

Using the New Provider Re-Enrollment Applications

Presented by HP Enterprise Services

Agenda

- Re-enrollment requirement
- Provider re-enrollment process
- Location of re-enrollment applications
- How to complete new re-enrollment applications
- What to expect once submitted
- Contact information



Re-enrollment requirement

As directed by the Nevada Division of Health Care Financing and Policy (DHCFP), HP Enterprise Services (HPES) will perform provider re-enrollment for Nevada Medicaid and Nevada Check Up providers on a recurring basis to ensure that every provider is re-enrolled at least every 36 months.*

*See FAQs at www.medicaid.nv.gov on the Provider Enrollment webpage for further information.

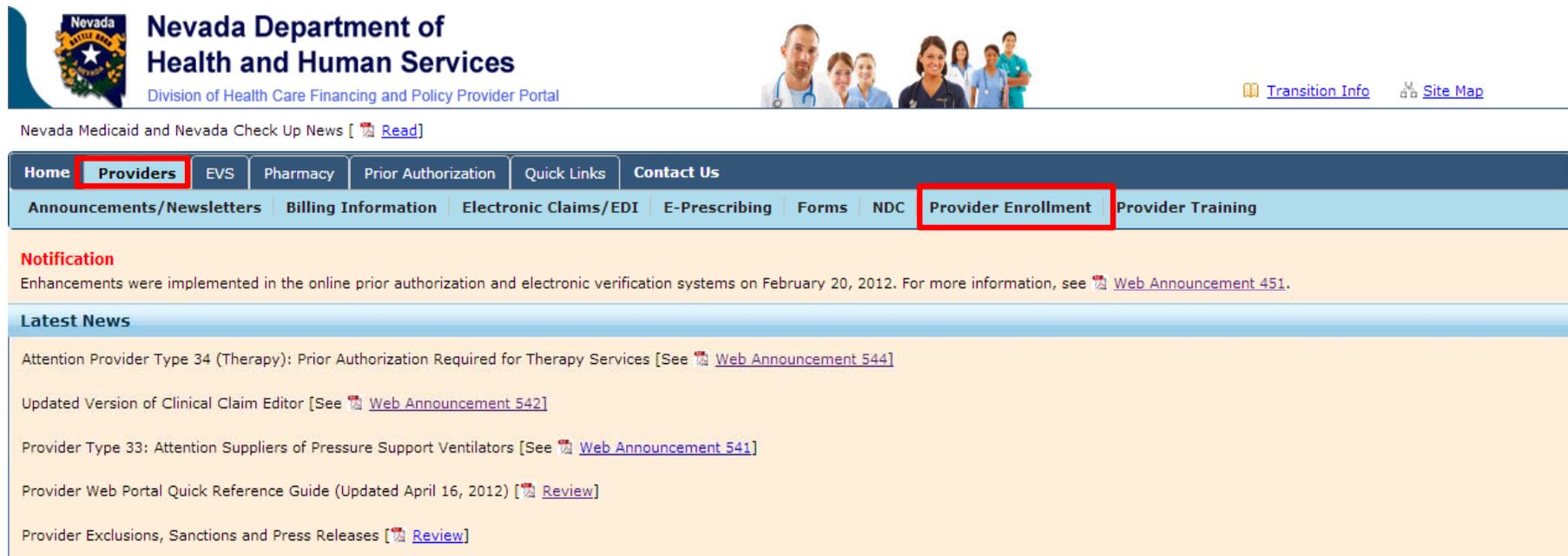


Provider re-enrollment process

- Providers identified from oldest enrollment to newest (most recent)
- 1/36 of providers will be contacted each month
- 60-day letter
- 20-day letter
- Validation and entry of re-enrollment information into Medicaid Management Information System (MMIS)



Location of re-enrollment applications



The screenshot shows the website for the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy Provider Portal. The navigation menu includes 'Home', 'Providers', 'EVS', 'Pharmacy', 'Prior Authorization', 'Quick Links', and 'Contact Us'. Below this, a secondary menu includes 'Announcements/Newsletters', 'Billing Information', 'Electronic Claims/EDI', 'E-Prescribing', 'Forms', 'NDC', 'Provider Enrollment', and 'Provider Training'. The 'Providers' and 'Provider Enrollment' links are highlighted with red boxes. The main content area features a 'Notification' section with text about system enhancements and a 'Latest News' section with several news items, each with a 'Review' link.

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

[Transition Info](#) [Site Map](#)

Nevada Medicaid and Nevada Check Up News [[Read](#)]

[Home](#) [Providers](#) [EVS](#) [Pharmacy](#) [Prior Authorization](#) [Quick Links](#) [Contact Us](#)

[Announcements/Newsletters](#) [Billing Information](#) [Electronic Claims/EDI](#) [E-Prescribing](#) [Forms](#) [NDC](#) [Provider Enrollment](#) [Provider Training](#)

Notification
Enhancements were implemented in the online prior authorization and electronic verification systems on February 20, 2012. For more information, see [Web Announcement 451](#).

Latest News

Attention Provider Type 34 (Therapy): Prior Authorization Required for Therapy Services [See [Web Announcement 544](#)]

Updated Version of Clinical Claim Editor [See [Web Announcement 542](#)]

Provider Type 33: Attention Suppliers of Pressure Support Ventilators [See [Web Announcement 541](#)]

Provider Web Portal Quick Reference Guide (Updated April 16, 2012) [[Review](#)]

Provider Exclusions, Sanctions and Press Releases [[Review](#)]

www.medicaid.nv.gov



Enrollment documents – www.medicaid.nv.gov

Mailing Address

Mail completed enrollment forms and required documentation to HP Enterprise Services, Provider Enrollment Unit, P.O. Box 30042, Reno, NV 89520-3042

Required Enrollment Documents

- [Provider Enrollment Instructions](#): You will need these instructions to complete Questions 1-4 in the Provider Enrollment Packet. The instructions include common enrollment questions and information about out-of-state providers and provider groups.
- [Provider Enrollment Packet](#): Complete and submit the forms in this packet to enroll as a Nevada Medicaid and Nevada Check Up provider. This Packet contains the Provider Enrollment Application (form FA-31) and the Division of Health Care Financing and Policy (DHCFP) Provider Contract.
- [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.

Recommended Enrollment Documents

- [Electronic Transaction Agreement for Service Centers \(FA-35\)](#): This form must be submitted if you wish to send electronic claims directly from your practice or if you are a Service Center (clearinghouse). [Click here](#) for further instructions.
- [Service Center Operational Information \(FA-36\)](#): This form must be submitted by all Service Centers (clearinghouses) and by all providers who wish to send electronic claims directly from their practice. [Click here](#) for further instructions.
- [Service Center Authorization Form for Providers \(FA-37\)](#): This form must be submitted by all providers who wish to send electronic claims. [Click here](#) for further instructions.
- [Payerpath Enrollment Form \(FA-39\)](#): This form must be submitted by all providers who wish to use Payerpath. Claim submission through Payerpath is free to all Nevada Medicaid providers. [Click here](#) for further instructions.

Re-Enrollment Documents

- [Provider Re-Enrollment Application \(Individuals\) \(FA-31A\)](#): This application must be submitted by active individual providers who have received a re-enrollment letter.
- [Provider Re-Enrollment Application \(Groups/Facilities\) \(FA-31B\)](#): This application must be submitted by active group/facility providers who have received a re-enrollment letter.





FA-31A

Provider Re-Enrollment Application (Individuals)

FA-31 A Provider Re-Enrollment Application (Individuals)

HP Enterprise Services

Provider Re-Enrollment Application (Individuals)

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

Section 1: General Information

1. Provider name: _____
2. Provider date of birth: _____
3. Social Security Number: _____
4. To become affiliated or remain with an existing Medicaid Provider Group, enter the Group's NPI and the date to begin the affiliation. Otherwise, leave this field blank. **This is required for provider types 14 and 82.**
Group NPI: _____ Affiliation begin date: _____
5. Enter the 2-digit number for the provider type you are enrolling: _____
See the Provider Enrollment Instructions for the list of provider types and corresponding 2-digit numbers.

Instructions:

1. Enter the name of the individual provider who is re-enrolling.
2. Enter the date of birth of the individual provider who is re-enrolling.
3. Enter the Social Security Number of the individual provider who is re-enrolling.
4. Enter the group NPI that the individual is affiliated with or wishes to become affiliated with and the start date of the affiliation.
5. Enter the 2-digit provider type that you are re-enrolling (must match current enrolled provider type).



FA-31A – Questions 6 through 8

6. Name your board certified specialties that pertain to the provider type you are enrolling. This is required for provider types 14, 17, 19, 20, 34, 38, 48, 57, 58 and 82. It is recommended for provider types 22, 54 and 76 when applicable. All other provider types may leave this question blank. **For provider types 14, 17 and 82 only, enter one specialty code per Application. A Provider Enrollment Packet must be submitted for each specialty being enrolled. See the Provider Enrollment Instructions for the list of specialty codes.**

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

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

License Number: _____

Name of Issuing Licensing Board, State or Entity: _____

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

6. Enter your primary specialty name and 3-digit code from the listing located in the Provider Enrollment Instructions and board name, if applicable. Example:
Primary Specialty: Pediatrics Specialty Code: 139 Board Name: American Board of Pediatrics
7. Enter your license number and name of issuing licensing board, if applicable. If your enrollment checklist requires that you provide a license, then this is where you enter the information from the license you are attaching.
8. Enter the NPI of the individual provider you are re-enrolling.



FA-31A – Questions 9 through 14

Section 2: Tax and Business Information

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

- Individual provider Hospital-based physician Sole proprietorship
 Corporation Limited Liability Company Non-profit



Nevada Medicaid uses information in questions 10 and 12 to generate the annual 1099 form for tax reporting purposes. Individual providers may provide a Social Security Number if a Federal Tax ID Number is not available.

10. Legal Name as registered with the Internal Revenue Service (IRS): _____

11. Doing Business As: _____

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

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

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

14. Are you currently accepting new patients? Yes No

9. Check the box that most closely describes the entity you are re-enrolling.
10. Enter the legal name of the tax ID or Social Security Number that this individual is re-enrolling with.
11. Enter the doing business as name, if applicable.
12. Enter the federal tax ID number or Social Security Number of the individual provider you are re-enrolling.
13. Check the box that best describes the program(s) for which you provide services.
14. Check the box that indicates if you are accepting new patients.



FA-31A – Questions 15 through 17

15. Can you accommodate recipients with special needs? Yes No

16. **Service Address:** Enter the physical location of the practice/business/facility where services will be rendered. This must be a street address and NOT a post office box.

Address (Line 1): _____

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

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

Fax: _____ TDD phone: _____

Contact name: _____ Contact phone: _____

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

Address (Line 1): _____

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

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

Fax: _____ TDD phone: _____

Contact Name: _____ Contact phone: _____

- 15. Check the box that indicates if you can accommodate recipients with special needs.
- 16. Enter the servicing address of the individual provider you are re-enrolling (physical location at which services are rendered, include updated contact information).
- 17. Enter the mail-to address of the individual provider you are re-enrolling (address where you would like to receive written correspondence, include updated contact information).



FA-31A – Questions 18 through 19

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

Address (Line 1): _____

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

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

Fax: _____ TDD phone: _____

Contact name: _____ Contact phone: _____

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

Address (Line1): _____

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

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

Fax: _____ TDD phone: _____

Contact name: _____ Contact phone: _____

- 18. Enter the pay-to address of the individual provider you are re-enrolling (paper checks will be sent to this address during the EFT testing period; include updated contact information).
- 19. Enter the remittance advice address (address where your paper remittance advice will be mailed to, include updated contact information).



FA-31A – Question 20

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

Check box if applicable: I will be receiving payment through the Group NPI listed in Question 4 that is already enrolled in EFT. *(Skip the rest of this question and continue with Question 21.)*

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

Business or personal bank account number: _____

Authorized signature: _____ Date: _____

FA-31A: Provider Re-Enrollment Application (Individuals) Page 2 of 4
12/28/2012

20. Every provider is required to sign up for Electronic Funds Transfer (EFT). If you are not already set up for EFT or are not affiliated with a group who is already enrolled in EFT, then this section must be completed. Enter the business or personal bank account number, an original (ink) authorized signature and date. Attach an original voided check or letter from the bank to the following page of the application.



FA-31A – Questions 21 through 22

Section 3: Background, Ownership and Disclosure of Disclosing Entity

21. Provide the name, Social Security Number (SSN) and date of birth of all managing employees.

Name 1: _____
SSN: _____ Date of birth: _____

Name 2: _____
SSN: _____ Date of birth: _____

21a. Who is authorized to make changes to enrollment and billing information? _____
|_____

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

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

- 21. Enter the name, Social Security Number (SSN) and date of birth of all managing employees.
21a. Enter the name of the person who is authorized to make changes to enrollment and billing information.
- 22. Check the appropriate box. If yes, provide additional information as requested.

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed by the individual provider.



FA-31A – Questions 23 through 25a

23. Do you or any owner, administrator or managing employee currently have a negative balance with any state or federal program (including Medicare and Medicaid)? Yes No

If yes, complete the following for all applicable entities/providers/employees.

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

To whom is the money owed? _____

24. Have you or any owner, administrator or managing employee ever been convicted of a misdemeanor, gross misdemeanor or felony? Yes No If yes, provide: all documentation of final disposition for each conviction (i.e., court documentation and parole/probation conditions).

Name used when convicted: _____ Date of conviction: _____

Charges: _____ Disposition: _____

Conditions of parole/probation: _____

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

25a. Do you or any owner, administrator or managing employee have any open or pending court cases?
 Yes No **If you answered yes to Questions 25 and/or 25a, please attach details, i.e., court documentation and parole/probation conditions.**

Questions 23 through 25a:

Check the appropriate box. If yes, provide additional information as requested.

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed by the individual provider.



FA-31A – Questions 26 through 27

26. Have you or any owner, administrator or managing employee ever been placed on the Federal Office of Inspector General, Health and Human Service (OIG/HHS) exclusion list or otherwise been suspended, terminated, debarred or denied from participation in Medicare, Medicaid, Title XVIII, Title XIX or any Medicaid programs since the inception of these programs? This includes termination from the Nevada Medicaid program or any other state Medicaid program. Yes No If yes, provide the following information related to the sanction as well as specific details.

Name used when sanctioned: _____

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

Sanction effective date: _____ Reinstatement date: _____

27. Have you ever been denied malpractice insurance? Yes No

If yes, explain: _____

Questions 26 through 27:

Check the appropriate box. If yes, provide additional information as requested

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed by the individual provider.



FA-31A – Questions 28 through 29

28. Have you had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked? Yes No

If yes, complete the following for each instance.

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

Explanation: _____

29. Are you a Nevada state employee (*past or current*)?

Yes No If yes, complete the following:

Individual's Name: _____ Agency of employment: _____

Title: _____ Dates of employment: _____

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

Questions 28 through 29:
Check the appropriate box. If yes, provide additional information as requested

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed by the individual provider.



FA-31A – Question 30

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

Yes No If yes, complete the following:

Name: _____

Social Security Number: _____ Tax ID: _____

Address: _____

Percentage of ownership: _____ Date of birth: _____

Is the individual related to any subcontractor or other owner with controlling interest? Yes No

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

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

Business name: _____

Business address: _____

Question 30:

Check the appropriate box. If yes, provide additional information as requested

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed by the individual provider.



FA-31A – Declaration

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 HP Enterprise Services. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Use dark blue or black ink only. This Application and corresponding contract must be dated within the last 60 days.

The provider enrolling must sign below.

Signature: _____ Date: _____

Print Name: _____



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

Declaration:

By signing the Declaration page of the Re-enrollment Application, you declare that the document and any attachments are true, accurate and complete to the best of your knowledge and belief. The signature must be an original (ink) signature of the individual provider who is re-enrolling. It must be dated within the last 60 days. The printed name of the individual provider who is re-enrolling must be legible.



DHCFP Provider Contract – Page 5

Provider Signature: _____	Date: _____
<i>Please Print or Type the following:</i>	
Provider Name: _____	
Provider National Provider Identified (NPI): _____	
Provider Atypical Provider Identifies (API) (if applicable and for use only when resubmitting this contract or re-enrolling): _____	
Provider Type: _____	
Federal Tax ID Number of Social Security Number: _____	
Legal Business Name: _____	
Physical/Street Address of the Practice/Business Facility (<i>cannot be a P. O. Box</i>): _____	

Provider Signature: Signature of individual provider who is re-enrolling.

Date: Must be dated within the last 60 days.

Provider NPI or API: Enter the individual NPI or API of the provider who is re-enrolling.

Provider Type: Enter the 2-digit provider type that you are re-enrolling (must match question 5 on page 1 of your provider re-enrollment application).

Federal Tax ID or SSN: Enter the FEIN or SSN provided on question 12 on page 1 of your provider re-enrollment application.

Legal Business Name: Enter the legal business name provided on question 10 on page 1 of your provider re-enrollment application.

Physical/Street Address: Enter the physical/street address provided on question 16 on page 2 of your provider re-enrollment application.



Background and Ownership Questions

The following definitions will assist in replying to Section 3 of the Individual and Group/Facility applications:

§ 42 CFR455

- ...an agent of a principal is any person, other than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.
- ...a managing employee is an individual (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof.





FA-31 B

Provider Re-Enrollment Application (Groups/Facilities)

FA-31 B Provider Re-Enrollment Application (Groups/Facilities)

HP Enterprise Services

Provider Re-Enrollment Application (Groups/Facilities)

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

Section 1: General Information

1. Provider name: _____
2. Enter the 2-digit number for the provider type you are enrolling: _____
See the Provider Enrollment Instructions for the list of provider types and corresponding 2-digit numbers.
3. Name your board certified specialties that pertain to the provider type you are enrolling. This is required for provider types 14, 17, 19, 20, 34, 38, 48, 57, 58 and 82. It is recommended for provider types 22, 54 and 76 when applicable. All other provider types may leave this question blank. **For provider types 14, 17 and 82 only, enter one specialty code per Application. A Provider Enrollment Packet must be submitted for each specialty being enrolled. See the Provider Enrollment Instructions for the list of Specialty Codes.**
Primary Specialty: _____ Specialty Code: _____ Board Name: _____

1. Enter the name of the group/facility provider that is re-enrolling.
2. Enter the 2-digit provider type that you are re-enrolling (must match current enrolled provider type.)
3. Enter your primary specialty name and 3-digit code from the listing located in the Provider Enrollment Instructions and Board Name, if applicable.
Example: Primary Specialty: Pediatrics Specialty Code: 139 Board Name: American Board of Pediatrics



FA-31 B – Questions 4 through 5

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

License Number: _____

Name of Issuing Licensing Board, State or Entity: _____

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

4. Enter your license number and name of issuing licensing board, if applicable. If your enrollment checklist requires that you provide a license, then this is where you enter the information from the license you are attaching.
5. Enter the NPI of the group/facility provider you are re-enrolling.



FA-31B – Questions 6 through 12

Section 2: Tax and Business Information

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

<input type="checkbox"/> Hospital-based physician	<input type="checkbox"/> Provider group	<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Corporation
<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited liability partner	<input type="checkbox"/> Non-profit	
<input type="checkbox"/> Indian health program (IHP)	<input type="checkbox"/> Limited liability company	<input type="checkbox"/> Managed care organization	

 Nevada Medicaid uses information in questions 7 and 9 to generate the annual 1099 form for tax reporting purposes.

7. Legal Name as registered with the Internal Revenue Service (IRS): _____

8. Doing Business As: _____

9. Tax Identifier (Federal Tax ID Number): _____

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

<input type="checkbox"/> Fee For Service Only	<input type="checkbox"/> Managed Care Only	<input type="checkbox"/> Both Fee For Service and Managed Care
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11. Are you currently accepting new patients? Yes No

12. Can you accommodate recipients with special needs? Yes No

6. Check the box that most closely describes the entity you are re-enrolling.
7. Enter the legal name of the tax ID or Social Security Number that this group/facility is re-enrolling with.
8. Enter the doing business as name, if applicable.
9. Enter the federal tax ID number or Social Security Number of the group/facility provider you are re-enrolling.
10. Check the box that best describes the program(s) for which you provide services.
11. Check the box that indicates if you are accepting new patients.
12. Check the box that indicates if you can accommodate recipients with special needs.



FA-31B – Questions 13 through 14

13. Service Address: Enter the physical location of the practice/business/facility where services will be rendered. This must be a street address and NOT a post office box.

Address (Line 1): _____

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

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

Fax: _____ TDD phone: _____

Contact name: _____ Contact phone: _____

14. Mail-To Address: HP Enterprise Services will mail written correspondence, excluding remittance advices, to this address. If you do not supply a mail-to address, written correspondence will be mailed to the service address.

Address (Line 1): _____

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

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

Fax: _____ TDD phone: _____

Contact Name: _____ Contact phone: _____

- 13. Enter the servicing address of the group/facility provider you are re-enrolling (physical location at which services are rendered, include updated contact information).
- 14. Enter the mail-to address of the group/facility provider you are re-enrolling (address where you would like to receive written correspondence, include updated contact information).



FA-31B – Questions 15 through 16

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

Address (Line 1): _____

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

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

Fax: _____ TDD phone: _____

Contact name: _____ Contact phone: _____

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

Address (Line1): _____

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

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

Fax: _____ TDD phone: _____

Contact name: _____ Contact phone: _____

15. Enter the pay-to address of the group/facility provider you are re-enrolling (paper checks will be sent to this address during the EFT testing period, include updated contact information).
16. Enter the remittance advice address (address where your paper remittance advice will be mailed to, include updated contact information).



FA-31B – Question 17

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

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

Business or personal bank account number: _____

Authorized signature: _____ Date: _____



**TAPE AN ORIGINAL, VOIDED CHECK HERE
OR ATTACH A LETTER FROM YOUR BANK THAT CONTAINS YOUR BANK'S
ROUTING NUMBER.
PHOTOCOPIED CHECKS AND BANK DEPOSIT SLIPS ARE NOT ACCEPTED.**

17. Every provider is required to sign up for Electronic Funds Transfer (EFT). If you are not already set up for EFT, then this section must be completed. Enter the business or personal bank account number, an original (ink) authorized signature and date. Attach an original voided check or letter from the bank.



FA-31B – Question 18

Section 3: Background, Ownership and Disclosure of Disclosing Entity

Questions apply to billing groups and to businesses/practices/facilities.

18. Provide the following information for **each person** with an ownership or controlling interest in the disclosing entity (*this includes relatives*) and for *any subcontracting company* in which the disclosing entity has direct or indirect ownership of five percent or more. This information is required per §42 CFR455.

Name 1: _____

Social Security Number: _____ Tax ID: _____

Address: _____

Percentage of ownership: _____ Date of birth: _____

Is the individual related to any subcontractor or other owner with controlling interest? Yes No

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

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

Business name 1: _____

Business address: _____

Federal Tax ID Number: _____

18. Enter the information for the person or entity that owns or has any controlling interest for the group/facility. Please note, all questions must be answered. Ownership percentage should add up to 100% if multiple owners are disclosed.

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed.



FA-31B – Questions 19 through 20

19. Provide the name, Social Security Number (SSN) and date of birth of all managing employees.

Name 1: _____
SSN: _____ Date of birth: _____

Name 2: _____
SSN: _____ Date of birth: _____

19a. Who is authorized to make changes to enrollment and billing information? _____

20. Have any **current agents, managing employees, employees or owners** with five percent or more controlling interest ever been placed on the Federal Office of Inspector General, Health and Human Service (OIG/HHS) exclusion list or otherwise been suspended, terminated, debarred or denied from participation in Medicare, Medicaid, Title XVIII, or Title XIX or any Medicaid programs since the inception of these programs? This includes termination from the Nevada Medicaid program or any other state Medicaid program.

Yes No

If yes, provide the name, Social Security Number (SSN), date of exclusion and the state, as well as specific details.

Name 1: _____ SSN: _____
Date: _____ State: _____

19. Enter the name, Social Security Number (SSN) and date of birth of all managing employees
19a. Enter the name of the person who is authorized to make changes to enrollment and billing information.
20. Check the appropriate box. If yes, provide additional information as requested

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed.



FA-31B – Questions 21 through 23

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

Name:	_____	Address:	_____
Name:	_____	Address:	_____
Name:	_____	Address:	_____

22. Is your group, any owner, administrator or managing employee enrolled, or have ever been enrolled, as a Medicaid provider with another state? Yes No

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

23. Does your group, any owner, administrator or managing employee currently have a negative balance with any state or federal program (including Medicare and Medicaid)? Yes No

If yes, complete the following for all applicable entities/providers/employees.

Provider/Entity/Employee name:	_____	Amount Owed:	_____
To whom is the money owed?	_____		

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

Questions 22 through 23:

Check the appropriate box. If yes, provide additional information as requested.

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed.



FA-31B – Questions 24 through 27

24. Has your group, any owner, administrator or managing employee ever been convicted of a misdemeanor, gross misdemeanor or felony? Yes No If yes, provide: all documentation on final disposition for each conviction (i.e., court documentation and parole/probation conditions).

Name used when convicted: _____ Date of conviction: _____

Charges: _____ Disposition: _____

Conditions of parole/probation: _____

25. Is your group, any owner, administrator or managing employee currently under investigation by any law enforcement, regulatory or state agency? Yes No

25a. Does your group, any owner, administrator or managing employee have any open or pending court cases? Yes No

If you answered yes to Questions 25 and/or 25a, please attach details.

26. Has your group or facility ever been denied malpractice insurance? Yes No

If yes, explain: _____

27. Has your group or facility had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked? Yes No

If yes, complete the following for each instance.

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

Explanation: _____

Questions 24 through 27:

Check the appropriate box. If yes, provide additional information as requested

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed.



FA-31B – Questions 28 through 29

28. Attach a list of the individual names and NPIs of all providers to be affiliated with this group. All providers listed must be enrolled with Nevada Medicaid.

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

Yes No If yes, complete the following:

Name: _____

Social Security Number: _____ Tax ID: _____

Address: _____

Percentage of ownership: _____ Date of birth: _____

Is the individual related to any subcontractor or other owner with controlling interest? Yes No

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

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

Business name: _____

Business address: _____

28. For GROUPS ONLY: Attach a list of individual names and NPIs of **all** providers to be affiliated with this group.

29. Check the appropriate box. If yes, provide additional information as requested.

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed.



FA-31B – Questions 30 through 31

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

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

Name: _____ Address: _____

31. Will you bill Medicare crossover claims only? Yes No

For Provider type 33 ONLY – Durable Medical Equipment

30. List the names and addresses off all manufacturers and suppliers with whom you have a business relationship relative to the provision of services, goods, supplies or merchandise. Attach additional sheets as necessary.

31. Check the appropriate box. If yes, provide additional information as requested.

NOTE: Attach additional sheets if necessary to answer each question completely. Each additional sheet must display the relevant question number from the Application and must be signed.



FA-31 B – Declaration

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 HP Enterprise Services. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Use dark blue or black ink only. This Application and corresponding contract must be dated within the last 60 days.

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

Signature: _____ Date: _____

Print Name: _____



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

Declaration:

By signing the Declaration page of the Re-enrollment Application, you declare that the document and any attachments are true, accurate and complete to the best of your knowledge and belief. The signature must be an original (ink) signature of an authorized administrator or business owner of the group/facility that is re-enrolling. It must be dated within the last 60 days. The printed name of the person signing must be legible.



DHCFP Provider Contract – Page 5

Provider Signature: _____	Date: _____
<i>Please Print or Type the following:</i>	
Provider Name: _____	
Provider National Provider Identified (NPI): _____	
Provider Atypical Provider Identifies (API) (if applicable and for use only when resubmitting this contract or re-enrolling): _____	
Provider Type: _____	
Federal Tax ID Number of Social Security Number: _____	
Legal Business Name: _____	
Physical/Street Address of the Practice/Business Facility (<i>cannot be a P. O. Box</i>): _____	

Provider Signature: Signature of an authorized administrator or business owner.

Date: Must be dated within the last 60 days.

Provider NPI or API: Enter the group/facility NPI or API that is re-enrolling.

Provider Type: Enter the 2-digit provider type that you are re-enrolling (must match question 2 on page 1 of your provider re-enrollment application).

Federal Tax ID or SSN: Enter the FEIN or SSN provided on question 9 on page 1 of your provider re-enrollment application.

Legal Business Name: Enter the legal business name provided on question 7 on page 1 of your provider re-enrollment application.

Physical/Street Address: Enter the physical/street address provided on question 13 on pages 1 and 2 of your provider re-enrollment application.



Submission process

- Mail completed re-enrollment application to:
Provider Enrollment Unit
PO Box 30042
Reno, NV 89520-3042
- Once received by HPES, the re-enrollment application will be logged internally and reviewed.
- If approved, you will receive a letter stating that you have been re-enrolled with a copy of your provider contract.
- If documentation is missing or errors are found, your re-enrollment packet may be returned to you with a letter indicating necessary corrections.



Contact Us

Contact information

Provider Enrollment Unit

- Phone: (877) 638-3472
Options 2, then 0, then 5
- Mail your re-enrollment application to:
Provider Enrollment
PO Box 30042
Reno, NV 89520-3042



