NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Medicaid and Long-Term Care

Service Provider Agreement

Medicaid & Long-Term Care Use Only	
Medicaid ID #	
N-Focus ID #	
Connect ID #	

READ INSTRUCTIONS BEFORE COMPLETING - SIGNATURE REQUIRED ON PAGE 6

Failure to complete required provider enrollment documents completely and accurately or submitting false information may be grounds for denial, termination, or civil or criminal prosecution.

Return the Service Provider Agreement application (MC-19) along with all applicable addendum(s) and attachments to: Maximus Nebraska Medicaid Provider Enrollment, PO Box 81890, Lincoln, NE 68501. The Service Provider Agreement, application fee (if applicable), and any required addendums and attachments **must be accurate, completed in their entirety and submitted together in order to begin the enrollment process**.

Section A: General Information

ENROLLMENT INFORMATION

1. Check Type of Enrollment Request:
   - ☐ a. **Initial Enrollment** - New Provider Number
   - ☐ b. **Re-Enrollment** - Previous Provider Number____________________
   - ☐ c. **Reactivation** - Previous Provider Number_____________________
   - ☐ d. **Revalidation** - Current Provider Number______________________
   - ☐ e. New FTIN for Existing Provider - Current Provider Number____________________
   - ☐ f. Add Member to Existing Provider Group - Current Provider Number____________________

2a. Type of Practice:
☐ Individual/Solo ☐ Group Member ☐ Group/Institution ☐ Facility ☐ Pharmacy
Pharmacy Types: ☐ Independent ☐ Professional ☐ Large Chain ☐ Small Chain
☐ Unit Dose, Large Chain ☐ Unit Dose, Independent ☐ Other___________________________________

2b. If Group, Institution, Facility, Pharmacy:
☐ Check here to request a waiver of the application fee payment

3. Requested Effective Date(s):

4. Provider Name and Physical Address:

Legal Name

Doing Business as Name (if applicable)

Physical Street Address (PO Box not accepted)

City, State, Zip + 4

Provider Phone Number	Provider Fax Number
Contact Name	Contact Title
Contact Phone Number	Contact Fax Number

E-Mail Address for Provider Contact

5. Pay to Name and Mailing Address: (if different from 4)

Name

Address

City, State, Zip + 4

PROVIDER INFORMATION

5a. Primary Organizational NPI #	5b. Primary Taxonomy Number	5c. Secondary Taxonomy Number

6. Federal Taxpayer Identification Name (Attach W9)	Federal Taxpayer Identification Number

Indicate Type (check one):
- ☐ EIN
- ☐ SSN

7. Provider Profit Status:
- ☐ 01 - 501(C)(3) Non-profit
- ☐ 02 - For Profit, Closely Held
- ☐ 03 - For Profit, Publicly Traded
- ☐ 04 - Other
- ☐ 88 - N/A - The individual only practices as part of a group
- ☐ Unknown

8. Medicare Enrollment:
☐ Yes ☐ No If Yes: ☐ Medicare Enrollment in Process ☐ Medicare Enrollment Completed

Medicare Enrollment Date	Medicare Number	NPI

9. Other State Medicaid Enrollment:
☐ Yes ☐ No If Yes: ☐ Other State Medicaid Enrollment in Process: State(s):____________________
☐ Other State Medicaid Enrollment(s) Completed: State(s):____________________

State:______________________________ Date Enrolled:______________________________ NPI:________________
State:______________________________ Date Enrolled:______________________________ NPI:________________
State:______________________________ Date Enrolled:______________________________ NPI:________________

10a. Provider Type Code	10b. Type of Provider	11a. Primary Specialty Code	11b. Primary Specialty

12. License/Certification No. (attach copy)	13. NCPDP # (pharmacy and dispensing physicians only)

14. 340 B Participant ☐ Yes ☐ No	15. CLIA # (Laboratory services only)
16a. If Hospital, Must Indicate Fiscal Year End	Number of Beds Acute Inpatient___________________________________ Rehab Inpatient___________________________________

16b. If Nursing Facility or ICF/MR Must Indicate Type of Ownership:
☐ State ☐ County ☐ City
Profit:
☐ Corporation ☐ Partnership ☐ Proprietorship ☐ LLC ☐ LLP

17. Is the provider an entity identified on the System for Award Management (SAM) website as debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits?
☐ Yes ☐ No
IF "YES" ATTACH AN EXPLANATION

18. Is the provider, any facility, employee or contractor providing services under this Agreement identified on the OIG list of Excluded Individuals/Entities website as excluded from receiving payment by a Federal health care program?
☐ Yes ☐ No
IF "YES" ATTACH AN EXPLANATION

19. Has there ever been disciplinary action against this provider license by a licensing board in any state?
☐ Yes ☐ No
IF "YES" ATTACH AN EXPLANATION

20. Has the provider ever been sanctioned or terminated by Medicare, Nebraska Medicaid, or any state health program as defined in 42 U.S.C. § 1320a-7?
☐ Yes ☐ No
IF "YES" ATTACH AN EXPLANATION

21. In compliance with Title 8 U.S.C. § 1324a, has employment eligibility been verified for all employees of this provider OR for individual providers, do you attest that you are in the United Stated legally and eligible to work per Pub.L. no. 104-193 (1997)?
☐ Yes ☐ No

22. Individual Providers

In compliance with neb. Rev. Stat 4-108 through 4-1-114, I attest as follows:
☐ I am a United States Citizen
☐ I am a qualified alien under the federal Immigration and nationality Act. My immigration status and alien number are as follows:______________________________ .

I agree to provide a copy of my USCIS documentation upon request. I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Section B: Individual Professionals Part of Provider Group

Complete for each individual professional that is part of the group provider and subject to the group service provider agreement. ATTACH ADDITIONAL PAGES AS NECESSARY.

INDIVIDUAL #1

1a. First Name	1b. MI	1c. Last Name	1d. Gender ☐ Male ☐ Female

1e. Email

2. Provider Type	3. Provider Specialty	4. Requested Effective Date of Enrollment

5. National Provider Identifier (NPI) ATTACH COPY OF NPPES CONFIRMATION	6a. Social Security Number (SSN)	6b. Date of Birth

7. Primary Professional License or Certification Name and Number ATTACH COPY OF YOUR LICENSE/ CERTIFICATION DOCUMENTS

8. Has there ever been disciplinary action against this provider's license by a licensing board in any state?
   ☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

9. Has the provider ever been sanctioned by Medicare, Nebraska Medicaid, or any state health program?
   ☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

10. Is this individual identified on the SAM website as debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving Federal Contracts, certain subcontracts, and certain Federal assistance and benefits?
    ☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

11. Is this individual identified on the OIG List of Excluded Individuals / Entities as excluded from receiving payment by a Federal health care program?
    ☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

12. In compliance with Title 8 U.S.C. § 1324a, has employment eligibility been verified for this individual?
    ☐ Yes ☐ No

INDIVIDUAL #2

1a. First Name	1b. MI	1c. Last Name	1d. Gender ☐ Male ☐ Female

1e. Email

2. Provider Type	3. Provider Specialty	4. Requested Effective Date of Enrollment

5. National Provider Identifier (NPI) ATTACH COPY OF NPPES CONFIRMATION	6a. Social Security Number (SSN)	6b. Date of Birth

7. Primary Professional License or Certification Name and Number ATTACH COPY OF YOUR LICENSE/ CERTIFICATION DOCUMENTS

8. Has there ever been disciplinary action against this provider's license by a licensing board in any state?
   ☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

9. Has the provider ever been sanctioned by Medicare or any state health program?
   ☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

10. Is this individual identified on the SAM website as debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving Federal Contracts, certain subcontracts, and certain Federal assistance and benefits?
    ☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

11. Is this individual identified on the OIG List of Excluded Individuals / Entities as excluded from receiving payment by a Federal health care program?
    ☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

12. In compliance with Title 8 U.S.C. § 1324a, has employment eligibility been verified for this individual?
    ☐ Yes ☐ No

Section C: Terms of Agreement

This Agreement between the Nebraska Department of Health and Human Services, Division of Medicaid & Long-Term Care (hereinafter the Department) and the approved service provider governs the provision of the service(s) indicated in this Agreement as defined in the Nebraska Department of Health and Human Services Program Manual, Nebraska Administrative Code (NAC) Titles 15, 185, 403, 404, 465, 471, 477, 480 and 482. Appropriate checklist(s) marked 'Provider Addendum (name of service)' and other appropriate additions to the agreement marked "Attachment (A, B, or C)" for services is/are attached and by this reference are made part of this agreement. **Once all screening and enrollment activities have been completed, and the provider has been approved, a written confirmation letter will be sent notifying the provider of their Service Provider Agreement effective date and Provider ID number.**

As a provider for Nebraska Medicaid & Long-Term Care programs specified in this agreement, the provider assures:

- Full compliance with the regulations and applicable policies and procedures of the Nebraska Department of Health and Human Services in the administration of program services. www.dhhs.ne.gov/Medicaid/ and www.dhhs.ne.gov/reg_medregs.aspx ;
- Full compliance with all applicable State and Federal statutory and regulatory law;
- Full compliance with requirement found in 42 CFR 455.105 (b) that upon request the provider will furnish to the State or US DHHS Secretary information about certain business transactions with wholly owned suppliers or any subcontractors;
- For entities receiving or making Medicaid payments totaling at least $5 million dollars annually, to implement written policies and procedures for the education of all employees, contractors, and agents that includes information pertaining to the False Claims Act and other provisions named in section 1902(a)(68)(A) of the Social Security Act, and to cooperate with the State's audit process;
- Full compliance with requirement found at 42 CFR 455.432 that the provider agrees to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations;
- Full compliance with requirement found at 42 CFR 455.434 that the provider consents to criminal background checks including fingerprinting when required to do so under State law or by level of screening based on risk of fraud, waste, or abuse as determined for that category of provider;
- That the payment determined in accordance with the policies of the Nebraska Department of Health and Human Services will be the full and complete payment for the services provided, and the amount paid for those claims submitted by Provider or Provider's authorized representative will be accepted as payment in full and that no additional payment will be claimed. If any additional payment is received, or will be received, from any other source that amount will be deducted from the amount charged the Department. Any payment received from another source after payment by the Department shall be remitted to the Department;
- That all goods and services for which payment will be claimed will be provided in compliance with the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (45 CFR, Parts 80, 84, and 90);
- That service records will be retained as are necessary to fully disclose the extent of the services provided to support and document all claims, for a minimum period of six years as required under HIPAA Section 164.530(j);
- Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20-74.24; and 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site. A client's/patient's signed Nebraska DHHS Application for Assistance includes a proper patient waiver (42 CFR 431.107);
- Operation of a drug-free workplace;
- Understanding that provider enrollment does not constitute employment by the State of Nebraska or guarantee referrals;
- This agreement will not be transferred to any other person or entity;
- That all information will be disclosed to Nebraska Department of Health and Human Services as required by policies of the Department;
- Understanding that any false claims (including claims submitted electronically), statements, documents, or concealment of material fact may be prosecuted under applicable State or Federal laws (42 CFR 455.18);

This entire form and any required addendums, enrollment forms, and/or attachments must be completed and submitted together. **Incomplete &/or unsigned Service Provider Agreements will be returned.**

My signature certifies I have read, understand, and will comply with the Terms of Agreement detailed above and the information on this form is true, accurate and complete.

Printed Name and Title of Provider/Authorized Official Completing this Form

Signature of Provider/Authorized Official (Stamped Signature NOT Accepted) Date

NOTE: It is the provider's responsibility to retain a copy of the completed agreement.

MEDICAID & LONG-TERM CARE USE ONLY	
☐ Approved ☐ Denied	Effective Dates through
By	
Title	
Program	
Comments	