature on file? Yes

Total Charged Amount: \$175.00
Total Allowed Amount: \$44.62
Total Co-pay Amount: \$0.00
Total Paid Amount: \$44.62

[Expand All](#) | [Collapse All](#)

Adjudication Errors +

Diagnosis Codes +

Service Details -

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	09/18/2018	09/18/2018	32	N	99308		1	1.000 Unit	\$175.00	\$44.62	\$0.00	\$44.62

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Adjust Copy Void Print Preview

After the user has viewed the claim, user will:

5. Scroll down to the bottom of the "Claim Information" page.
6. Click the **Copy** button.

Copying a Professional Claim, continued

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

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My Home | **Eligibility** | **Claims** | **Care Management** | **File Exchange** | **Resources**

[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Search Payment History](#) | [Treatment History](#)

[Claims](#) > [Search Claims](#) > [View Professional Claim](#) > Copy Claim

Copy Professional Claim

Select the information you would like to have copied to the new claim. Press Copy to initiate the claim and continue entering claim information.

<input type="radio"/> Recipient Information Recipient ID Last Name First Name Birth Date Patient Number	<input type="radio"/> Service Information Service Facility Location Diagnosis Code(s) Place(s) of Service Procedure Code(s) Modifier(s) Diagnosis Pointer(s) Detail Charge Amount(s) Units Unit Type(s) Rendering Provider(s) NDC Code Type(s) NDC Code(s) NDC Unit Price(s) NDC Quantity(s) NDC Unit of Measure(s)	<input type="radio"/> Recipient and Service Information Copies data listed in previous 2 columns.	<input checked="" type="radio"/> Entire Claim Copies data listed in columns 1 and 2 PLUS: Referring Provider Accident Related Accident State Accident Country Pregnancy Indicator Authorization Number Emergency Indicator(s) EPSDT Indicator(s) Family Plan Indicator(s) NDC Prescription #(s) NDC Prescription Type(s) Other Insurance Details All Dates
-------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

8

7. Select what portion of the claim to copy (for this example, the user has selected **Entire Claim**).
8. Click the **Copy** button.

Copying a Claim, continued

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Provider Information

Billing Provider ID	1578564860	ID Type	NPI
*Billing Provider Service Location	<input type="text" value="20-HOSPITALISTS OF ARIZONA-2510 W DUNLAP AVE STE 290,PHOENIX,ARIZONA,850212759"/>		
Rendering Provider ID	<input type="text" value="1841251725"/>	ID Type	NPI
Rendering Provider Service Location	<input type="text" value="24-SHAVER, NANCY C-1919 E THOMAS RD EAST BLDG,PHOENIX,ARIZONA,850167710"/>		
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>
Supervising Provider ID	<input type="text"/>	ID Type	<input type="text"/>
Service Facility Location ID	<input type="text"/>	ID Type	<input type="text"/>

Patient Information

*Recipient ID	<input type="text" value="67032685329"/>	First Name	MROBMLV
Last Name	GIOXBIK	Birth Date	05/01/2002

Claim Information

Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text"/>	Admission Date	<input type="text" value="09/18/2018"/>
*Patient Number	<input type="text" value="053036404FKE"/>	Authorization Number	<input type="text"/>
*Transport Certification	<input type="radio"/> Yes <input checked="" type="radio"/> No		
*Does the provider have a signature on file?	<input type="radio"/> Yes <input type="radio"/> No		
Include Other Insurance	<input type="checkbox"/>		
		Total Charged Amount	\$175.00

9

As the user goes through Steps 1-3, the user may make updates.

9. Click the **Continue** button.



Adjusting a Claim

Adjusting a Claim

My Home | Eligibility | **Claims** | Care Management | File Exchange | Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Treatment History

1 Search Claims

Search Claims

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.
Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID

Recipient Information

Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type

Service From To Claim Status

Search Reset

3 Search Results

To see service line information, or to view the remittance advice, click on the '+' next to the claims ID. Total Records: 1

	Claim ID	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
+	2218262000035	Professional	Finalized Payment	09/18/2018	67032685329	1841251725	\$44.62	-	

To begin the claim adjustment process:

1. Return to the “Search Claims” page.
2. Enter the search criteria.
3. Click the **Search** button.
4. Click the [blue Claim ID](#) link.

NOTE: Denied Claims cannot be adjusted. The **Claim Status** column will indicate “Finalized Payment” if a claim is paid.

Adjusting a Claim, continued

Recipient: FROSTLEY, GLENN
Birth Date: 05/01/2002

Claim Information

Claim Status: Finalized Payment
Date Type: _
Accident Related: _
Patient Number: 053036404FKE
Related Claim ICN: _
Transport Certification: No
Previous Claim ICN: _
Note: _
Date of Current: _
Admission Date: 09/18/2018
Authorization Number: _
Does the provider have a signature on file? Yes

Total Charged Amount: \$175.00
Total Allowed Amount: \$44.62
Total Co-pay Amount: \$0.00
Total Paid Amount: \$44.62

[Expand All](#) | [Collapse All](#)

Adjudication Errors +

Diagnosis Codes +

Service Details -

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	Charge Amount	Allowed Amount	Co-pay Amount	Paid Amount
1	09/18/2018	09/18/2018	32	N	99308		1	1.000 Unit	\$175.00	\$44.62	\$0.00	\$44.62

No Other Insurance Details exist for this claim

No Attachments exist for this claim

6

[Adjust](#) [Copy](#) [Void](#) [Print Preview](#)

On the “View Professional Claim” page, the user will:

5. Scroll down to the bottom of the page.
6. Click the **Adjust** button.

Adjusting a Claim, continued

Resubmit Professional Claim ID 2218262000035: Step 1

* Indicates a required field.

Claim Type Professional

7 **Provider Information**

Billing Provider ID 1578564860 ID Type NPI
 *Billing Provider Service Location 20-HOSPITALISTS OF ARIZONA-2510 W DUNLAP AVE STE 290,PHOENIX,ARIZONA,850212759
 Rendering Provider ID 1841251725 ID Type NPI
 Rendering Provider Service Location 24-SHAVER, NANCY C-1919 E THOMAS RD EAST BLDG,PHOENIX,ARIZONA,850167710
 Referring Provider ID ID Type
 Supervising Provider ID ID Type
 Service Facility Location ID ID Type

Patient Information

Claim Status Finalized Payment
 *Recipient ID 67032685329
 Last Name GIOXBIK First Name MROBMLV
 Birth Date 05/01/2002

Claim Information

Date Type Date of Current
 Accident Related Admission Date 09/18/2018
 *Patient Number 053036404FKE Authorization Number
 *Transport Certification Yes No
 *Does the provider have a signature on file? Yes No
 Include Other Insurance Total Charged Amount \$175.00

8 **Adjudication Errors**

Claim / Service #	HIPAA Adj	Description	EOB
Claim	7499	CLAIM PROCESSED BY CLINICAL CLAIM EDITOR	7499
Service # 1	4084	ALLOWED AMT LESS THAN BILLED AMOUNT VARIANCE	0507

9 Continue Cancel

From here, the user may:

7. Review and make any necessary edits to the provider, patient or claim information.
8. Review the **Adjudication Errors** panel to identify any issues that may need to be resolved.
9. Click on the **Continue** button at the bottom of the page to proceed to the next step.

Adjusting a Claim, continued

[Expand All](#) | [Collapse All](#)

Adjudication Errors +

Diagnosis Codes +

Service Details -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
<u>1</u>	09/18/2018	09/18/2018	32-Nursing Facility	99308-Nursing fac care subseq	\$175.00	1.000 Unit	
2						0.000	

2 *From Date To Date *Place of Service EMG

*Procedure Code Modifiers *Diagnosis Pointers

*Charge Amount *Units *Unit Type EPSDT Family Plan

Cla Number Authorization Number

Rendering Provider ID ID Type

Rendering Provider Service Location

Referring Provider ID ID Type

NDCs for Svc. # 2 -

Attachments -

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

10

10. Click the **Resubmit** button.

Adjusting a Claim, continued

Patient Information											
Recipient ID 67032685329						Gender Female					
Recipient MROBMLV V GIOXBIK											
Birth Date 05/01/2002											
Claim Information											
Claim Status Finalized Payment						Date of Current _					
Date Type _						Admission Date 09/18/2018					
Accident Related _						Authorization Number _					
Patient Number 053036404FKE											
Related Claim ICN _											
Transport Certification No											
Previous Claim ICN 2218262000035											
Note _											
Does the provider have a signature on file? Yes						Total Charged Amount \$175.00					
Expand All Collapse All											
Adjudication Errors											
Diagnosis Codes											
Service Details											
#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
<u>1</u>	09/18/2018	09/18/2018	32	N	99308		1	1.000 Unit	<input type="checkbox"/>	<input type="checkbox"/>	\$175.00
No Other Insurance Details exist for this claim											
No Attachments exist for this claim											
Back to Step 1 Back to Step 2 Back to Step 3 Print Preview				<div style="border: 1px solid gray; border-radius: 50%; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center; margin: 0 auto;">11</div>		<div style="border: 2px solid red; padding: 2px; display: inline-block; margin-right: 10px;">Confirm</div> <div style="border: 2px solid red; padding: 2px; display: inline-block;">Cancel</div>					

11. Click the **Confirm** button.

NOTE: Click the **Cancel** button to cancel the adjustment.

Adjusting a Claim, continued

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

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My Home | **Eligibility** | **Claims** | **Care Management** | **File Exchange** | **Resources**

[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Search Payment History](#) | [Treatment History](#)

[Claims](#) > Claim Receipt

Resubmit Professional Claim: Confirmation ?

Professional Claim Receipt

Your Professional Claim was successfully resubmitted. The claim status is Finalized Payment.

The Claim ID is 5918263000001.

Click **Print Preview** to view the claim details as they have been saved on the payer's system.
Click **Copy** to copy member or claim data.
Click **Adjust** to resubmit the claim.
Click **View** to view the details of the submitted claim.

[Print Preview](#) [Copy](#) [Adjust](#) [View](#)

The “Resubmit Professional Claim: Confirmation” page will appear after the claim has been submitted. It will display the claim status and adjusted Claim ID.



Submitting an Appeal for a Claim

Submitting an Appeal for a Claim

Provider

Welcome Carson

Name CARSON TAHOE HOSPITAL

Provider ID 1255360160 (NPI)

Location ID 1013843

▶ [My Profile](#)

▶ [Switch Provider](#)

Provider Services

▶ [Member Focused Viewing](#)

▶ [Search Payment History](#)

▶ [Revalidate-Update Provider](#)

▶ [Pharmacy PA](#)

▶ [PASRR](#)

▶ [EHR Incentive Program](#)

▶ [EPSDT](#)

▶ [Presumptive Eligibility](#)

Broadcast Messages

Hours of Availability
The Nevada Provider Web Portal is unavailable between midnight and 12:25 AM PST Monday-Saturday and between 8 PM and 12:25 AM PST on Sunday.

Welcome Health Care Professional!



We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and search for claims, payment information, and access Remittance Advices, our secure site provides access to eligibility, answers to frequently asked questions, and the ability to process authorizations.

Prior Authorization Quick Reference Guide [\[Review\]](#)

Provider Web Portal Quick Reference Guide [\[Review\]](#)

[Contact Us](#)



[Secure Correspondence](#)

From the home page, the user will:

1. Select **Secure Correspondence** to start the Appeal process.

Submitting an Appeal for a Claim, continued

The screenshot shows the 'Secure Correspondence - Create Message' form. The 'Message Category' dropdown is highlighted with a red box and a callout bubble containing the number '2'. The form fields are as follows:

Field	Value
*Subject	Appeal of a denied claim
*Message Category	Claims - Appeals
Email	john.doe@myhealth.com
Confirm Email	john.doe@myhealth.com
Phone Number	
*Preferred Method of Communication	Email
*Service Provider ID	1234567890
*Provider Type	20 - Physician
*Denial Reason	Denied with EOB 0245.
*Message	Claim was Denied. Please review additional documentation.

The user will then:

2. Select “Claims – Appeals” from the **Message Category** drop-down and fill out all of the required fields.

Submitting an Appeal for a Claim, continued

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
3	*Transmission Method	EL-Electronic Only			
	*Upload File				Browse...
	*Attachment Type				
	Description				
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					
4	<input type="button" value="Send"/>	<input type="button" value="Cancel"/>			

Next, the user will need to:

3. Click the **Browse** button and locate the file supporting the appeal request.
4. Click the **Send** button.

NOTE: Once the user clicks **Send** and the appeal has been created, the system will create a Contact Tracking Number (CTN). The user can use the CTN to check on the status of the appeal.

Submitting an Appeal for a Claim, continued

Secure Correspondence - Message Box

Access your messages by selecting the individual subject line. Whenever a new message is sent, a confirmation e-mail precedes the request. For additional information, contact us.

Status	CTN #	Subject	Category	Open Date	Last Modified
Open	4256	Appeal of a denial		09/18/2018	
Open	4255	testing		09/18/2018	
Open	4253	Testing from MO		09/18/2018	
Open	4252	Testing 6268 in MO	Level 2 Support - Account Issues	09/18/2018	
Open	4251	Testing 6268	Claims - Appeals	09/06/2018	

Confirmation

5 Your secure message was successfully sent.

OK

After the user clicks the **Send** button, a confirmation message will populate with “Your secure message was successfully sent”

User will then need to:
5. Click the **OK** button.

Submitting an Appeal for a Claim, continued

Secure Correspondence - Message Box [Back to My Home](#) ?

Access your messages by selecting the individual subject line. Whenever a new message is sent, a confirmation e-mail precedes the request. For additional queries please contact us. [Create New Message](#)

Total Records: 13

Status	CTN #	Subject	Message Category	Date Opened	Last Activity Date
Open	4256	Appeal of a denied claim	Claims - Appeals	10/02/2018	10/02/2018
Open	4255	testing	Claims - Appeals	09/27/2018	09/27/2018
Open	4253	Testing from MO	Level 2 Support - Account Issues	09/19/2018	09/19/2018
Open	4252	Testing 6268 in MO	Level 2 Support - Account Issues	09/18/2018	09/18/2018
Open	4251	Testing 6268	Claims - Appeals	09/06/2018	09/06/2018
Open	4227	Testing sample for 5916	Level 2 Support - Account Issues	08/14/2018	08/14/2018
Closed	4217	Help	Other	07/08/2018	08/03/2018
Open	4218	Testing Help	Other	07/08/2018	07/08/2018
Open	4219	Testing help..	Other	07/08/2018	07/08/2018
Open	4188	Testing in Model	Level 2 Support - Account Issues	04/09/2018	04/09/2018

1 2

After the user clicks the **OK** button, they will be directed to the **Secure Correspondence - Message Box**, where the new CTN can be seen.



Voiding a Claim

Voiding a Claim

My Home | **Eligibility** | **Claims** | **Management** | **File Exchange** | **Resources**

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Treatment History

[Search Claims](#)

Search Claims

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.

Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID

Recipient Information

Recipient ID

Service Information

Rendering Provider ID **ID Type** **Claim Type**

Service From **To** **Claim Status**

To search for a claim the user will need to:

1. Hover over **Claims**.
2. Select **Search Claims**.
3. Enter **Claim ID**.
4. Click the **Search** button.

Voiding a Claim, continued

Search Claims ?

Medical/Dental

A minimum one field is required.
Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.

Claim searches are limited to a maximum range of 45 days.

Claim Information

Claim ID

Recipient Information

Recipient ID

Service Information

Rendering Provider ID ID Type Claim Type

Service From To Claim Status

Once the user has clicked the **Search** button, the results will display below.

To open the claim, the user will:

- Click the [blue Claim ID](#) link to open the claim.

NOTE: Denied Claims cannot be voided. The **Claim Status** column will indicate “Finalized Payment” if a claim is paid.

Search Results

To see service line information, or to view the remittance advice, click on the '+' next to the claims ID. Total Records: 1

	Claim ID	TCN	Claim Type	Claim Status	Service Date	Recipient ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Recipient Responsibility
<input type="button" value="+"/>	5918263000001	5	Professional	Finalized Payment	09/18/2018	67032685329	1841251725	\$44.62	09/21/2018	

Voiding a Claim, continued

Claim Information

Claim Status Finalized Payment
Date Type _ Date of Current _
Accident Related _ Admission Date 09/18/2018
Patient Number 053036404FKE Authorization Number _
Related Claim ICN _
Transport Certification No
Previous Claim ICN 2218262000035
Note _
Does the provider have a signature on file? Yes

Total Allowed Amount \$44.62 Total Co-pay Amount \$0.00 Total Charged Amount \$175.00
Total Paid Amount \$44.62

[Expand A](#)

Adjudication Errors

Diagnosis Codes

Service Details

#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	Charge Amount	Allowed Amount	Co-pay Amount
<u>1</u>	09/18/2018	09/18/2018	32	N	99308		1	1.000 Unit	\$175.00	\$44.62	\$0

No Other Insurance Details exist for this claim

No Attachments exist for this claim

6

[Adjust](#) [Copy](#) [Void](#) [Print Preview](#) [RA Copy \(PDF\)](#)

To void the claim, the user will:

6. Click the **Void** button.

Voiding a Claim, continued

Does the provider have a signature on file? Yes

Total Charged Amount \$175.00
Total Paid Amount \$44.62
Allowed Amount \$44.62 Total Co-pay Amount \$0.00

Confirmation

Are you sure you want to void this Professional Claim ID 5918263000001?

7 OK Cancel

To Date	Place of Service	Ptrs	Unit	Charged Amt	Co-pay		
09/18/2018	32	N	99308	1	1.000 Unit	\$175.00	\$44.62

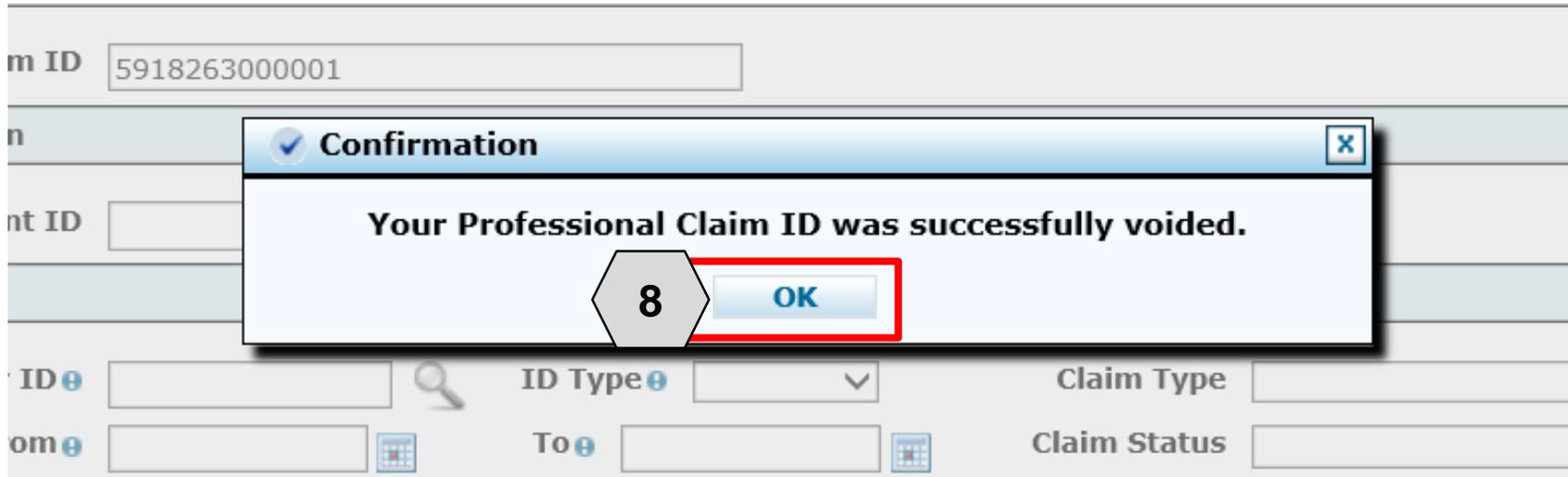
Insurance Details exist for this claim

Insurance Details exist for this claim

Just Copy Void Print Preview

7. Click the **OK** button.

Voiding a Claim, continued



8. Click the **OK** button.



Resources

Additional Resources

- Forms: <https://www.medicaid.nv.gov/providers/forms/forms.aspx>
- EVS General Information: <https://www.medicaid.nv.gov/providers/evsusermanual.aspx>
- Secure Provider Web Portal: <https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx>
- Billing Information: <https://www.medicaid.nv.gov/providers/BillingInfo.aspx>
- Medicaid Services Manual: <http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/>

DHCFP Contact Information:

E-Mail: pcsprogram@dhcfp.nv.gov



Contact Nevada Medicaid



Contact Nevada Medicaid

Prior Authorization Department: 800-525-2395

Customer Service Call Center: 877-638-3472 (M-F 8 am to 5 pm Pacific Time)

Provider Field Representative:

E-mail: NevadaProviderTraining@dxc.com



Thank You