Enrolling as an Individual Provider with Nevada Medicaid

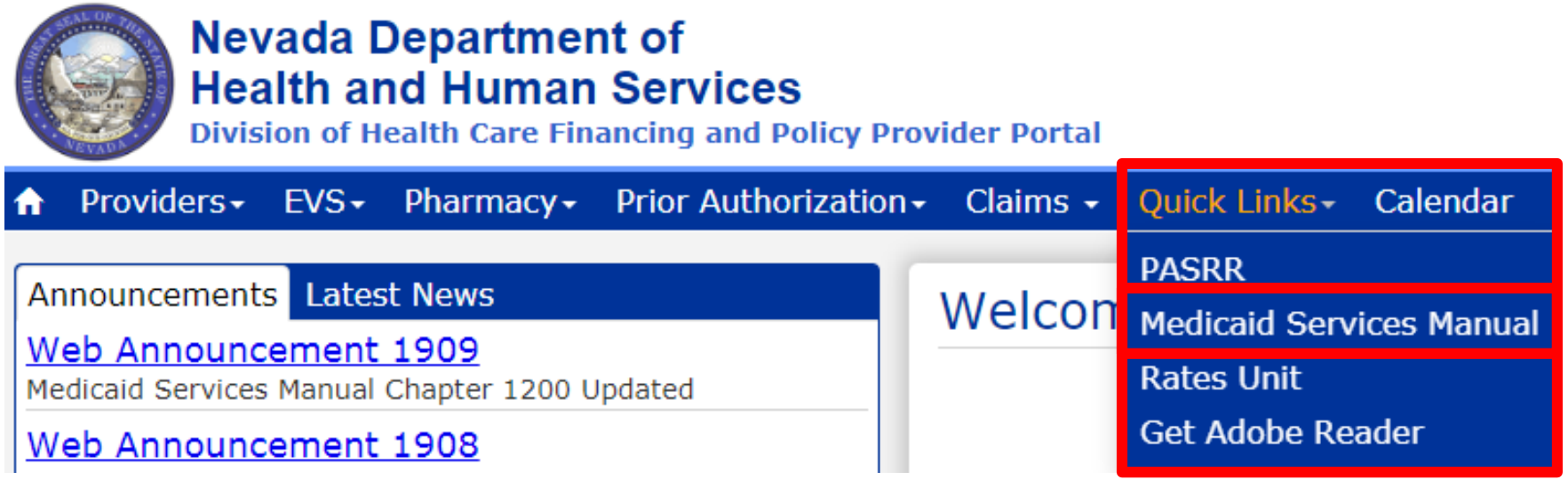
Objectives

Objectives:

- Locate Medicaid Services Manual (Medicaid Policy)
- Review the Provider Enrollment Webpage, including:
    - Provider Enrollment Information Booklet
    - Enrollment Checklists
    - Business Associate Addendum
    - The Online Provider Enrollment User Manuals
    - Provider Revalidation Report
    - Hospital Presumptive Eligibility Documents
    - Recommended Enrollment Documents
    - Changes to Provider Information
    - Contact Information for Provider License Updates and Voluntary Terminations
- Enroll with Nevada Medicaid as an Individual Provider via the Online Provider Enrollment (OPE) Tool
- Cover Resources
- Contact Nevada Medicaid

Medicaid Services Manual (Nevada Medicaid Policy)

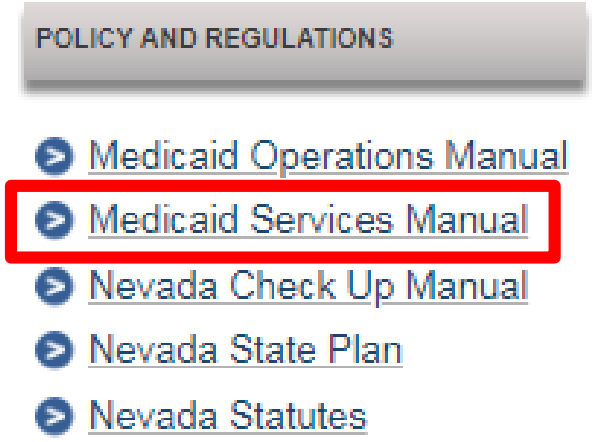
Medicaid Services Manual



The Medicaid Services Manual Chapters are required to be read and understood by providers prior to enrolling in the Nevada Medicaid program. To locate the Policy, users can navigate to one of the following web addresses: www.medicaid.nv.gov or dhcfp.nv.gov.

If using the Medicaid website, locate and hover over the Quick Links from the top blue tool bar and select Medicaid Services Manual.

Medicaid Services Manual, continued



If using the DHCFP website, locate and hover over the Resources tab from the top tool bar and select Manuals **or** scroll down to the bottom of the page and locate the Policy under Policy and Regulations.

Medicaid Services Manual, continued

MEDICAID SERVICES MANUAL

The Medicaid Services Manual is a compilation of regulations adopted under NRS 422.2368 and 422.2369. It sets guidelines and limitations regarding how the Division operates and what services are covered. Changes to the MSM are approved at public hearings.
The document works in concert with Billing Guidelines, which are procedural in nature and can be found on the Nevada Medicaid's fiscal agent website. Reimbursement rates and fee schedules are on the DHCFP website

- Public Hearing Schedule
- Nevada Medicaid's fiscal agent Billing Guidelines
- Rates and Fee Schedules

The Medicaid Services Manual page contains information regarding Public Hearings, Billing Guidelines and links to the Rates Unit.

Medicaid Policy Chapters are located on the same page below this information.

Medicaid Services Manual, continued

MSM Chapters

Each MSM chapter contains a link to both the current and historical versions of the specific chapter. The chapters are organized by most current year, and most current date within year.

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 Rates and Supplemental Reimbursement
- 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
- 2900 Federally Qualified Health Centers
- 3000 Indian Health
- 3100 Hearings
- 3200 Hospice
- 3300 Program Integrity
- 3400 Telehealth Services
- 3500 Personal Care Services Program
- 3600 Managed Care Organization
- 3900 Home and Community Based Waiver for Assisted Living
- Addendum

All providers must read the following chapters:

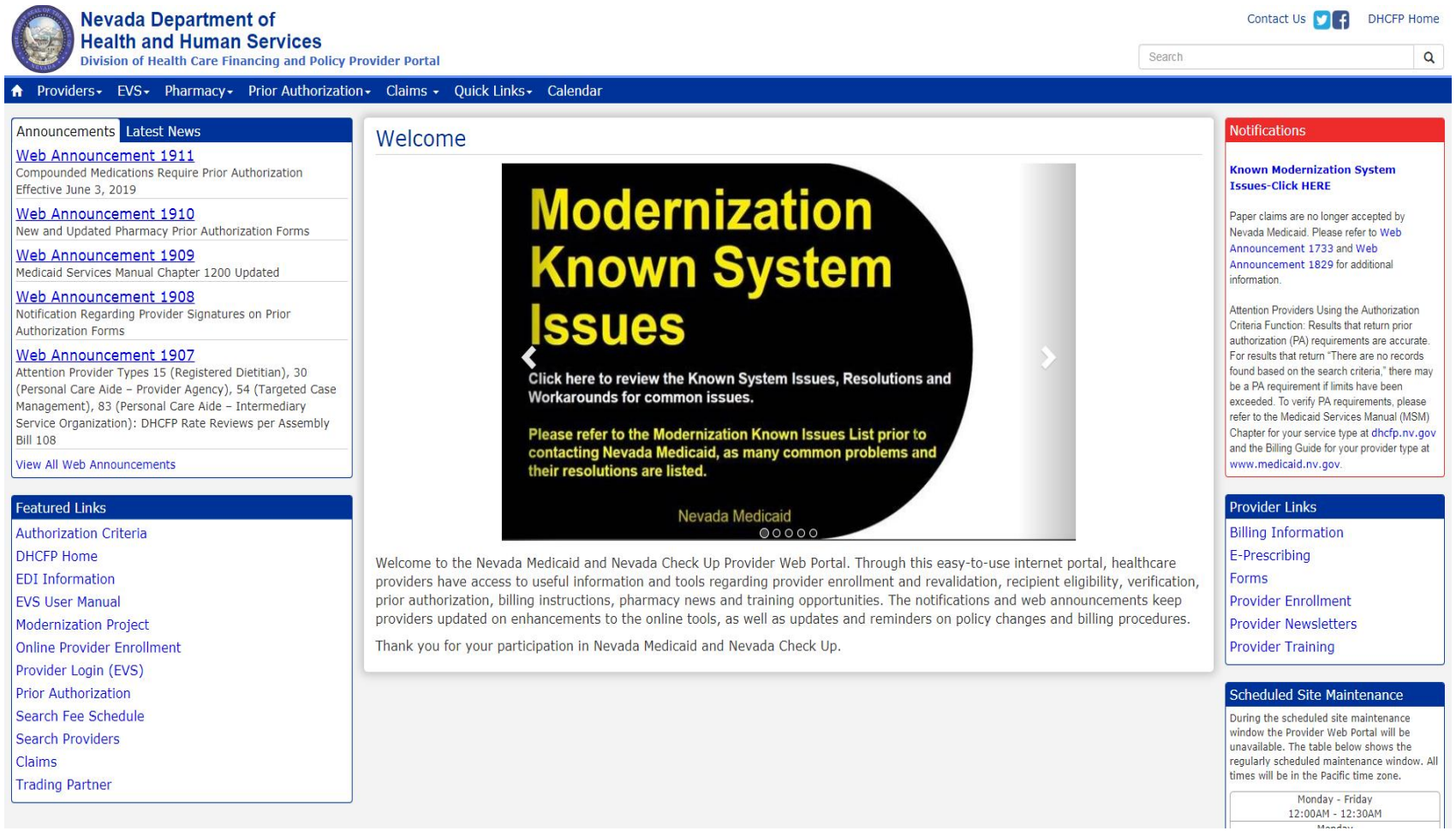
- Chapter 100: Medicaid Program
- Chapter 700: Rates and Supplemental Reimbursement
- Chapter 3300: Program Integrity

In addition to the above referenced chapters, providers will need to review their Provider Type specific Billing Guideline from the Medicaid website in order to determine which additional chapters must be read. Users can also review the Enrollment Checklists to determine which chapters are required to be read.

Policy chapters will review important information such as Coverage & Limitations, Prior Authorization Requirements and other pertinent information related to Nevada Medicaid.

Provider Enrollment Webpage

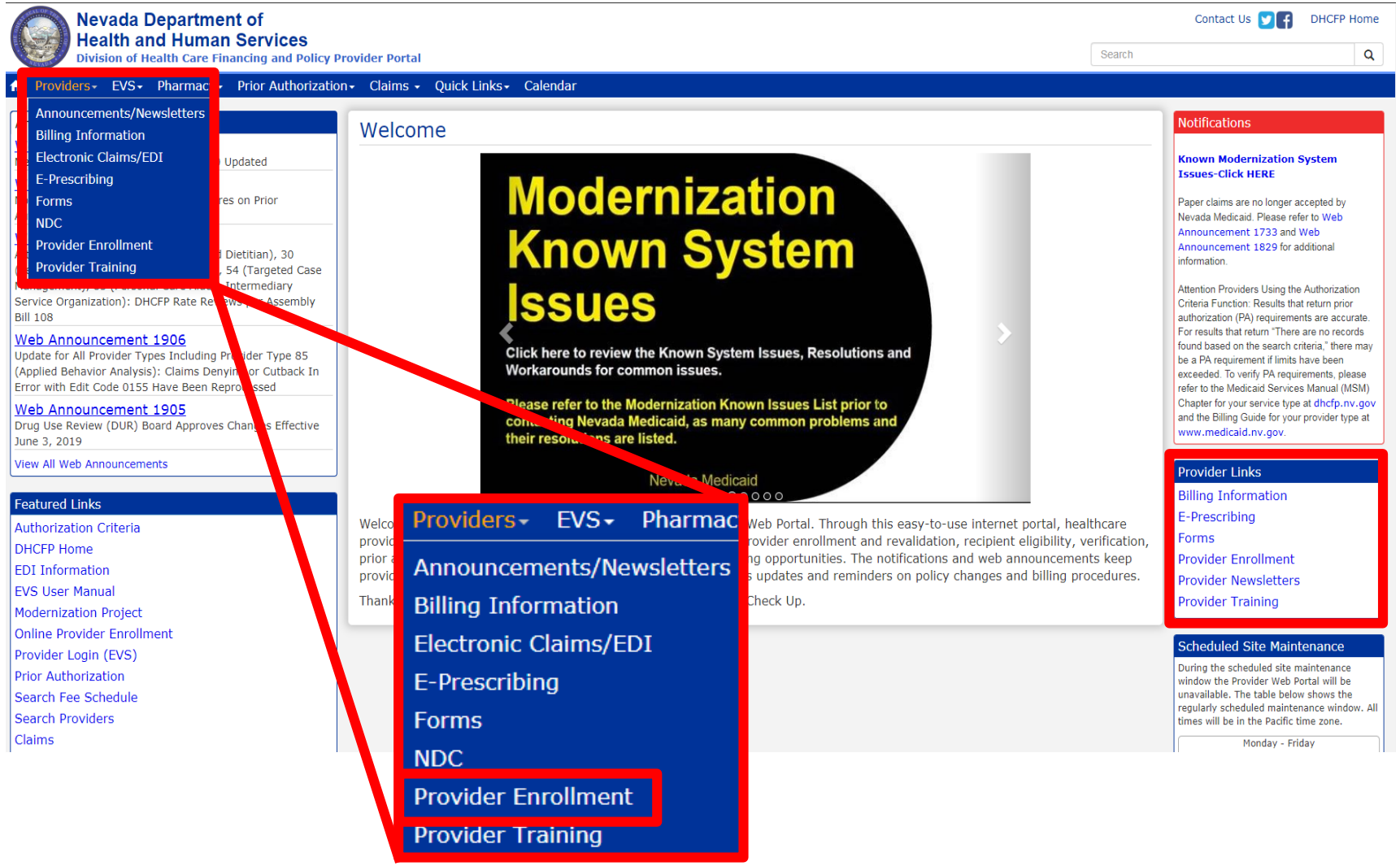
Provider Enrollment Webpage



The Nevada Medicaid website is designed to assist providers with understanding the Nevada Medicaid program and includes information regarding enrollment, billing, access to the Electronic Verification System (EVS) and additional resources to assist providers.

Link: www.medicaid.nv.gov

Provider Enrollment Webpage, continued



To begin the enrollment process with Nevada Medicaid, highlight Providers from the top tool bar and select Provider Enrollment from the drop-down menu or select Provider Enrollment from the Provider Links section on the right-hand side of the page.

Provider Enrollment Webpage, continued

Provider Enrollment

Effective January 12, 2019, all providers will be required to submit their Provider Enrollment Applications electronically via the Online Provider Enrollment (OPE) Tool at https://www.medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx, A er enrollment applications 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. B

Thank you for your interest in the Nevada Medicaid and Nevada Check Up Program. This page contains all of the information and forms you will need to become a Nevada Medicaid provider. If you have any questions, please contact the Provider Enrollment Unit at (877) 638-3472 from 8a.m. to 5p.m. Monday through Friday.

Effective 12/1/2015, access Online Provider Enrollment for individual, group or OPR enrollments. C

Provider Documentation Reminders: (See Web Announcement 1125 for reminders that will assist providers in adhering to the documentation responsibilities required of each Nevada Medicaid/Nevada Check Up provider.)

All enrollment documents including attachments require an *original* signature from the provider or an authorized representative (use dark blue or black ink).

The Provider Enrollment webpage contains all necessary information in order to properly enroll in Nevada Medicaid, including:

A. Access to the Online Provider Enrollment (OPE) tool
B. Link to modernization announcements
C. Additional link to the OPE tool

Required Enrollment Documents – Provider Enrollment Information Booklet

Required Enrollment Documents

- Provider Enrollment Information Booklet: UPDATED FOR MMIS MODERNIZATION IMPLEMENTATION. All providers will need the information contained in this booklet, which includes common enrollment questions and information about out-of-state providers and provider groups.
- Enrollment Checklists: Copies of certain documents must be included with your Provider Enrollment Packet (e.g., copy of professional certification, proof of insurance, background check). The Enrollment Checklists show required documentation for each provider type.
- Business Associate Addendum (NMH-3820): This document must be signed and submitted with your Provider Enrollment/Revalidation Packet if it is listed on the Provider Enrollment Checklist for your Provider Type and when requested by the Division of Health Care Financing and Policy (DHCFP) or Nevada Medicaid.
- Advance Directives Compliance Self-Evaluation & Certification (NMH-3827): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.
- Civil Rights Compliance Self-Evaluation & Certification (NMH-3828): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.

The Provider Enrollment Information Booklet is an overview of the Medicaid Program and includes information such as: Welcome to Nevada Medicaid, Required Documents, Information for Trading Partners and Out of State Providers, Catchment Area Information, how to Report Business Information as well as a full list of all Provider Types and associated Specialty Codes.

Required Enrollment Documents – Enrollment Checklists

Required Enrollment Documents

- Provider Enrollment Information Booklet: UPDATED FOR MMIS MODERNIZATION IMPLEMENTATION. All providers will need the information contained in this booklet, which includes common enrollment questions and information about out-of-state providers and provider groups.
- Enrollment Checklists: Copies of certain documents must be included with your Provider Enrollment Packet (e.g., copy of professional certification, proof of insurance, background check). The Enrollment Checklists show required documentation for each provider type.
- Business Associate Addendum (NMH-3820): This document must be signed and submitted with your Provider Enrollment/Revalidation Packet if it is listed on the Provider Enrollment Checklist for your Provider Type and when requested by the Division of Health Care Financing and Policy (DHCFP) or Nevada Medicaid.
- Advance Directives Compliance Self-Evaluation & Certification (NMH-3827): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.
- Civil Rights Compliance Self-Evaluation & Certification (NMH-3828): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.

Enrollment Checklists are separated out by Provider Type. In order to determine the documentation that is required to accompany the application, select Enrollment Checklists. All Provider Types require the checklist to be followed.

Required Enrollment Documents – Enrollment Checklists, continued

Provider Enrollment Checklists

To see which documents must be submitted with your Provider Enrollment Packet, click the name of your provider type(s) in the list below. If your provider type is not in the list below, please contact the Provider Enrollment Unit at (877) 638-3472 for requirements.

Note: Out of state providers must also submit proof of Medicaid eligibility in the state that services are/were rendered.

Provider Type	Title	Updated Date
10	Outpatient Surgery, Hospital Based	04/20/16
11	Hospital, Inpatient	02/18/16
12	Hospital, Outpatient	02/18/16
13	Psychiatric Hospital, Inpatient	04/20/16
14	Behavioral Health Outpatient Treatment	n/a
15	Registered Dietitian	12/15/17
16	Intermediate Care Facilities for Individuals with Intellectual Disabilities, Public	04/20/16
17	Special Clinics	n/a
19	Nursing Facility	04/20/16
20	Physician, M.D., Osteopath, D.O.	08/25/17
21	Podiatrist	08/25/17
22	Dentist	01/03/13
23	Hearing Aid Dispenser & Related Supplies	08/25/17
24	Advanced Practice Registered Nurse	08/30/17
25	Optometrist	08/25/17
26	Psychologist	07/19/16
27	Radiology and Non-invasive Diagnostic Centers	12/01/14
28	Pharmacy	04/28/17
29	Home Health Agency	07/05/17

Each Provider Type will have access to a Provider Type specific Checklist.

Locate the appropriate Provider Type and select the Title of the Provider Type to open the checklist.

It is important to review each item listed on the Checklist as the information will be different for each Provider Type.

Required Enrollment Documents – Business Associate Addendum (NMH-3820)

Required Enrollment Documents

- Provider Enrollment Information Booklet: UPDATED FOR MMIS MODERNIZATION IMPLEMENTATION. All providers will need the information contained in this booklet, which includes common enrollment questions and information about out-of-state providers and provider groups.
- Enrollment Checklists: Copies of certain documents must be included with your Provider Enrollment Packet (e.g., copy of professional certification, proof of insurance, background check). The Enrollment Checklists show required documentation for each provider type.
- Business Associate Addendum (NMH-3820): This document must be signed and submitted with your Provider Enrollment/Revalidation Packet if it is listed on the Provider Enrollment Checklist for your Provider Type and when requested by the Division of Health Care Financing and Policy (DHCFP) or Nevada Medicaid.
- Advance Directives Compliance Self-Evaluation & Certification (NMH-3827): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.
- Civil Rights Compliance Self-Evaluation & Certification (NMH-3828): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.

The Business Addendum may be a requirement depending on the Provider Type selected to enroll with. The Addendum is an additional contract with the Division of Health Care Financing and Policy (DHCFP) that is made between a Covered Entity and a Business Associate that outlines responsibilities of each party concerning Protected Health Information (PHI). If this form is required per the Checklist, make sure to read and understand the content as well as complete the last page of the form. All pages must be included when submitting an application. If any pages are missing, the application may be returned, which will cause a delay in the processing of the application.

Required Enrollment Documents – Advance Directive Compliance (NMH-3827)

Required Enrollment Documents

- Provider Enrollment Information Booklet: UPDATED FOR MMIS MODERNIZATION IMPLEMENTATION. All providers will need the information contained in this booklet, which includes common enrollment questions and information about out-of-state providers and provider groups.
- Enrollment Checklists: Copies of certain documents must be included with your Provider Enrollment Packet (e.g., copy of professional certification, proof of insurance, background check). The Enrollment Checklists show required documentation for each provider type.
- Business Associate Addendum (NMH-3820): This document must be signed and submitted with your Provider Enrollment/Revalidation Packet if it is listed on the Provider Enrollment Checklist for your Provider Type and when requested by the Division of Health Care Financing and Policy (DHCFP) or Nevada Medicaid.
- Advance Directives Compliance Self-Evaluation & Certification (NMH-3827): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.
- Civil Rights Compliance Self-Evaluation & Certification (NMH-3828): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.

The Advance Directive form may be a requirement depending on the Provider Type selected to enroll with. This form will have a variety of questions that must be answered and if the form is a requirement, the form should be sent to the Division of Health Care Financing and Policy:

Email: civilrights@dhcfp.nv.gov or

Mailing Address: Recipient Civil Rights Officer
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Required Enrollment Documents – Civil Rights Compliance (NMH-3828)

Required Enrollment Documents

- Provider Enrollment Information Booklet: UPDATED FOR MMIS MODERNIZATION IMPLEMENTATION. All providers will need the information contained in this booklet, which includes common enrollment questions and information about out-of-state providers and provider groups.
- Enrollment Checklists: Copies of certain documents must be included with your Provider Enrollment Packet (e.g., copy of professional certification, proof of insurance, background check). The Enrollment Checklists show required documentation for each provider type.
- Business Associate Addendum (NMH-3820): This document must be signed and submitted with your Provider Enrollment/Revalidation Packet if it is listed on the Provider Enrollment Checklist for your Provider Type and when requested by the Division of Health Care Financing and Policy (DHCFP) or Nevada Medicaid.
- Advance Directives Compliance Self-Evaluation & Certification (NMH-3827): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.
- Civil Rights Compliance Self-Evaluation & Certification (NMH-3828): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.

The Civil Rights form may be a requirement depending on the Provider Type selected to enroll with. This form will have a variety of questions that must be answered and if the form is a requirement, the form should be sent to the Division of Health Care Financing and Policy using the following:

Email: civilrights@dhcfp.nv.gov or

Mailing Address: Recipient Civil Rights Officer
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Online Provider Enrollment User Manual

Online Provider Enrollment User Manual

- Chapter 1: Getting Started
- Chapter 2: Initial Enrollment Application
- Chapter 2 Addendum: Ownership & Relationships Example
- Chapter 3: Revalidation and Updates

The Online Provider Enrollment User Manual will contain pertinent information for using the OPE tool and provide additional details regarding each question that is contained within the application.

Chapter 1: Getting Started – Overview of how to use the OPE tool

Chapter 2: Initial Enrollment Application – Provides step-by-step instructions on how to complete an initial application

Chapter 2 Addendum: Ownership & Relationships Example – Provides additional clarification for users when answering the Ownership Disclosure and Relationship questions

Chapter 3: Revalidation and Updates – Instructions on how to revalidate or make changes to a provider profile through the Electronic Verification System (EVS)

Revalidation Report

Revalidation Report

- Provider Revalidation Report: The Nevada Medicaid Provider Revalidation Report lists each provider and the date their next revalidation is due. To avoid contract termination, your revalidation application must be processed and approved prior to the revalidation due date.

The Provider Revalidation Report is a PDF document that allows any user to view a National Provider Identifier (NPI) to determine the date by which their contract will need to be revalidated. Providers are required to revalidate with Nevada Medicaid every five (5) years. The only exception is that Durable Medical Equipment (Provider Type 33) providers must revalidate every three (3) years.

Viewing the report will assist providers with making sure that their contract with Nevada Medicaid does not terminate. If a contract terminates due to a provider not submitting a revalidation, the provider will then need to complete and submit a brand new application. If a provider's contract terminates and the provider attempts to bill for dates of service that happen after their termination date, those particular claims will be denied.

Hospital Presumptive Eligibility Documents

Hospital Presumptive Eligibility Documents

- Web Announcement 1846: Hospital Presumptive Eligibility Annual Training Calendar Dates and Sign-up Guidelines for 2019 (Posted February 22, 2019)
- Web Announcement 1008: Attention ALL Hospital Presumptive Eligibility Providers: Guidance Policy Available
- Web Announcement 861 with Training Schedule: Implementation of Hospital Presumptive Eligibility Option for Acute Care Hospitals (Provider Types 11 and 75)
- Nevada Medicaid Hospital Presumptive Eligibility Provider Addendum: Qualified hospitals must complete and submit the Nevada Medicaid Hospital Presumptive Eligibility Provider Addendum.
- Hospital Presumptive Eligibility Training Sign-Up Sheet: Complete this form listing the hospital employees that will be attending the mandatory training for Presumptive Eligibility. You will be notified by the DWSS in regards to the training dates and times. Keep in mind that each employee making PE determinations MUST be trained by DWSS and complete a competency examination prior to making ANY determinations.

Hospital Presumptive Eligibility Documents must be completed depending on the Provider Type being enrolled with. There is also information contained in this section regarding training that is conducted by the State of Nevada.

Recommended Enrollment Documents

Recommended Enrollment Documents

- Effective February 1, 2019, all providers will be required to submit their Electronic Data Interchange (EDI) enrollment application electronically via the Provider Web Portal [https://portaluat.medicaid.nv.gov/hcp/provider/Home] , as paper EDI application submissions will no longer be accepted with the go-live of the new modernized Medicaid Management Information System (MMIS).
- Ordering, Prescribing and Referring Provider Enrollment Frequently Asked Questions (FAQs)

Recommended Enrollment Documents contains information regarding the use of Electronic Data Interchange (EDI) claim submissions as well as a Frequently Asked Questions document for Ordering, Prescribing and Referring (OPR) providers who are interested in Nevada Medicaid.

Changes to Provider Information

Changes to Provider Information

Changes to any information presented on your enrollment documents must be reported to Nevada Medicaid within five business days.

- To complete changes online, please login to the Secure Web Portal, and choose "Revalidate-Update Provider".
- To report a change in business ownership, resubmit a completed Provider Enrollment Application.
- Provider license updates and voluntary terminations can be mailed or e-mailed to Nevada Medicaid for processing

As of February 1, 2019, any provider that is already enrolled in Nevada Medicaid can make changes to their provider profiles via the EVS secure Provider Web Portal. For instructions, please review Chapter 3 (Revalidation and Updates) of the Online Provider Enrollment User Manual that was previously discussed and can be located on the Provider Enrollment webpage of the Medicaid website.

Contact Information for Provider License Updates & Voluntary Terminations

Contact Information for Provider License Updates and Voluntary Terminations Only

Mail completed provider license updates and/or voluntary terminations to Nevada Medicaid, Provider Enrollment Unit, P.O. Box 30042, Reno, NV 89520-3042 or E-mail: nv.providerapps@dxc.com for processing

Should a provider wish to submit their updated license information or if a provider will be terminating a contract, that information is to be emailed to: nv.providerapps@dxc.com or mailed to the P.O. Box. It is important to note that any documentation besides an updated license or a contract termination will not be reviewed and processed via this email address. Changes to a provider profile will **not** be accepted via email and those changes must be made via the EVS secure Provider Web Portal.

Enrolling as an Individual Provider with Nevada Medicaid via the OPE Tool

Initial Application

Provider Enrollment

Effective January 12, 2019, all provider [illegible] ia the Online Provider Enrollment (OPE) Tool a https://www.medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx, [illegible] s paper enrollment applications 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.

Thank you for your interest in the Nevada Medicaid and Nevada Check Up Program. This page contains all of the information and forms you will need to become a Nevada Medicaid provider. If you have any questions, please contact the Provider Enrollment Unit at (877) 638-3472 from 8a.m. to 5p.m. Monday through Friday.

Effective 12/1/2015, access Online Provider Enrollment for individual, group or OPR enrollments.

Provider Documentation Reminders: (See Web Announcement 1125 for reminders that will assist providers in adhering to the documentation responsibilities required of each Nevada Medicaid/Nevada Check Up provider.)

All enrollment documents including attachments require an *original* signature from the provider or an authorized representative (use dark blue or black ink).

Featured Links

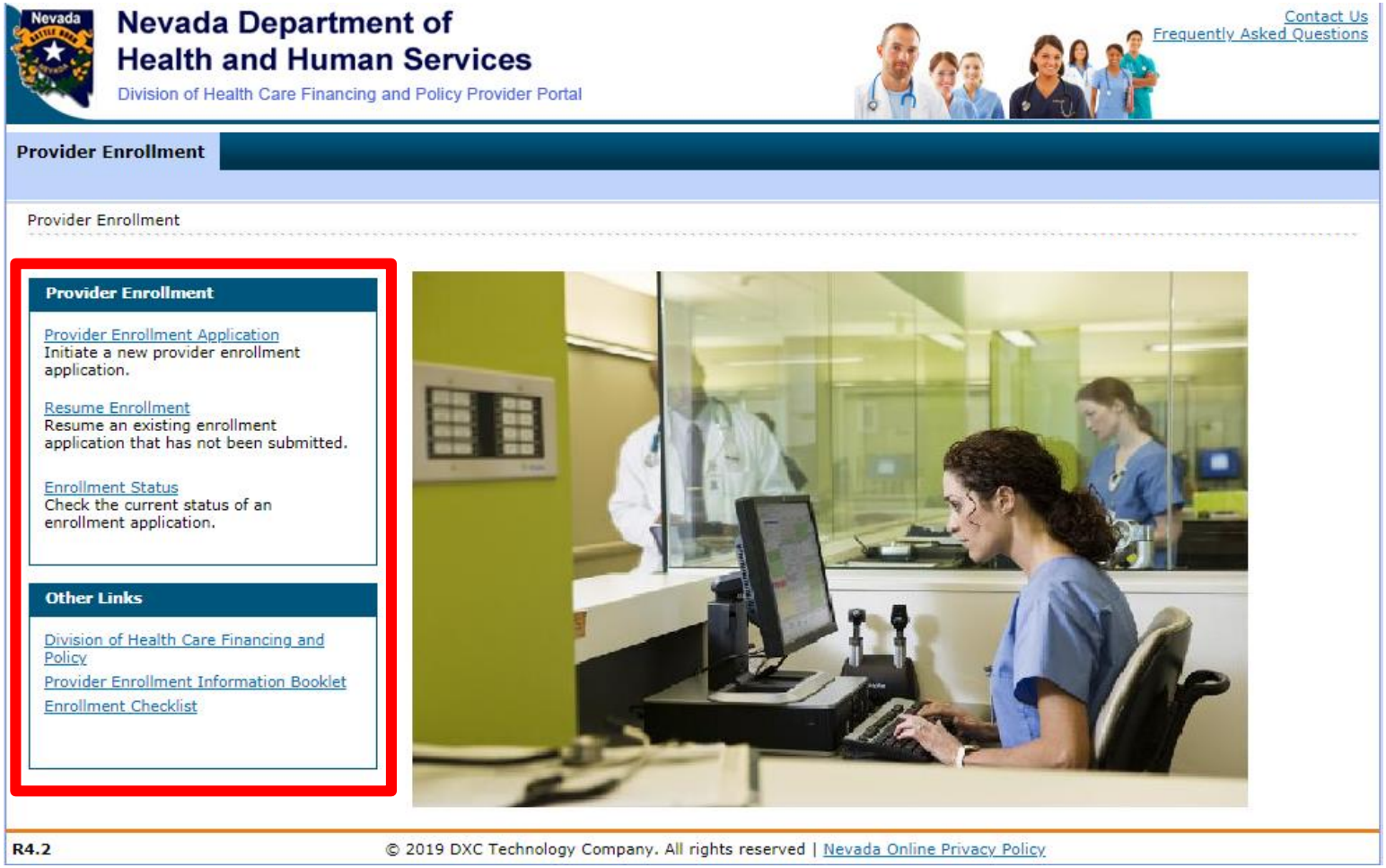
- Authorization Criteria
- DHCFP Home
- EDI Information
- EVS User Manual
- Modernization Project
- Online Provider Enrollment
- Provider Login (EVS)
- Prior Authorization
- Search Fee Schedule
- Search Providers
- Claims
- Trading Partner

Provider Links

- Billing Information
- E-Prescribing
- Forms
- Provider Enrollment
- Provider Newsletters
- Provider Training

The OPE tool may be accessed from a variety of different locations, including: the Provider Enrollment webpage, Featured Links (left-hand side of every webpage) or Provider Links (right-hand side of every webpage).

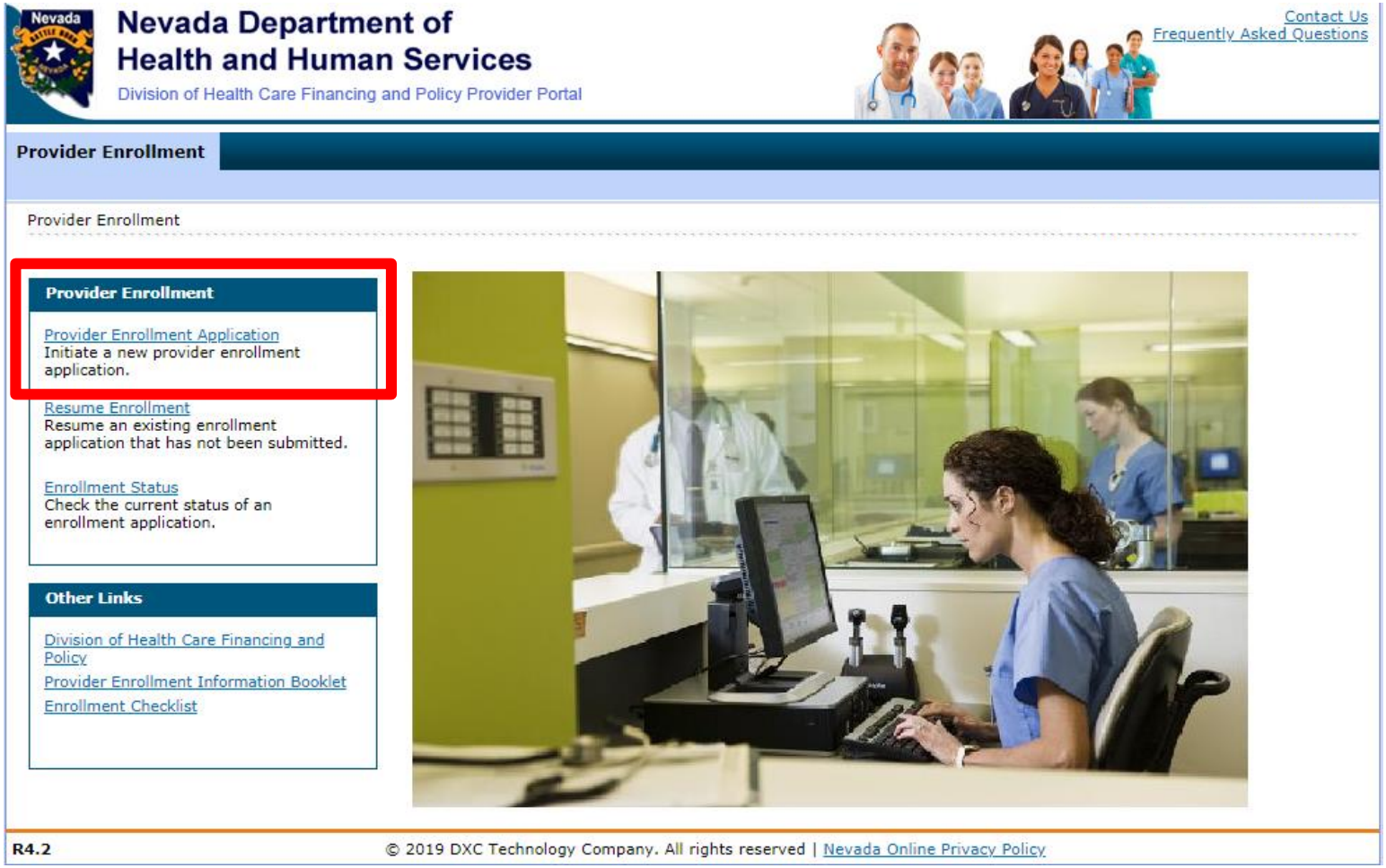
Landing Page



The OPE landing page will have several options that a user can select from:

- Provider Enrollment Application will begin a new application
- Resume Enrollment allows certain users to complete an application at a later time
- Enrollment Status allows users to check the status of their application online, which eliminates the requirement to call the Nevada Medicaid Customer Service Center

Landing Page, continued



In order to begin a new application, select Provider Enrollment Application.

For providers that are enrolling as two different provider types, two applications must be submitted - one for each provider type.

Frequently Viewed/Used Buttons

The Continue button is typically located at the end of each page of the application and will allow the user to continue with the application.

The Finish Later button is typically located at the end of each page of the application and will allow the user to complete the application at a later time. When the user is going to resume the application, the user must have the FEIN/SSN, Authorization Tracking Number and valid password.

The Cancel button is typically located at the end of each page of the application and will allow the user to stop or cancel the application process.

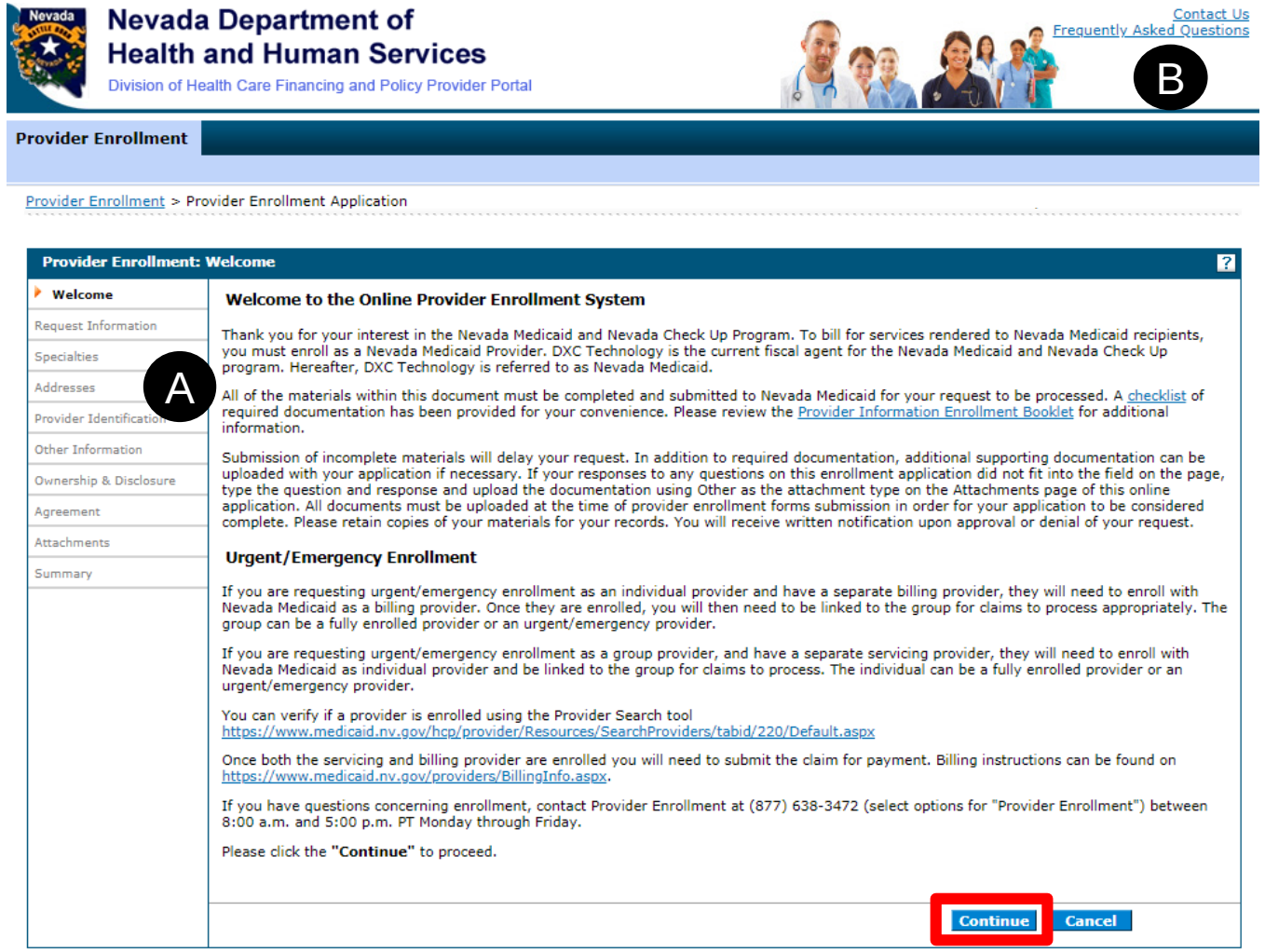
Frequently Viewed/Used Buttons

The Question Mark or Help button is typically located toward the top right of each page. Selecting the Help button will provide the user with details of the currently viewed page as well as basic information regarding each question of the application.

The Add button is located throughout the application regarding specific questions. When a user is answering a question that has an Add button, the Add button must be selected after inputting all applicable information in order for the information to save to the application before submitting. If a user forgets to select Add, the OPE tool will not allow the user to continue until Add is selected.

The Reset button is located throughout the application regarding specific questions and will accompany the Add button. If the user inputs all applicable information and before selecting Add determines that the information is incorrect, select Reset to erase the information and input the correct information.

Welcome Page



The Welcome page provides relevant information regarding enrolling in the Nevada Medicaid program, as well as:
(A) Table of Contents. Table of Contents will always be available and once a user has completed a section, the Table of Contents will hyperlink each completed section of the application in case a user needs to go back and update information.
(B) Contact Us and FAQ links.

In order to continue with the application, select Continue.

Request Information

Provider Enrollment: Request Information

- Welcome
- **Request Information**
- Specialties
- Addresses
- Provider Identification
- Other Information
- Ownership & Disclosure
- Agreement
- Attachments

Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later". The contact person will potentially be contacted to answer any questions regarding the information provided in this request.

* Indicates a required field.

Initial Enrollment Information

***Enrollment Type**	Individual
Ownership change	☐
Electronic Health Records (EHR)	☐
***Provider Type**	
***Requested Enrollment Effective Date**	06/06/2019

Enrollment Type: This will be selected from a drop-down menu. Select Individual.

Ownership Change: If this option is selected, user will be prompted with a pop-up indicating that a copy of the purchase agreement **must** be attached.

Electronic Health Records: This option is for a provider that is interested in signing up for the EHR Program. For more information, please visit dhcfp.nv.gov

Provider Type: Select the appropriate provider type from the drop-down menu. Reminder: if the provider is enrolling as two different provider types, an application for each provider type must be submitted separately. Nevada Medicaid cannot advise a provider as to which provider type they should select. Providers should review the Billing Information and Policy Chapters to make an informed decision.

Requested Enrollment Effective Date: If an application is approved, this will be the start date of the provider's contract. The provider can back date an Application up to 180 days depending on services previously rendered. If requesting an effective date of more than 180 days, a written explanation and any supporting documentation are required to be submitted along with the application.

Request Information, continued

Group Association

To become affiliated or remain with an existing Medicaid Provider Group, enter the Group's NPI and the date to begin the affiliation. Otherwise, leave this field blank. **This is required for provider types 14 and 82.**

Would You Like to be Linked to a Group? Yes No

NPI	Affiliation Begin Date	Action

*NPI

*Affiliation Begin Date

Add Cancel

If an individual provider would like to be linked to a Group, select Yes. The affiliation date cannot pre-date the Requested Enrollment Effective Date. When an individual is linking to a Group, the Group **must already be enrolled** in order to complete the Group linkage. The user will then need to provide the NPI of the Group as well as the date that the individual would like to be linked to the group. Once the information is properly filled out, select Add. Linking to a Group is required if a provider is enrolling as a Provider Type 14 (Behavioral Health) and/or a Provider Type 82 (Behavioral Health Rehabilitative Treatment) or Provider Type 85 (Applied Behavior Analysis).

If enrolling as Provider Type 14 with a Specialty of 305, 306 or 307, it is not required for those specific providers to link to a Group.

If the individual will not be linking to a group, select No.

Request Information, continued

Group Association

To become affiliated or remain with an existing Medicaid Provider Group, enter the Group's NPI and the date to begin the affiliation. Otherwise, leave this field blank. **This is required for provider types 14 and 82.**

***Are you PT 014 with Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, or Clinical Professional Counselor specialty?**	○ Yes ◉ No
Would You Like to be Linked to a Group?	○ Yes ◉ No

This question **only** pertains to Provider Type 14 and must be completed. If the answer is Yes to the first question, there are no additional fields that need to be completed. If the PT 14 is linking to a Group, the fields will remain the same as on the previous slide.

Providers will only indicate Yes if they are fully licensed. Interns should **only** select No. If an intern selects Yes, this will cause issues with their Specialty Code that was selected.

Request Information, continued

Provider Information

A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

Federal Tax ID θ

***SSN** θ

***Are you currently enrolled as a Provider?** ○ Yes ◉ No

***Were you previously enrolled as a Provider?** ○ Yes ◉ No

Federal Tax ID: This should only be used for a Group application as the FEIN is used to identify a business entity.

SSN: Social Security Number of the individual provider. Do not input both the FEIN and SSN. Please reference Web Announcement 1899 (Requirement for Completing an Application, Revalidation or Re-Enrollment Differ for Individual Providers and Group Providers).

Indicate whether or not the provider is currently enrolled as a provider.

Indicate whether or not the provider was previously enrolled as a provider in Nevada Medicaid. If yes is selected, an additional field requiring the previous NPI be input will appear. If no is selected, no additional information will need to be provided for this question.

Request Information, continued

Contact Information

This contact information is required for correspondence regarding the associated application. Provide the appropriate contact person and information who can assist with the request.

*Last Name

*First Name

*Telephone Number

Telephone Number Extension

Fax Number

*Contact Email

*Confirm Email Address

*Preferred Method of Communication Email

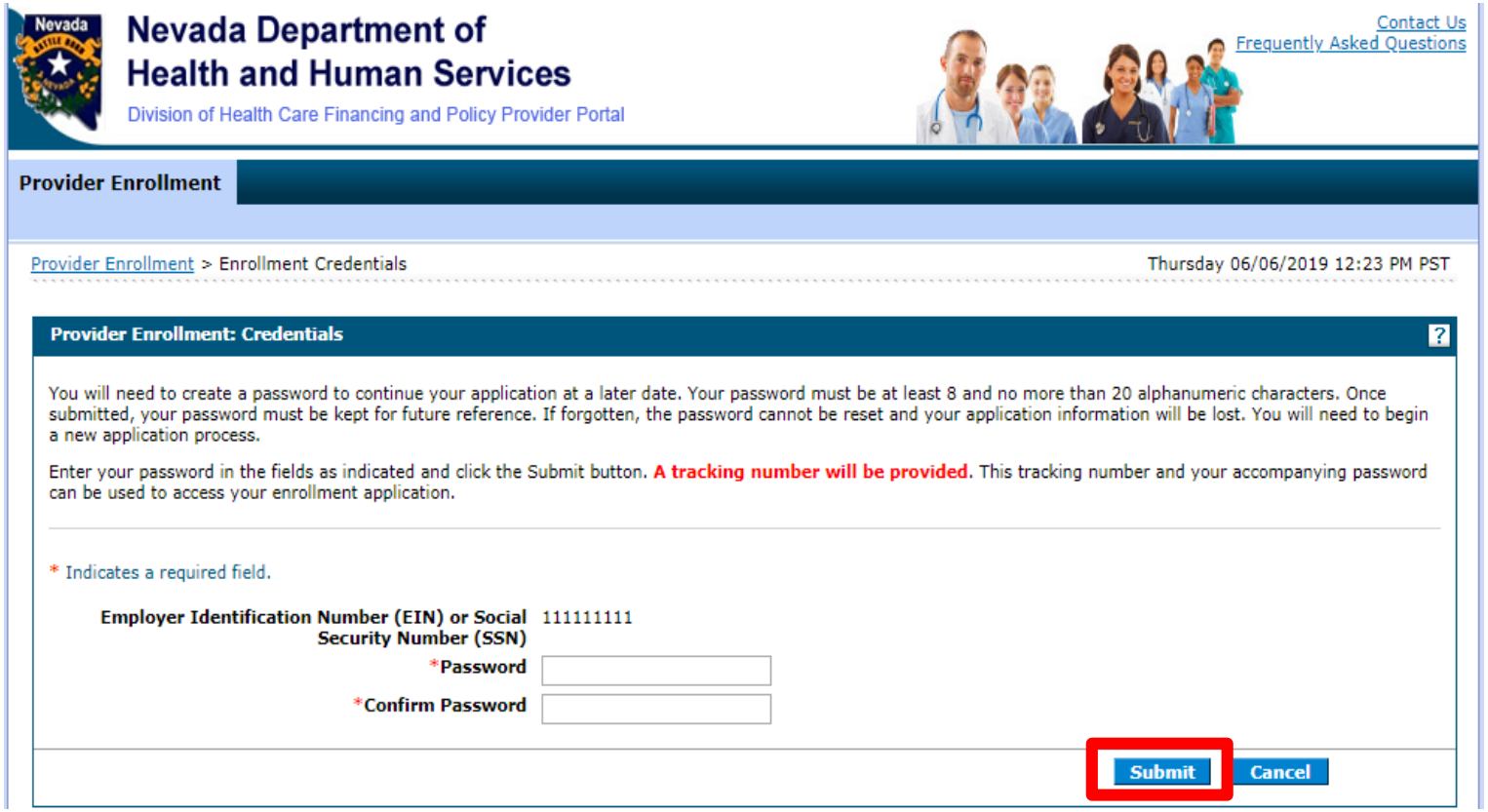
Continue | Finish Later | Cancel

The Contact Information section does not have to be filled out with the provider's information. This section is for a contact regarding the application, should Nevada Medicaid have any questions.

Last Name: Last name of the person of contact
First Name: First name of the person of contact
Telephone Number: Telephone number of the person of contact
Contact Email: Email address of the person of contact
Confirm Email Address: Confirm the email address of the person of contact
Preferred Method of Contact: Select from drop-down menu of Email or Phone

Once the Contact Information has been completed, select Continue.

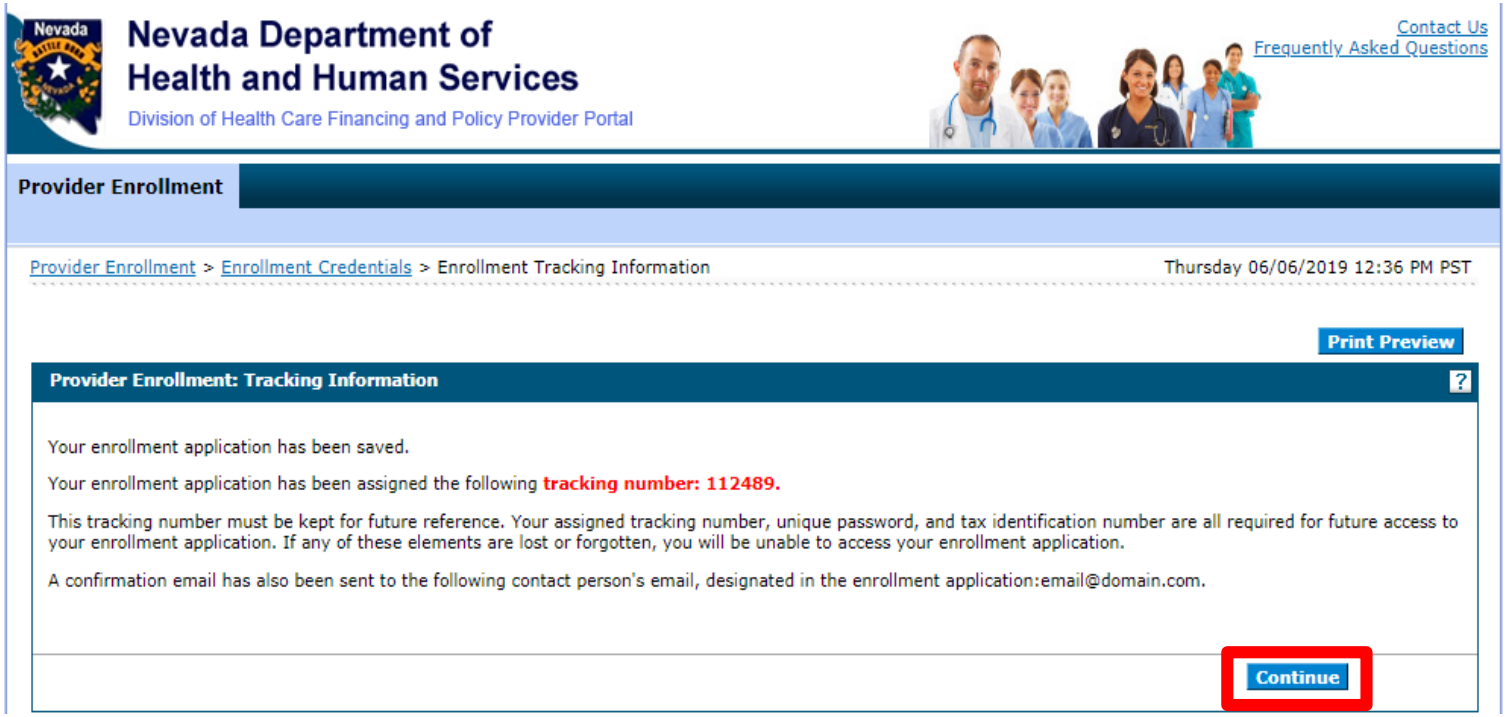
Provider Enrollment Credentials



The user will then need to create and confirm a password for the application. If the user cannot remember the password that was created and needs to access the application at a later date, the user will need to complete an entirely brand new application as Nevada Medicaid is unable to reset passwords for the OPE tool.

Once the password is confirmed, select Submit.

Provider Enrollment Credentials, continued



Once the password has been submitted, the Application Tracking Number (ATN) will be generated. Users should take note of the ATN as this will be used to verify status after the application has been submitted. In addition to the ATN, users will also be required to record the FEIN or SSN and password. Again, this is due to the fact that Nevada Medicaid is unable to reset a password for the OPE tool.

Select Continue.

Provider Enrollment Credentials, continued

Tue 6/11/2019 7:52 AM

Division of Health Care Financing and Policy Provider Portal <NVMMIS.edisupport@dxc.com>

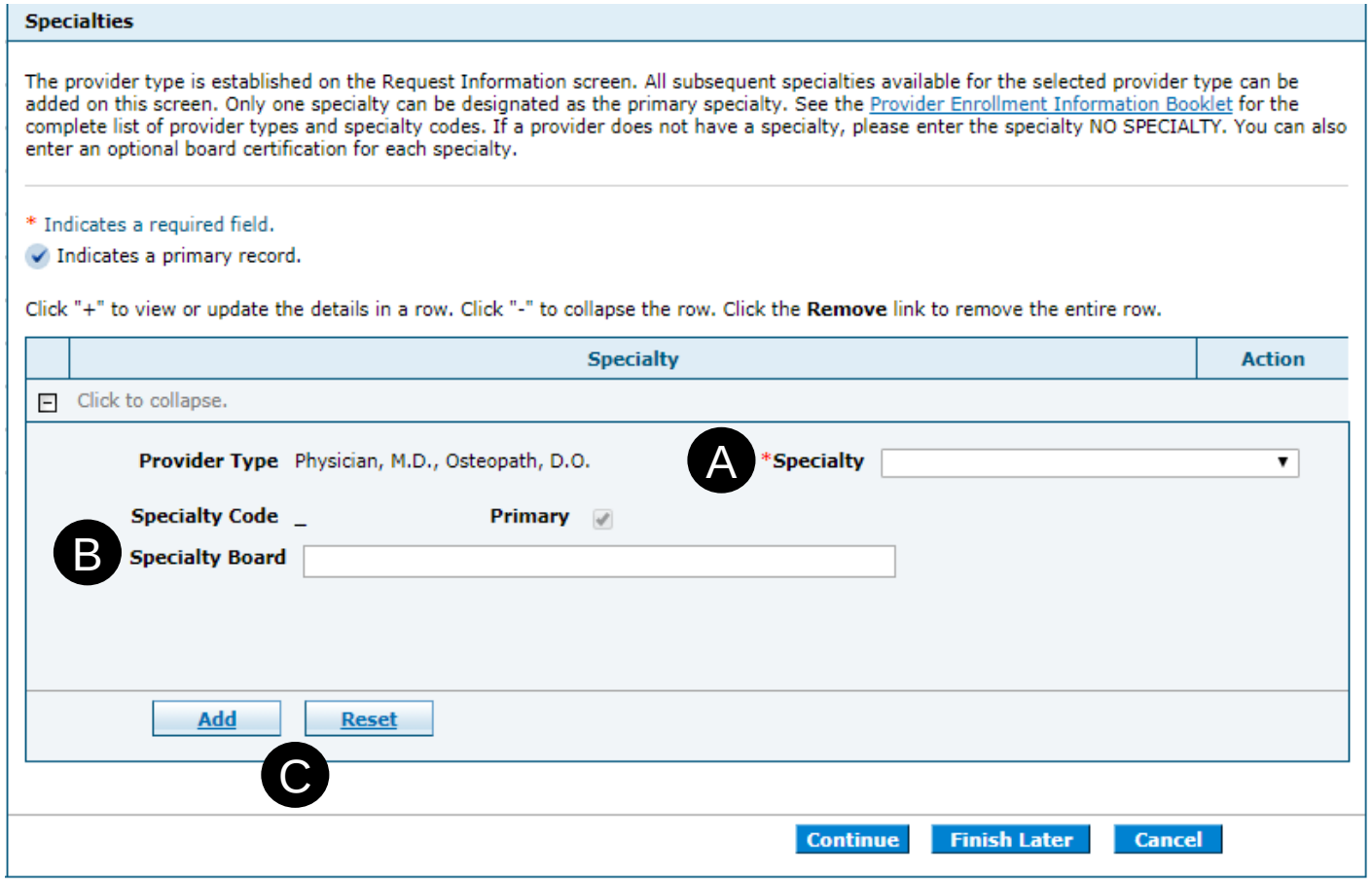
Provider Enrollment Application

To

Thank you for your interest in Nevada Medicaid Program. Your Nevada Medicaid Program tracking number is 112780. This tracking number must be kept for future reference. The tracking number, unique password, and Federal Tax ID or SSN are all required for future access to your enrollment application. You will not be able to retrieve your enrollment application without all of the required information. Remember to return to the Provider Portal at https://medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx to complete your enrollment application.

A system-generated email will be sent to the contact email listed on the application.

Specialties



All provider types are required to indicate a Specialty. (See the Provider Enrollment Information Booklet for a list of Provider Types and associated Specialties.)

Select the appropriate specialty from the Specialty drop-down list (A). If the provider type does not require a specialty, select No Specialty. Indicate the Board, if applicable (B), that approved of the specialty and select Add (C). If Add is not selected, the system will not allow users to continue.

Specialties, continued

Specialties

The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on this screen. Only one specialty can be designated as the primary specialty. See the Provider Enrollment Information Booklet for the complete list of provider types and specialty codes. If a provider does not have a specialty, please enter the specialty NO SPECIALTY. You can also enter an optional board certification for each specialty.

* Indicates a required field.
✔ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click the **Remove** link to remove the entire row.

	Specialty	Action
+	✔ Allergy	
+	Anesthesiology	Remove
+	Click to add specialty.	

Continue | Finish Later | Cancel

If the provider has more than one specialty, select the + symbol and follow previous steps.

If the user selects an incorrect specialty, select Remove from the Action column.

The first specialty selected will be the primary specialty.

Once all specialties are added, select Continue.

Provider Addresses

Provider Addresses

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

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

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

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

Enter each type of valid provider address including location(s) where a provider renders services, as well as location(s) used for billing and payment.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Collapse the row and click the **"Remove"** link to remove the entire row or **"Copy"** link to copy the entire row.

	Type	Street	City	State	Action
+	Click to add address.				

Continue | Finish Later | Cancel

This section allows users to input address information for the provider.

Service Address must be a physical address and cannot be a P.O. Box.

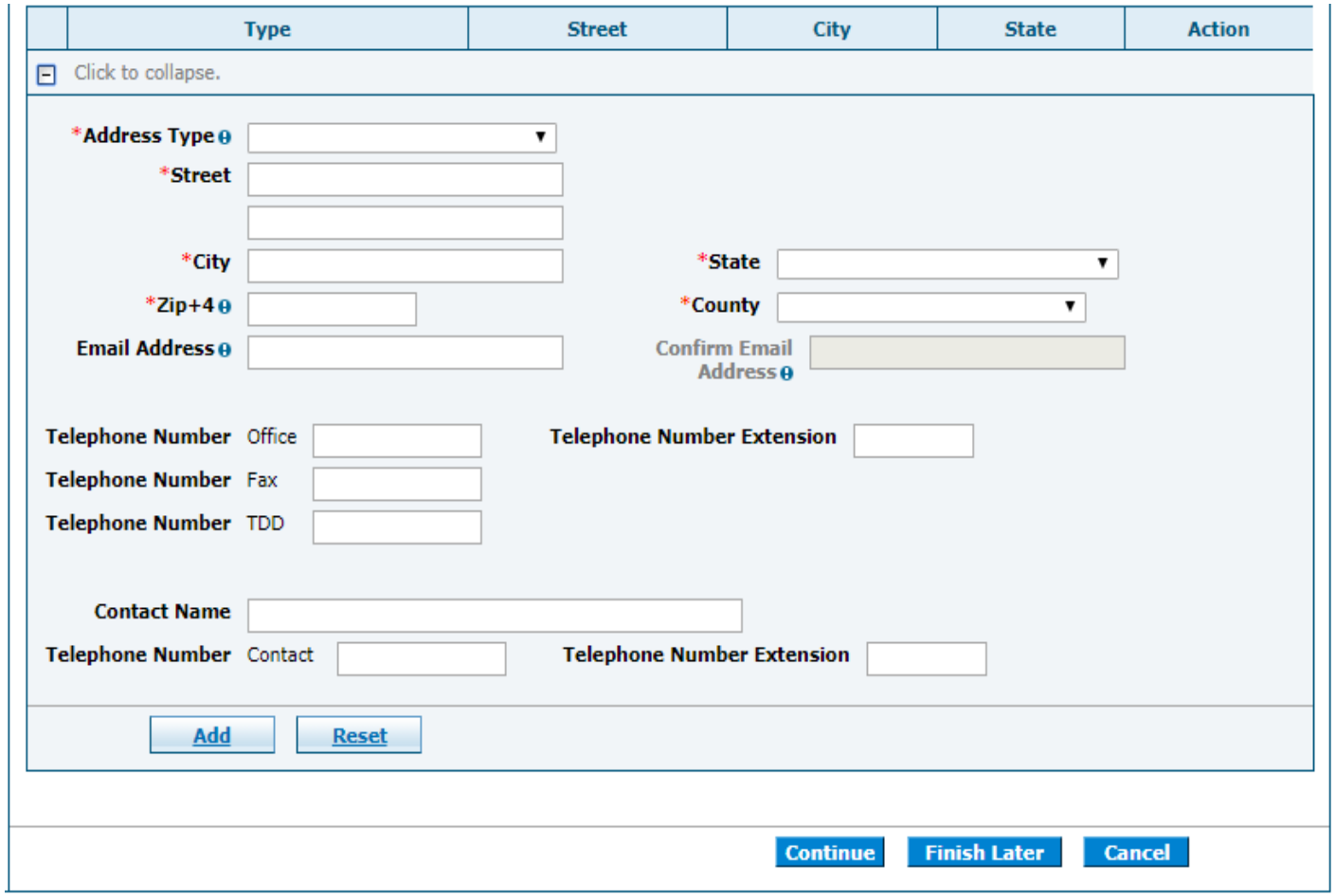
Pay To Address is the address that Nevada Medicaid will send paper checks until Bank Information is approved for Electronic Funds Transfer.

Mail To Address is the address that Nevada Medicaid may send written correspondence.

Remittance Advice address is the address that Nevada Medicaid will send RA's that are older than six (6) months. All other RA's are available electronically.

When the user is ready to input and add address information to the application, select the + to add a new address.

Provider Addresses, continued



Address Type: Select from drop-down menu (Service, Mail-To, Pay-To, Remittance Advice)

Street: Street Address. For service address, this must be a physical address. All other addresses can either be a physical address or a P.O. Box.

City: City

Zip+4: Zip Code. User can locate the additional 4 digits by running a post office address search or inputting 4 zeroes.

State: Select the state the address is located in from the drop-down menu.

County: Select the county the address is located in from drop-down menu.

Provider Addresses, continued

Type	Street	City	State	Action

Click to collapse.

*Address Type: Service
*Street: 9850 Double R Blvd
Suite 102
*City: Reno
*State: Nevada
*Zip+4: 895210000
*County: Washoe
Verify Address
Email Address
Confirm Email Address
Telephone Number Office *
Telephone Number Extension
Telephone Number Fax
Telephone Number TDD
*Contact Name
Telephone Number Contact *
Telephone Number Extension
Add Reset

Continue Finish Later Cancel

Once the address information is completed, the user is required to select Verify Address. A pop up window will then appear asking to confirm information. User can click on Select or User Original Address to complete the address information.

Address Verification: Results

To continue, select one of the options below.

Original Address

**Original address may be undeliverable.

Line 1 9850 Double R Blvd
Line 2 Suite 102
City Reno
State Nevada
Zip+4 89521-0000
County Washoe

Use Original Address

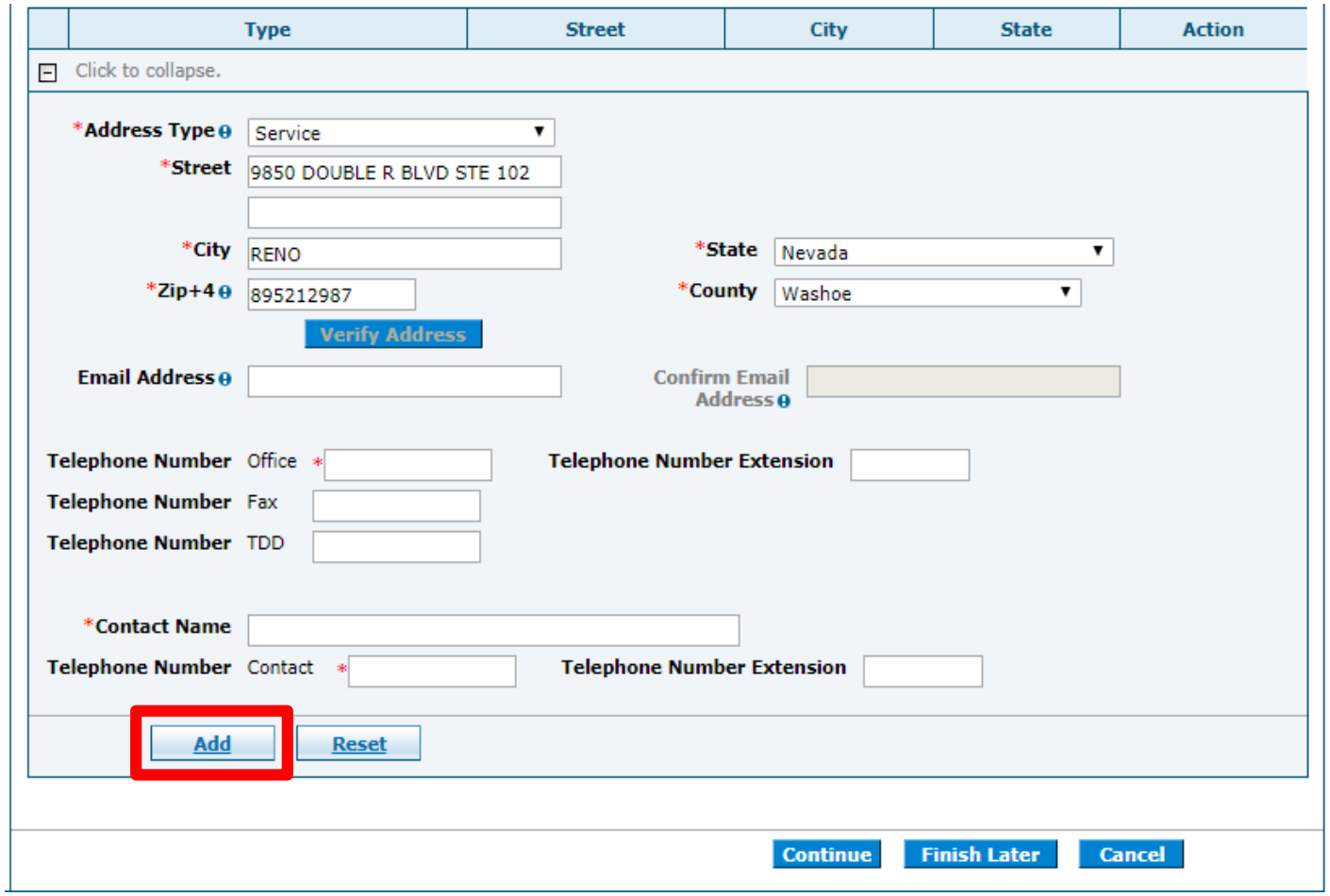
Recommended Address Formatted for Deliverability

Click on **SELECT** to choose the address.

Address	City, State	County	ZipCode	Action
9850 DOUBLE R BLVD STE 102	RENO, Nevada	Washoe	89521-2987	Select

Cancel

Provider Addresses, continued



Once the address information has been verified, the user will then be required to input an active telephone number and contact information.

All other fields are optional.

Once all fields have been populated, select the Add button.

Provider Addresses, continued

	Type	Street	City	State	Action
+	Service	9850 DOUBLE R BLVD STE 102	RENO	Nevada	Copy Remove
+	Click to add address.				

Continue Finish Later Cancel

The user can then select the + or the Copy link to add any additional address information pertaining to the Mail-To, Pay-To and Remittance Advice addresses.

Select Remove in order to delete an address.

Once all addresses have been completed, select Continue.

Provider Identification

Provider Legal Name

The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9, and is used by the Nevada Medicaid to generate the annual 1099 form for tax purposes.

***Last Name**	
***First Name**	
Middle	
Doing Business As Name	

The provider's legal name **must** match their W-9 form.

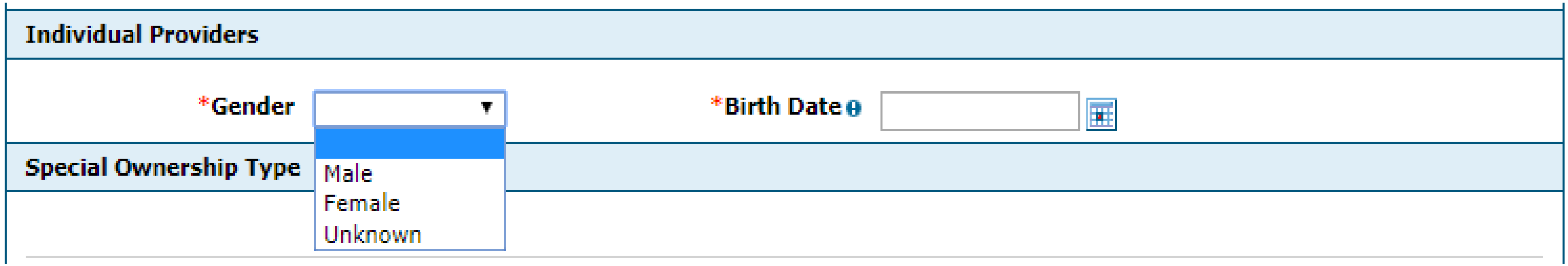
Last Name: Input provider's legal last name

First Name: Input provider's legal first name

Middle: Provider's legal middle initial, if applicable

Doing Business as Name: If the individual provider will be operating a separate business and using a Tax ID, input the other business name. This information must match what is on file with the IRS. If there is no other business, leave the field blank.

Provider Identification, continued



Individual providers will select a gender from the drop-down menu, as well as their birth date.

Provider Identification, continued

Special Ownership Type

Special Ownership Type

County-owned
Government-owned
No owner
Non-Profit
State-owned

NPI

The NPI is the National Prov ceived through the NPPES Registry for all healthcare providers.

***NPI**

If the practice will be owned by a different entity than listed, indicate the Special Ownership Type from the drop-down menu. If there is no Special Ownership Type, user can select the blank option.

Provider Identification, continued

NPI

The NPI is the National Provider Identifier that is applied for and received through the NPPES Registry for all healthcare providers.

*NPI

Enter the provider's NPI. This information will be obtained from the National Plan & Provider Enumeration System (NPPES). Nevada Medicaid cannot assist in obtaining an NPI. For more information, please visit: nppes.cms.hhs.gov.

Provider Identification, continued

License

*Name of Issuing Licensing Board, State or Entity

*License Number

*License State

*Effective Date

*End Date

Name of Issuing Licensing Board, State or Entity: This answer will be selected from the drop-down menu

License Number: This information will come directly from the license that was issued by the appropriate Board, State or Entity

License State: Select from the drop-down menu to indicate which state issued the license

Effective and End Dates: This will be the dates the license is active. After the application is completed, if the provider is issued an updated license, the provider must submit the new license to Nevada Medicaid.

Provider Identification, continued

Business Information

*Nevada Secretary of State Issued Business ID

*Nevada Secretary of State Registered Name

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

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

CLIA Certification

CLIA Number

Nevada Secretary of State Issued Business ID: This number will be issued from the Nevada Secretary of State. Nevada Medicaid cannot assist in obtaining the SOS number. For more information, please visit: www.nvsos.gov/sos

Nevada Secretary of State Registered Name: This is the name used by the provider to create and obtain a valid business in the State of Nevada

The last question in the section must be selected from the drop-down menu and match the type of entity that the provider is enrolling as. This will be determined from the provider's W9 Form that was filed with the IRS.

Provider Identification, continued

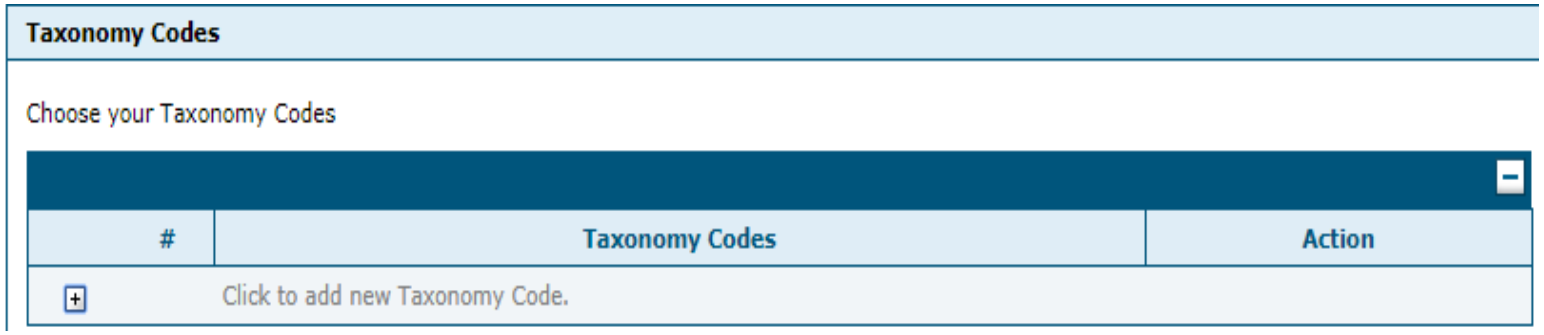
CLIA Certification	
CLIA Number	
Drug Enforcement Administration (DEA) Number	
DEA #	

CLIA (Clinical Laboratory Improvement Amendments): If a provider will be completing laboratory tests in their office, the provider must have the appropriate certification. If not, the provider's claims may deny due to incomplete information.

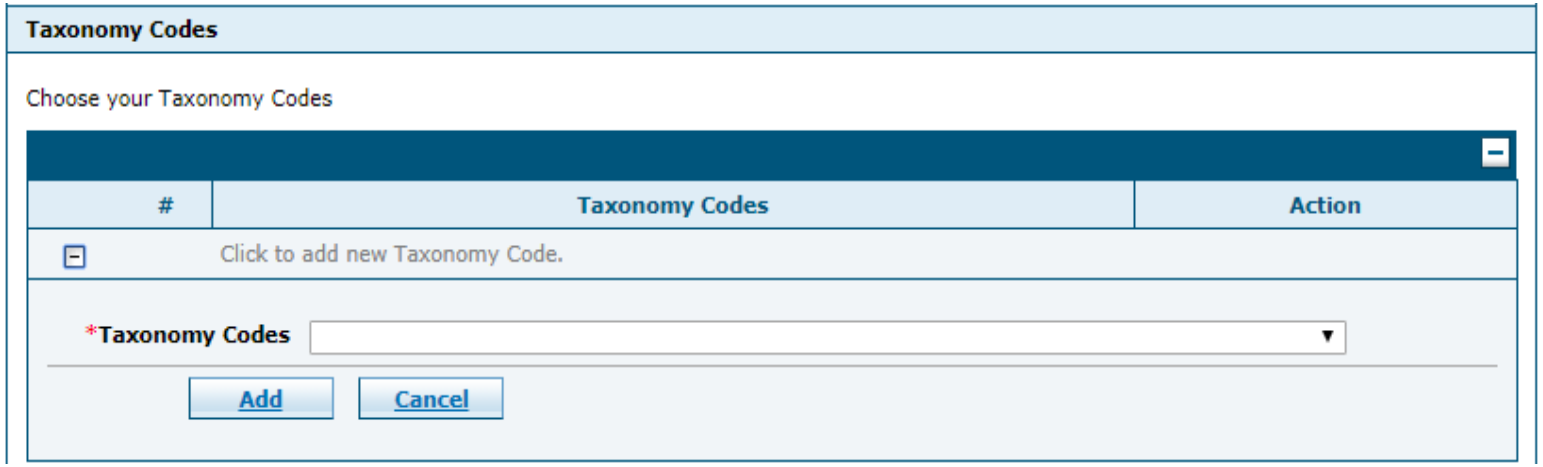
DEA (Drug Enforcement Administration) Number: If a provider will be dispensing pharmaceuticals in the office, the provider must have a DEA number issued.

Note: If the provider does not have either one of these pieces of information because lab tests are not being completed in office nor are pharmaceuticals being dispensed, the user can input a bypass code of nine 9s (999999999) into each field.

Provider Identification, continued



Providers are required to have a Taxonomy Code. Taxonomy Codes are determined by the provider and not Nevada Medicaid. Providers should review NPPES for their registered taxonomy code. To add a Taxonomy Code, select the + symbol.



The user will then need to select the appropriate Taxonomy Code from the drop-down menu and select Add. Nevada Medicaid cannot advise a provider as to which taxonomy code should be selected.

Provider Identification, continued

Taxonomy Codes

Choose your Taxonomy Codes

#	Taxonomy Codes	Action
+	102X00000X - Poetry Therapist	Remove
+	Click to add new Taxonomy Code.	

Continue | Finish Later | Cancel

Once the user has input the Taxonomy Code, the user can add additional codes by selecting the + symbol.

If the Taxonomy Code is incorrect, select Remove from the Action column.

After all Taxonomy Codes have been entered, select Continue.

EFT Information

Provider Enrollment: EFT Information

- Welcome
- Request Information
- Specialties
- Addresses
- Provider Identification
- **EFT Enrollment**
- Other Information
- Ownership & Disclosure
- Agreement
- Attachments
- Summary

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

Electronic Funds Transfer (EFT) Authorization: I hereby authorize Nevada Medicaid and its subsidiaries to transfer my Nevada Medicaid and Nevada Check Up payments to the personal or business bank account shown below. I also authorize any necessary debit entries to correct payment errors. I understand the payments made through electronic funds transfers will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. This agreement will remain in effect until I notify Nevada Medicaid or the banking institution otherwise. I understand that Nevada Medicaid and/or my banking institution may also cancel this agreement at any time. All such cancellation notices must be made in writing and acted upon in a reasonable and timely manner.

If you have questions about completing the Electronic Funds Transfer Agreement, contact the Provider Enrollment Unit. If you have questions regarding your payment or the EFT program in general, contact the Customer Service Center. Both Nevada Medicaid departments may be contacted by phone at (877) 638-3472.

You will need to attach a voided check, or a letter from your bank that contains your bank's routing number.

Forms

The EFT Authorization form must be completed, including a signature and date, and uploaded to this application using the Attachments page before being submitted. All documents must be uploaded at the time of provider enrollment form submission in order for your application to be processed and considered complete.

EFT Authorization Download

Financial Institution Information

***Financial Institution Routing Number**

***Provider's Account Number with Financial Institution**

Reason For Submission New Enrollment

***Include with Enrollment Submission**

Requested EFT Start/Change/Cancel date 06/06/2019

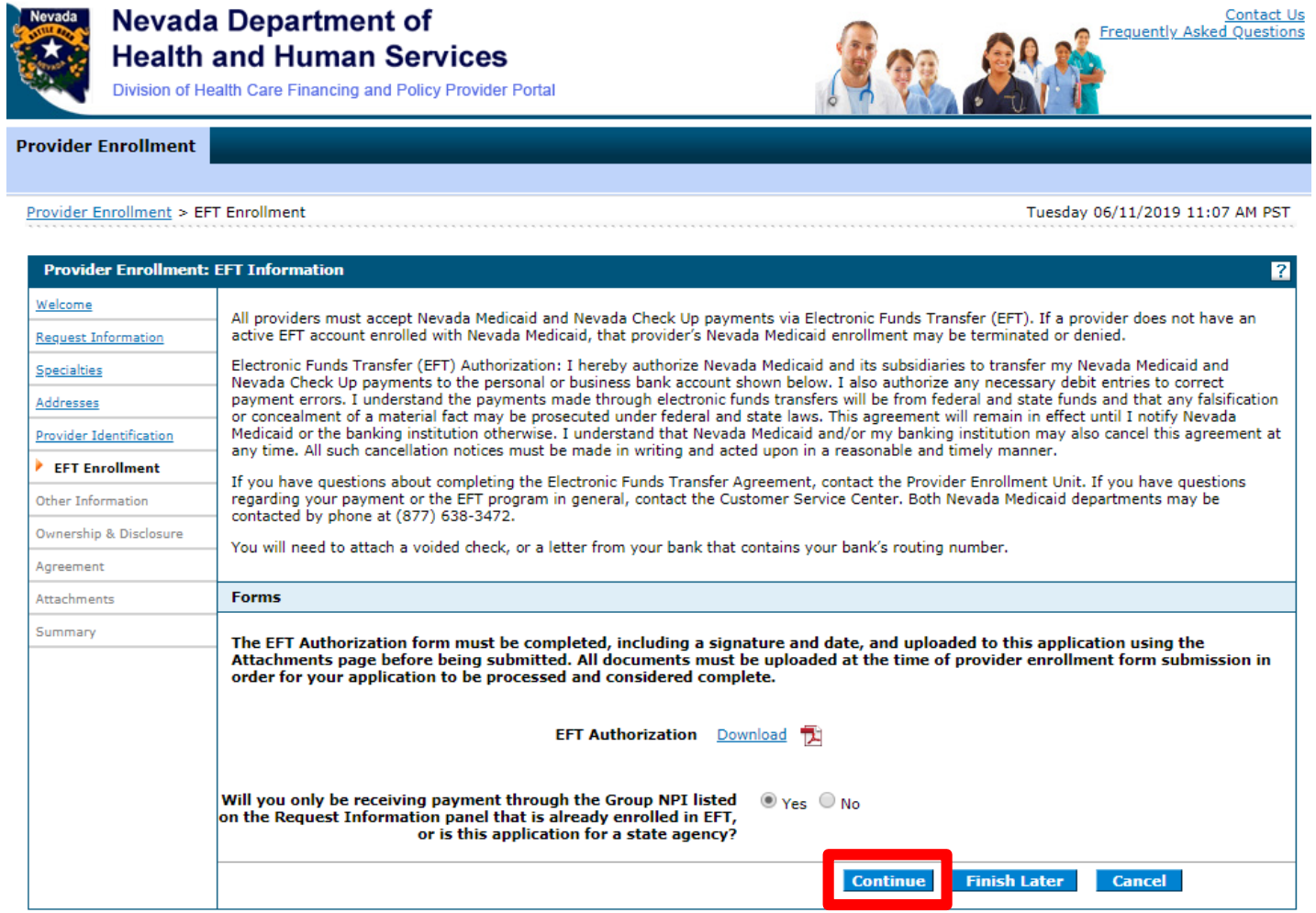
Continue **Finish Later** **Cancel**

Providers will be asked to provide Electronic Funds Transfer (EFT) information for Nevada Medicaid to make payments to the provider after claims processing.

Download the EFT Authorization, input the bank's Routing Number (9 digits), Account Number and indicate if a Bank Letter or Voided Check is being attached. The date will auto-populate based on the effective date of the application that was completed previously. Select Continue.

Note: EFT requests are not approved immediately. Nevada Medicaid is required to run "tests" to verify the bank information. EFT approvals can take up to 15 days.

EFT Information, continued



If the Individual provider previously indicated that they would be linking to a Group, the Group will then receive payments on behalf of the Individual. Therefore, the user will select Yes, they will be receiving payment from the Group.

Select Continue.

EFT Information, continued

Nevada Medicaid and Nevada Check Up

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

Electronic Funds Transfer (EFT) Authorization: I hereby authorize Nevada Medicaid (Nevada Medicaid refers to the fiscal agent for Nevada Medicaid) and its subsidiaries to transfer my Nevada Medicaid and Nevada Check Up payments to the personal or business bank account shown below. I also authorize any necessary debit entries to correct payment errors. I understand the payments made through electronic funds transfers will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. This agreement will remain in effect until I notify Nevada Medicaid or the banking institution otherwise. I understand that Nevada Medicaid and/or my banking institution may also cancel this agreement at any time. All such cancellation notices must be made in writing and acted upon in a reasonable and timely manner.

Business or personal bank account number: _____

Authorized signature: _____ Date: _____

TAPE AN ORIGINAL, VOIDED CHECK HERE

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

PHOTOCOPIED CHECKS AND BANK DEPOSIT SLIPS ARE NOT ACCEPTED.

The EFT form must be completed and uploaded later in the application as an attachment and must accompany either a Bank Letter or a Voided Check.

Other Information

Additional Information

*Are you enrolled in Medicare? ○ Yes ◉ No

*Days and Hours of Operation

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

*Are you currently accepting new patients? ○ Yes ○ No

*Can you accommodate recipients with special needs? ○ Yes ○ No

Are you enrolled in Medicare: Select the appropriate answer. Later in the application there will be a similar question and both answers must match. If not, the application will be returned for corrections.

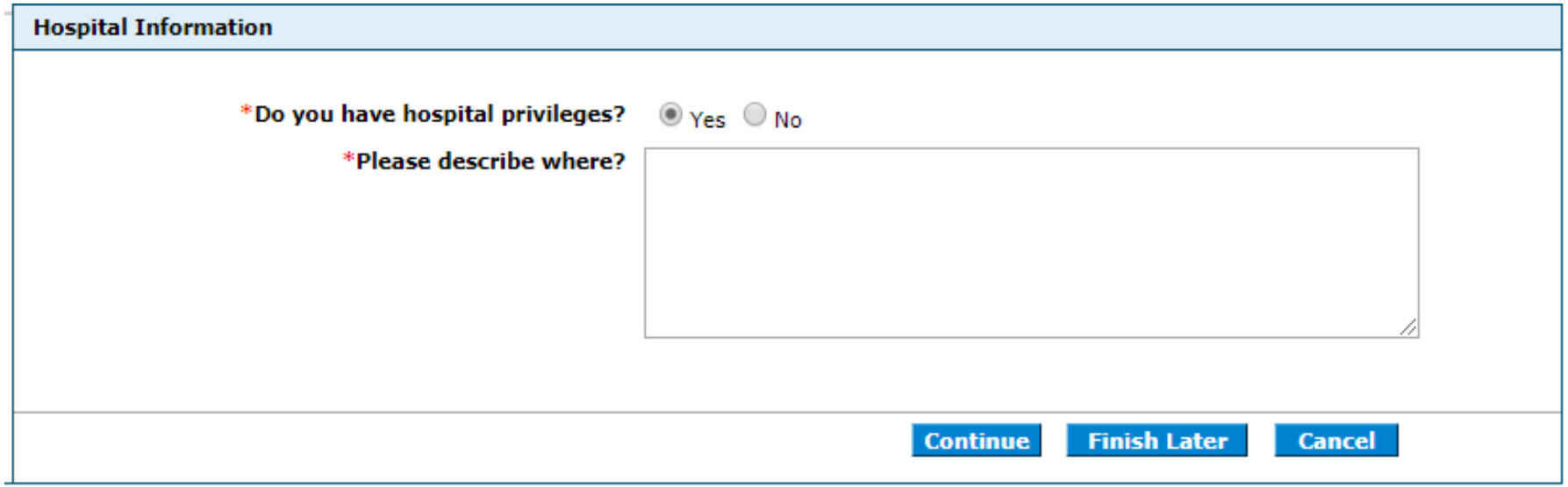
Days and Hours of Operation: Input days and time that the practice is open.

The next question will be selected from a drop-down menu and will indicate if the provider is seeing Fee For Service (FFS) recipients, Managed Care Organization (MCO) recipients or both FFS and MCO recipients. For more information regarding FFS and MCO recipients, please review the Billing Manual located on the Billing Information webpage of the Nevada Medicaid website.

Are you currently accepting new patients: Select the appropriate answer.

Can you accommodate recipients with special needs: Select the appropriate answer.

Other Information, continued



If the provider will be associated with a hospital, the hospital information must be input into the free form text box. If the provider will not have hospital privileges, select No and the free form text field will not appear.

After the questions have been answered, select Continue.

Ownership & Disclosure

Ownership Information

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

Ownership is defined as all individuals and corporations having direct or indirect ownership interest, or controlling interest in the disclosing entity (this includes relatives) and for any subcontracting company in which the disclosing entity has direct or indirect ownership of 5 percent or more. Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. Managing Employee is defined as a general manager, business manager, administrator, officer, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency. Board Member is defined as anyone who sits on a board of directors for any entity.

Information is required on the following:

- Group and Individual Enrollment applicants are required to enter all individuals or entities that:
  - have a direct or indirect ownership interest or controlling interest in the disclosing entity of 5 percent or more;
  - have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
  - owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
  - is an officer or director of a disclosing entity that is organized as a corporation; or
  - is a partner in a disclosing entity that is organized as a partnership.
- Group and Individual Enrollment applications are required to indicate the chain of ownership between the direct and indirect owners. Use the Related Corporations, Owners, Agents or Managing Employees Information grid below to indicate the chain of ownership.
- Group and Individual Enrollment applications are required to enter all Agents and Managing Employees.
- Group applications are required to enter all board member(s) if they are formed as a corporation.
- Anyone listed in the above entities that own 5 percent or more of any other business (health care related or non-health care related) is required to disclose that information.

Note: Owners are generally the Corporation or Owner entity types, but can also be board members/trustees.
The information on ownership, board member(s), managing employee(s), and agent(s) needs to be added in the Ownership (Direct & Indirect) / Managing Employee grid below. Ownership information sent as an attachment will not be accepted.

This is not required for:

- Individuals linking to group
- Provider Type 38
- Groups and individuals with a Special Ownership type value of Government or State Owned selected on the Provider Identification panel

Note: County owned organizations, Non-Profit organizations, and school districts are required to disclose all Board Members and Managing Employees/Agents.

All providers must read and understand the instructions that are listed on this page in order to properly complete the application. Users should also refer to Chapter 2 Addendum of the OPE User Manual for clarification regarding information and formatting that must be followed in order to properly complete the application. If any information is incorrect, Nevada Medicaid will return the application for review and corrections.

For Individual providers linking to a Group, the Ownership Information is not required. Individuals linking will still be required to indicate Managing Employee/Agent.

Examples are outlined on the next three slides.

Ownership & Disclosure, continued

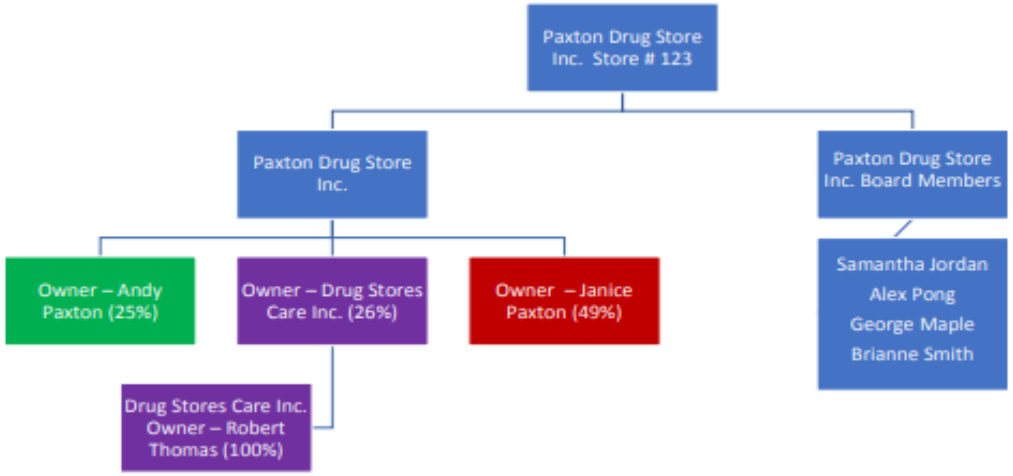
Chapter 2 Addendum. Ownership & Relationships Example

As part of the modernized Medicaid Management Information System (MMIS) update on February 1, 2019, providers are now required to identify all ownership in their company and outline the relationships that exist as outlined in Chapter 2 of the Online Provider Enrollment User Manual.

This process can be complex, so the purpose of this addendum is to provide an example.

2.1 Storyline

Paxton Drug Store #123 is completing their initial provider enrollment application. They are owned by Paxton Drug Store Inc. The parent company has four board members: Samantha, Alex, George and Brianne. Paxton Drug Store Inc. Is owned by Andy Paxton, Janice Paxton and Drug Stores Care Inc. This company is owned by Robert Thomas.



2.2 Completing the Ownership Information Section

The provider must input all details regarding information:

- Paxton Drug Store owns 100% of Paxton Drug Store #123.
- Samantha Jordan, Alex Pong, George Maple and Brianne Smith are board members, but do not own any shares of the company.
- Andy Paxton owns 25% of Paxton Drug Store, Janice Paxton owns 49% and Drug Stores Care owns 26%.
- Robert Thomas owns 100% of Drug Stores Care.

Online Provider Enrollment User Manual, Chapter 2 Addendum 1
03/07/2019

Ownership & Disclosure, continued

Ownership Information

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

Ownership is defined as all individuals and corporations having direct or indirect ownership interest, or controlling interest in the disclosing entity (this includes relatives) and for any subcontracting company in which the disclosing entity has direct or indirect ownership of 5 percent or more. Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. Managing Employee is defined as a general manager, business manager, administrator, officer, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency. Board Member is defined as anyone who sits on a board of directors for any entity.

Information is required on the following:

- Group and Individual Enrollment applicants are required to enter all individuals or entities that:
  - have a direct or indirect ownership interest or controlling interest in the disclosing entity of 5 percent or more;
  - have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
  - owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
  - is an officer or director of a disclosing entity that is organized as a corporation; or
  - is a partner in a disclosing entity that is organized as a partnership.
- Group and Individual Enrollment applications are required to indicate the chain of ownership between the direct and indirect owners. Use the Related Corporations, Owners, Agents or Managing Employees Information grid below to indicate the chain of ownership.
- Group and Individual Enrollment applications are required to enter all Agents and Managing Employees.
- Group applications are required to enter all board member(s) if they are formed as a corporation.
- Anyone listed in the above entities that own 5 percent or more of any other business (health care related or non-health care related) is required to disclose that information.

Note: Owners are generally the Corporation or Owner entity types, but can also be board members/trustees.
The information on ownership, board member(s), managing employee(s), and agent(s) needs to be added in the Ownership (Direct & Indirect) / Managing Employee grid below. Ownership information sent as an attachment will not be accepted.

This is not required for:

- Individuals linking to group
- Provider Type 38
- Groups and individuals with a Special Ownership type value of Government or State Owned selected on the Provider Identification panel

Note: County owned organizations, Non-Profit organizations, and school districts are required to disclose all Board Members and Managing Employees/Agents.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **"Remove"** link to remove the entire row.

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
1	Corporation	Paxton Drug Store	684864644	100	Remove
2	Board Member/Trustee	Samantha Jordan	549227364	0	Remove
3	Board Member/Trustee	Alex Pong	281228574	0	Remove
4	Board Member/Trustee	George Maple	254681538	0	Remove
5	Board Member/Trustee	Brianne Smith	425116842	0	Remove
6	Owner	Andy Paxton	225683148	25	Remove
7	Owner	Janice Paxton	254169841	49	Remove
8	Corporation	Drug Stores Care	625479153	26	Remove
9	Owner	Robert Thomas	259741258	100	Remove
	Click to add Type of Entity.				

2.3 Completing the Ownership or Controls Relationship Section

Now that all corporations, board members and owners have been input, the provider must link the people and/or corporations. This section does not include board members.

- Andy, Janice & Drug Stores Care are owners of Paxton Drug Store
- Andy is the spouse of Janice Paxton
- Robert Thomas owns Drug Stores Care

Online Provider Enrollment User Manual, Chapter 2 Addendum 2
03/07/2019

Ownership & Disclosure, continued

Ownership or Control Relationships

In the Related Corporations Owners, Agents or Managing Employees Information grid below, indicate if any person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

Group and Individual Enrollment applications are required to use this grid to indicate the chain of ownership between the direct and indirect owners.

Is any person (individual or corporation) with an ownership or control interest in the disclosing entity related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or is any disclosed corporation an owner of any other disclosed corporation?

* ◉ Yes ○ No

Related Corporations, Owners, Agents, or Managing Employees Information

#	Corporation/Owner/Agent/Managing Employee Name	Relationship	Corporation/Owner/Agent/Managing Employee Name	Action
+	Andy Paxton	Is The Owner Of	Paxton Drug Store	Remove
+	Janice Paxton	Is The Owner Of	Paxton Drug Store	Remove
+	Andy Paxton	Is The Spouse Of	Janice Paxton	Remove
+	Drug Stores Care	Is The Owner Of	Paxton Drug Store	Remove
+	Robert Thomas	Is The Owner Of	Drug Stores Care	Remove
+	Click to add Relationship information.			

2.4 Note about Completing the Ownership Information Section

There may be times when ownership total does not equal 100%, as it did in Section 2.2, because some owners own less than 5% and would not be listed. When that happens, put detailed notes in the *Explanation if total ownership is less than* field.

There may also be times when the parent company is publicly traded and cannot provide people's names who own 5% or more of the company. In this situation, it is suggested to attach a letter explaining the circumstances to aid in processing the application more quickly.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **"Remove"** link to remove the entire row.

Type of Entity Information

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
+ 1	Owner	Mike Jones	123456789	92	Remove
+ 2	Managing Employee	Sandy Smith	123456789	N/A	Remove
+	Click to add Type of Entity.				

***Explanation if total ownership less than 100%**

There are two people who own 4% each.

Online Provider Enrollment User Manual, Chapter 2 Addendum 3
03/07/2019

Ownership & Disclosure, continued

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

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: If A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Ownership & Disclosure, continued

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

Ownership & Disclosure, continued

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

Disclosing entity means a Medicaid provider or a fiscal agent.

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

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

Ownership & Disclosure, continued

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

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

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

Ownership & Disclosure, continued

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

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

Ownership & Disclosure, continued

Subcontractor means:

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

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

Ownership & Disclosure, continued

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **"Remove"** link to remove the entire row.

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action

Click to add Type of Entity.

Type of Entity
Title
Corporation Name
Ownership Type
Last Name
First Name
Middle
Birth Date
SSN
Federal Tax ID
Street
City
State
Zip+4
% of Ownership
Employee Indicator

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

Yes No

Add Cancel

Type of Entity: This will be selected from a drop-down menu (Corporation, Managing Employees and/or Agent, or Owners). Depending upon the selection that is made, the questions may vary.

The next three slides cover the questions that must be answered depending on the Type of Entity selected.

Ownership & Disclosure, continued

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action

Click to add Type of Entity.

Type of Entity: Corporation

*Corporation Name

*Ownership Type

*Federal Tax ID

*Street

*City

*State

*Zip+4

*% of Ownership

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* Yes No

Add Cancel

If Corporation is selected as the Type of Entity, the questions will be different. User must complete each question that is listed. If the user indicates Yes, that the entity owns more than 5% of any other business, additional questions must be answered.

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* Yes No

Other Business Interests

#	Business Name	Federal Tax ID	Action

Click to add Other Business Interests.

*Business Name

*Federal Tax ID

*Street

*City

*State

*Zip+4

Add Cancel

Ownership & Disclosure, continued

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action

Click to add Type of Entity.

Type of Entity: Managing Employees and/or Agent

*Title

*Last Name

*First Name

Middle *Birth Date

*SSN

*Street

*City

*State *Zip+4

*Employee Indicator

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* Yes No

Add Cancel

If Managing Employees and/or Agent is selected as the Type of Entity, the questions will be different. User must complete each question that is listed. If the user indicates Yes, that the entity owns more than 5% of any other business, additional questions must be answered.

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* Yes No

Other Business Interests

#	Business Name	Federal Tax ID	Action

Click to add Other Business Interests.

*Business Name

*Federal Tax ID

*Street

*City

*State

*Zip+4

Add Cancel

Ownership & Disclosure, continued

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action

Click to add Type of Entity.

Type of Entity: Owners

*Title

*Ownership Type

*Last Name

*First Name

Middle *Birth Date

*SSN

*Street

*City

*State *Zip+4

*% of Ownership

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* Yes No

If Owners is selected as the Type of Entity, the questions will be different. User must complete each question that is listed. If the user indicates Yes, that the entity owns more than 5% of any other business, additional questions must be answered.

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* Yes No

Other Business Interests

#	Business Name	Federal Tax ID	Action

Click to add Other Business Interests.

*Business Name

*Federal Tax ID

*Street

*City

*State

*Zip+4

Add Cancel

Ownership & Disclosure, continued

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **"Remove"** link to remove the entire row.

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
1	Owner	First Last	111111111	90	Remove
2	Managing Employee	First Last	123333333	N/A	Remove
	Click to add Type of Entity.				

Explanation if total ownership less than 100%

The percentage of ownership must equal 100%. If there are any owners of the business that own **less** than 5% of the practice, that information must be disclosed in the free form text field.

Ownership & Disclosure, continued

Does any individual and/or corporation have an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity?

Yes No

Mortgage, deed of trust, note or other obligation information

#	Name	SSN	Federal Tax ID	Action

Click to add Individual and/or Corporation.

*Type of Entity

Name

Last Name

First Name

Middle

Birth Date

SSN

Federal Tax ID

Street

City

State

Zip+4

% of Ownership

Add Cancel

If any of the entities that were previously listed own more than 5% of a mortgage, deed, trust, note or other obligations, that information must be listed. The required fields will change depending on the Type of Entity selected.

If the entities do not own more than 5% of a mortgage, deed, trust, note or other obligations, the fields will not populate and user can move to the next question.

The next slide will show the different questions that must be answered depending upon the Type of Entity selected.

Ownership & Disclosure, continued

Does any individual and/or corporation have an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity?

Yes No

Mortgage, deed of trust, note or other obligation information

#	Name	SSN	Federal Tax ID	Action

Click to add Individual and/or Corporation.

*Type of Entity: Corporation

*Name

*Federal Tax ID

*Street

*City

*State

*Zip+4

*% of Ownership

Add Cancel

Does any individual and/or corporation have an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity?

Yes No

Mortgage, deed of trust, note or other obligation information

#	Name	SSN	Federal Tax ID	Action

Click to add Individual and/or Corporation.

*Type of Entity: Owners

*Last Name

*First Name

Middle

*Birth Date

*SSN

*Street

*City

*State

*Zip+4

*% of Ownership

Add Cancel

Ownership & Disclosure, continued

Ownership or Control Relationships

In the Related Corporations Owners, Agents or Managing Employees Information grid below, indicate if any person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

Group and Individual Enrollment applications are required to use this grid to indicate the chain of ownership between the direct and indirect owners.

Is any person (individual or corporation) with an ownership or control interest in the disclosing entity related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or is any disclosed corporation an owner of any other disclosed corporation?

◉ Yes ○ No

Related Corporations, Owners, Agents, or Managing Employees Information

#	Corporation/Owner/Agent/Managing Employee Name	Relationship	Corporation/Owner/Agent/Managing Employee Name	Action

Click to add Relationship information.

*Corporation/Owner/Agent/Managing Employee Name

Is The

*Relationship (including Business Ownership)

Of

*Corporation/Owner/Agent/Managing Employee Name

Add Cancel

If any of the owners are related to one another, that information must be disclosed. Complete the fields and select Add. If there are no relationships between owners, indicate No and the fields will not appear.

Ownership & Disclosure, continued

Background and Disclosure of Disclosing Entity

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

Who is authorized to make changes to enrollment and billing information?

Change Authorization Information

#	Legal Name	Action
	Click to add Change Authorizations.	

*Last Name

*First Name

Add Cancel

This question is regarding who in the practice is authorized to make changes on behalf of the provider. If information about a provider's profile must be changed and the user that is submitting the changes is not an authorized person, those changes cannot be made. Changes can only be accepted from the Managing Employee or Authorized Representative.

Input the Authorized Representative's Last Name and First Name and select Add.

Ownership & Disclosure, continued

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

* ◉ Yes ○ No

Currently Enrolled or Previously Enrolled Information

#	Program	State	Effective Date	Action
	Click to add Program.			

*Program

*State

*Effective Date

Add Cancel

If any owner, agent, managing employee or anyone else that has controlling interest in the practice has ever been enrolled in either Medicaid and/or Medicare, that information must be listed on the application and the answer to this question must match the similar question that was asked previously. Once fields are completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

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

* ◉ Yes ○ No

Negative Balance/Owed Money Information

#	Provider/Entity/Employee Name	Amount Owed	To Whom Is The Money Owed	Action
⊟	Click to add Negative Balances.			

***Provider/Entity/Employee Name**

***Amount Owed** 0.00

***To Whom Is The Money Owed**

Add Cancel

If any owner, agent, managing employee or person with controlling interest owes monies to a state and/or federal program, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

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

* ◉ Yes ○ No

Conviction Information

#	Name Used When Convicted	Date Of Conviction	Action
⊟	Click to add Convictions.		

*Name Used When Convicted

*Date Of Conviction

*Charges

*Disposition

*Conditions Of Parole/Probation

Add Cancel

If any owner, agent, managing employee or person with controlling interest has ever been convicted of a misdemeanor, gross misdemeanor or felony (see Chapter 100 of the Medicaid Services Manual for further clarification), all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

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

* ◉ Yes ○ No

Sanction Information

#	Name Used When Sanctioned	Provider ID	Group ID	Sanction Effective Date	Reinstatement Date	Action
⊟	Click to add OIG/HHS Sanctions.					

If no NPI/API, use IPN for either provider ID or Group ID number.
Either provider ID or Group ID is required

*Name Used When Sanctioned

Provider ID

Group ID

*Sanction Effective Date

*Reinstatement Date

Add Cancel

If any owner, agent, managing employee or person with controlling interest has ever been placed on the Office of Inspector General's exclusion list, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Are you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest currently under investigation by any law enforcement, regulatory or state agency?

* ◉ Yes ○ No

***Please Provide Details**

If any owner, agent, managing employee or person with controlling interest is currently under investigation, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Do you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest have any open or pending court cases?

* ◉ Yes ○ No

***Please Provide Details Including Court Documentation**

If any owner, agent, managing employee or person with controlling interest currently has an open or pending court case, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever been denied malpractice insurance?

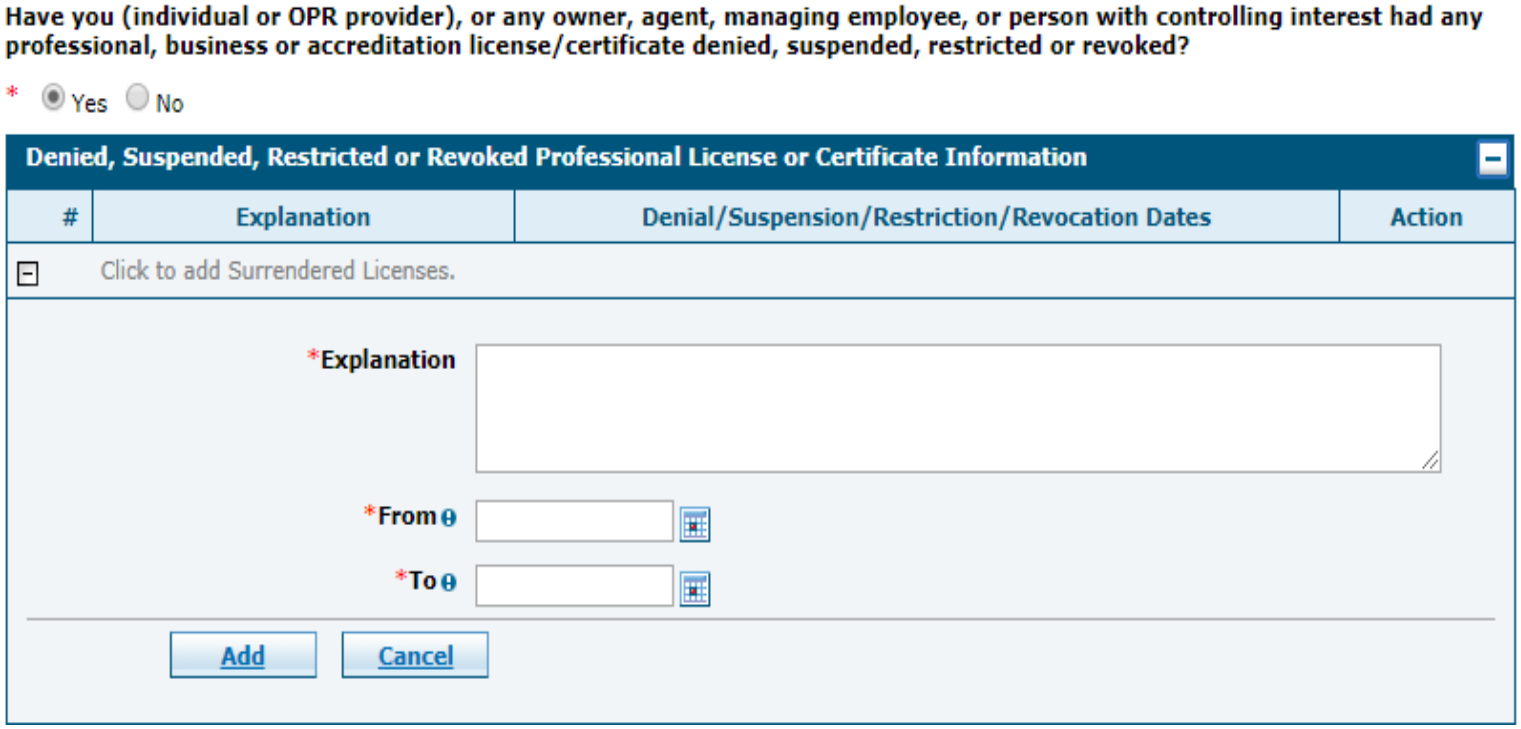
* ◉ Yes ○ No

***Explain**

If any owner, agent, managing employee or person with controlling interest has been denied malpractice insurance, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued



If any owner, agent, managing employee or person with controlling interest has had their license denied, suspended, restricted or revoked, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever voluntarily surrendered any professional license or certificate?

* ◉ Yes ○ No

Voluntary Surrender of Professional License or Certificate Information

#	Explanation	Voluntary Surrender Dates	Action
⊟	Click to add denied, suspended, restricted or revoked information.		

*Explanation

*From

*To

Add Cancel

If any owner, agent, managing employee or person with controlling interest has voluntarily surrendered their license, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Are you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest a Nevada state employee (past or current)?

* Yes No

Past or Current Nevada State Employee Information

#	Individual's Name	Agency of Employment	Title	Dates of Employment	Action

Click to add State Employment.

*Individual's Name

*Agency of Employment

*Title

*Employment Start

Employment End

If a current employee, please provide supervisor's name.

First Name

Last Name

Add Cancel

Continue Finish Later Cancel

If any owner, agent, managing employee or person with controlling interest has previously or currently works for the State of Nevada, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

After this question has been completed, select Continue.

Agreement

Instructions

The terms of the request are outlined below. You must accept these terms in order to submit the request. Failure to accept these terms means that the request will not be submitted or saved.

Changes can be made to the existing request by going back to the appropriate screen using the links available on the left-hand side. Once changes are made, the request can be reviewed from the Summary Page after signing and continuing.

Once the request is submitted and confirmed, a tracking number will be assigned.
Note: The Nevada Medicaid and Nevada Check Up Provider Contract is required with every request. A link to this document is provided below.

There are three (3) sections of the Provider Enrollment: Agreement page. The first section is the Instruction section, which will provide instructions regarding the additional sections of the Agreement page. Providers must read and understand before proceeding with the remainder of the application.

Agreement, continued

Terms of Agreement

Provider Name	First Last
Street	9850 DOUBLE R BLVD STE 102 RENO Nevada, 89521-2987
Employer Identification Number (EIN) or Social Security Number (SSN)	111111111
NPI	1234512345
Contact Name	First Last
Contact Email	email@domain.com

Please read and print for your records the Nevada Medicaid and Nevada Check Up Provider Contract. Please note that the Acceptance checkbox below will remain disabled until the provider contract document has been read.

Nevada Medicaid and Nevada Check Up Provider Contract Download

Get ADOBE® READER®

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge as the Provider or legal representative of the provider, that you understand your electronic signature is binding to the same extent as your written signature.

A

*I accept the terms and conditions of the application and contract. ☐ **I understand that my electronic signature is equivalent to written signature.**

***Provider or Authorized Representative Signature**

***Title**

Submission Date 06/10/2019

The second section of the Agreement page is the Terms of Agreement. The user must indicate that they accept the terms and condition (A) and complete the remaining fields.

In order to complete the section, the user **must** download the Nevada Medicaid and Nevada Check Up Provider Contract in order to be able to complete the question regarding the acceptance of the terms.

For this example, the question has been greyed out until the user downloads the contract. Once the contract has been downloaded, the question will then appear and can be answered.

Agreement, continued

Declaration

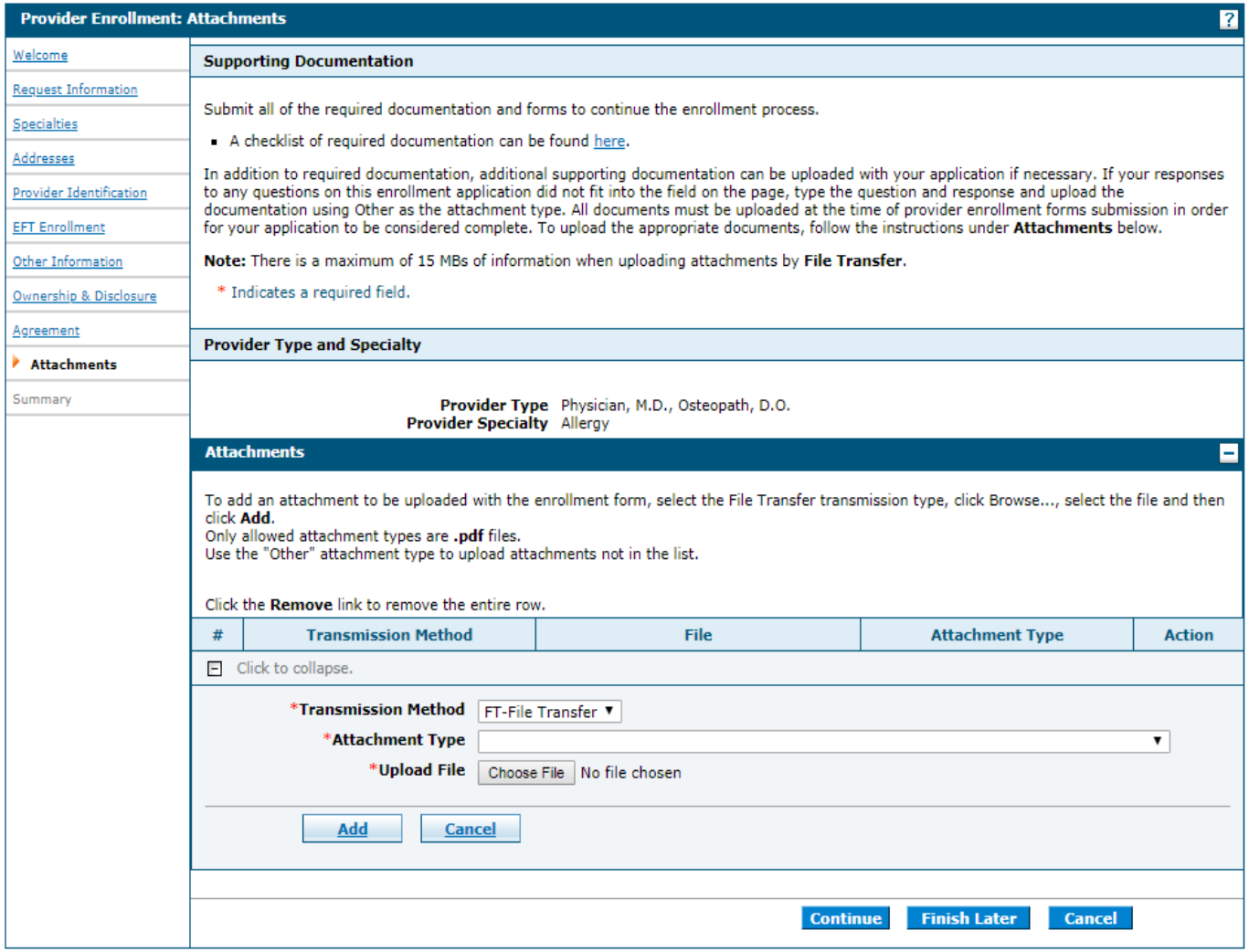
I declare under penalty of perjury under the laws of the State of Nevada that the information in this document and any attachments are true, accurate and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the provider(s) listed on this Application. I understand that Nevada Medicaid will rely on this information in entering into or continuing a Nevada Medicaid Provider Contract and that this form will be incorporated into and become a part of my Nevada Medicaid Provider Contract. I understand that I am required to notify Nevada Medicaid within five days of changes to information on this Application. I understand that I am responsible for the presentation of true, accurate and complete information on all invoices/claims submitted to Nevada Medicaid. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Continue | Finish Later | Cancel

The last section covers the Declaration, which indicates that the user has answered all questions to the best of their ability.

Once the Declaration is read and understood, select Continue.

Attachments



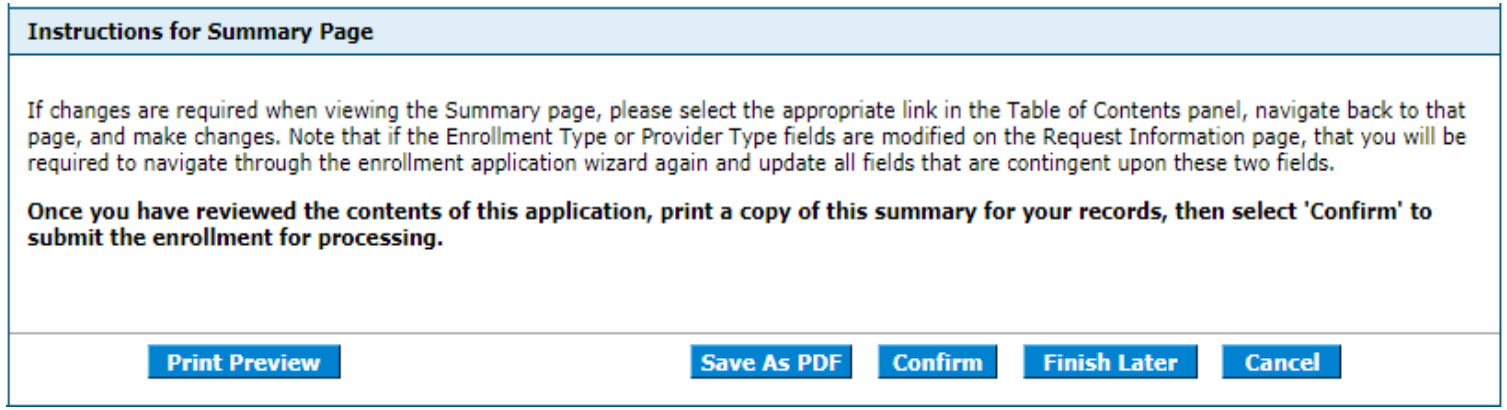
The next section is where users will need to upload all required documents. Users will need to review the Enrollment Checklist for the Provider Type to determine if all documents have been uploaded.

Transmission Method will always default to FT-File Transfer and this does not need to be changed. Select the Attachment Type from the drop-down menu. Select Choose File and locate the appropriate document for uploading. Once the document is placed in the application, select Add.

Users will also need to make sure that the proper EFT documentation is also uploaded.

Once all applicable documents are uploaded, select Continue.

Summary



The Summary Page will allow users to view the information input into the application before submitting to Nevada Medicaid for approval.

Once the user reviews and determines that there are no changes necessary, select Confirm in order to submit to Nevada Medicaid for processing. After submitting, users can view the status of the application by logging into the OPE tool. Users will also receive mailed communication from Nevada Medicaid indicating whether or not the application has been accepted.

After submission, users should allow **at least a minimum of 2-3 weeks for processing.** There are some cases in which the processing can take more time.

Resources

Resources

- Provider Enrollment Webpage: https://www.medicaid.nv.gov/providers/enroll.aspx
- Online Provider Enrollment Tool: https://www.medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx
- Ownership & Relationship Appendix (Chapter 2): https://www.medicaid.nv.gov/Downloads/provider/NV_OPE_User_Manual_Ch2_Addendum.pdf
- Web Announcement 1899: https://www.medicaid.nv.gov/Downloads/provider/web_announcement_1899_20190521.pdf
- Provider Billing Information: https://www.medicaid.nv.gov/providers/BillingInfo.aspx
- Medicaid Services Manual (Medicaid Policy): http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

Contact Nevada Medicaid

Contact Us – Customer Service

- Customer Service Call Center:
  877-638-3472 (Monday through Friday 8 a.m. to 5 p.m. Pacific Time)

- Provider Field Representative:
  Email: NevadaProviderTraining@dxc.com

Thank You