

471-000-90 Form MC-19, "Medical Assistance Provider Agreement" and Completion Instructions



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 * SIGNATURE REQUIRED ON PAGE 5

Return the provider enrollment application along with all applicable addendum(s) and attachments to the appropriate program contact information listed on the addendum(s).

Section A: General Information

ENROLLMENT INFORMATION

- Check Type of Enrollment Request:

<input type="checkbox"/> a. New Provider Number	<input type="checkbox"/> b. New FTIN Number	<input type="checkbox"/> c. Provider Renewal
<input type="checkbox"/> d. Add Member to Provider Group	<input type="checkbox"/> e. Update Expired Provider Number	
<input type="checkbox"/> f. Current provider number (if b, c, d, or e is checked) _____		
- Limited Enrollment:

<input type="checkbox"/> Specific Client Name _____	Date of Birth _____
<input type="checkbox"/> Medicare crossover claims only (Medicaid only)	
- Requested Effective Date(s): _____

PROVIDER INFORMATION

- Federal Taxpayer Identification Name and Number
Indicate Type (check one):
 EIN SSN

Issued to: _____	Number: _____
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- Provider Name and Physical Address:

Legal Name _____	
Doing Business as Name (if applicable) _____	
Contact Name & Title (if business) _____	
Physical Street Address (PO Box not accepted) _____	
City, State, Zip + 4 _____	
Phone Number _____	Fax Number _____
E-Mail Address for Provider Contact _____	
- Pay to Name and Mailing Address: (if different from 5)

Name _____
Address _____
City, State, Zip + 4 _____

7a. Provider Type Code	7b. Type of Provider	8a. Primary Specialty Code	8b. Primary Specialty

9. NCPDP #	10. License/Certification No. (attach copy)	11. Medicare/CCN Number (attach copy)
12a. Primary Organizational NPI #	12b. Primary Taxonomy Number	12c. Secondary Taxonomy Number

13. CLIA # (Laboratory services only)

14. Type of Practice
 Individual/Sole Proprietor Facility Group Pharmacy

15. Is the provider an entity identified on the EPLS 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

16. 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

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

18. 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

19. 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 States legally and eligible to work per Pub.L. no. 104-193 (1997)?
 Yes No

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

1. Licensee Full Name and Title

2. Provider Type	3. Provider Speciality	4. Requested Effective Date of Enrollment
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5. National Provider Identifier (NPI) ATTACH COPY OF NPES CONFIRMATION	6. Social Security Number (SSN)
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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 EPLS 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

1. Licensee Full Name and Title

2. Provider Type	3. Provider Speciality	4. Requested Effective Date of Enrollment
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5. National Provider Identifier (NPI) ATTACH COPY OF NPES CONFIRMATION	6. Social Security Number (SSN)
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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 EPLS 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, 205, 404, 465, 467, 471, 472, 473, 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. A complete Agreement is effective upon acceptance by the Department, which will be signified by the billing system noting in its electronic files that the Agreement has been accepted and the provider is permitted to submit claims.

As a provider for the 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/regsg.htm ;
- Full compliance with all applicable Federal statutory and regulatory law;
- Full compliance with requirement found in 42 CFR 455.105 (b)(2) 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 me or my 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 HIPPA 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); and

This form and any required addendums, enrollment forms, and/or attachments must be completed and submitted together.

My signature certifies I have read and understand the Terms of Agreement as referenced 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



Division of Medicaid and Long-Term Care

Nebraska Service Provider Agreement Instructions

Use of this document

Form MC-19, "Nebraska Service Provider Agreement," is –

1. The required enrollment agreement between providers and Medicaid, Aged and Disabled Waiver, Traumatic Brain Injury Waiver, Developmental Disabilities Waiver, Social Services for the Aged and Disabled, Medically Handicapped Children's Program, and Disabled Persons and Family Support programs;
2. The computer input document to establish each provider's computer files for payment; and
3. Required to be signed, approved, and on file with Department before payment for covered services can be made.
4. Required for each physical location where services are being provided.

Completion: The provider or the provider's authorized representative shall complete, sign, and date Form MC-19 and any applicable addenda indicated in the provider type table.

DISTRIBUTION: Fax or mail the Nebraska Service Provider Agreement, required addenda, and any required attachments to the contact facsimile or mailing address provided on the addendum.

* For Medicaid provider types that do not require an addendum, providers need to mail the Form MC-19 and required attachments to Nebraska Department of Health and Human Services, Medicaid Provider Enrollment, P.O. Box 95026, Lincoln, NE 68509-5026.

Required attachments for all providers:

W-9 MLTC-62 Copy of Professional License (if applicable)

Section A: General Information

1. Check type of enrollment request:

- a. Check "New Provider Number" if you do NOT currently have a Nebraska Medicaid provider number at this location
- b. Check "New FTIN Number" (federal tax identification number) if you have a provider number and require a new provider number because your FTIN has changed
- c. Check "Provider Renewal" if your agreement has an effective end date
- d. Check "Add Member To Group" if you are adding a group member
- e. Check "Updated Expired Provider Number" if your provider eligibility has expired
- f. Current Provider Number: Enter current Nebraska provider number, if b, c, d, or e is checked

2. Limited Enrollment: Check box if this enrollment is limited to Medicare crossover claims or a specific Medicaid client, list name of client and date of birth (DOB).

3. Requested Effective Date: Date you are requesting to begin services.

4. Federal Taxpayer Identification Name and Number: Enter the nine-digit employer identification number of your business (EIN) and the name to whom it was issued. For individuals, this is your social security number (SSN) and the full name to whom it was issued. This is the number under which income will be reported to the Internal Revenue Service for Federal 1099 purposes. A W-9 must be provided with this form.

5. Provider Name and Address: Enter the full name of the provider. When enrolling as an individual/solo practice, enter the individual provider's name AND title. When enrolling as a group practice, enter the group name. Enter the physical location address, city, state, zip code+4, your telephone and fax number, and an e-mail address to contact you. Note: A post office box without a physical location address will not be accepted. Each location must enroll separately.

6. Pay to Name and Address (if different from 5): Complete only if payment will be made to a name and/or address other than the provider identified in Field 5. A post office box is acceptable in this field. The name in this field must match the FTIN name in field 4.

7a. Provider Type Code: Enter the appropriate PROVIDER TYPE CODE from the list on the next page.

Choose only ONE.

7b. Provider Type: Enter the appropriate PROVIDER TYPE that corresponds with the Provider Type Code entered in 7a.

Type Code (field 7a)	Program	Type of Provider (field 7b)	Addendum Required	Required Attachments
30	Medicaid	Adult Day Care - Bath Services, Registered Nurse		MS-84
9	Medicaid	Ambulatory Surgical Center (ASC)		Copy of License; MS-84
15	Medicaid	Anesthesiologist		Copy of License; MS-84
41	Medicaid	Assertive Community Treatment (ACT MRO Program)		MS-84
68	Medicaid	Audiologist		Copy of License; MS-84
83	Medicaid	Autism Waiver - Applied Behavioral Analysis Technician		MS-84
	Medicaid	Autism Waiver - EIBI Autism Waiver		FA-84
83	Medicaid	Autism Waiver - Lead Therapist		MS-84
83	Medicaid	Autism Waiver - Supervising Behavioral Therapist		MS-84
5	Medicaid	Chiropractor		Copy of License; MS-84
12	Medicaid	Clinic - Hospital Based, Licensed Mental Centers		MS-84;
13	Medicaid	Clinic - Professional (PC)		MS-84
44	Medicaid	Community Support (CSW) MRO Program	MC-208	MS-84;
45	Medicaid	Day Rehabilitation (DAYR) MRO Program	MC-208	MS-84;
77	Medicaid	Day Treatment Provider (DAY)	MC-205, MC-208	MS-84;
40	Medicaid	Dentist (DDS)		Copy of License; MS-84
21	Medicaid	Dispensing Physician (MD)		Copy of License; MS-84
61	Medicaid	Emergency Transportation		MS-84
17	Medicaid	Federally Qualified Health Center (FQHC)		MS-84; CMS Documentation of Status; Out of State rate letter
60	Medicaid	Hearing Instrument Specialist (HEAR)		MS-84
14	Medicaid	Home Health Agency (HHAG)		MS-84
59	Medicaid	Hospice (HSPC)		MS-84
10	Medicaid	Hospital	MC-212, MC-201	Copy of License; CLIA certification; CMS-1539
25	Medicaid	Indian Health Hospital Clinic (IHSH)	MC-212, MC-201	SSA-1539; MS-84
16	Medicaid	Laboratory (Independent)		CMS-1539
42	Medicaid	Licensed Dental Hygienist (LDH)		Copy of License; MS-84
78	Medicaid	Licensed Drug & Alcohol Counselor (LDAC)	MC-204, MC-205	Copy of License; MS-84
39	Medicaid	Licensed Independent Mental Health Practitioner (LIMHP)	MC-204, MC-205	Copy of License; MS-84;
63	Medicaid	Licensed Medical Nutrition Therapist (LMNT)		Copy of License; MS-84; list of specific services providing
36	Medicaid	Licensed Mental Health Practitioner (LMHP)	MC-204, MC-205	Copy of License; MS-84;
31	Medicaid	Licensed Practical Nurse (LPN)		Copy of License; MS-84
67	Medicaid	Licensed Psychologist (PHD)	MC-204, MC-205	Copy of License; MS-84;
69	Medicaid	Medicaid in Public Schools (MIPS) Occupational Therapist		Copy of License; MS-84
32	Medicaid	Medicaid in Public Schools (MIPS) Physical Therapist		Copy of License; MS-84
68	Medicaid	Medicaid in Public Schools (MIPS) Speech Pathologist		Copy of License; MS-84

Type Code (field 7a)	Program	Type of Provider (field 7b)	Addendum Required	Required Attachments
35	Medicaid	Direct Care Staff		MS-84;
34	Medicaid	Community Treatment Aide (CTA)	MC-203, MC-205, MC-208	MS-84;
37	Medicaid	Mental Health Professional/Masters Level Equivalent (MHP)		Copy of License; MS-84;
61	Medicaid	Non-Emergency Transportation (NET)	MC-211	MS-84
28	Medicaid	Nurse Midwife (NW)		Copy of License; MS-84
29	Medicaid	APRN-Nurse Practitioner	MC-207	Copy of License; Copy of National Specialty Certification; MS-84
11	Medicaid	Nursing Facility	MC-200	Copy of License; MS-84
11	Medicaid	Nursing Facility - Hospice in Nursing Facility		Copy of License; MS-84
69	Medicaid	Occupational Therapist		Copy of License; MS-84
66	Medicaid	Optical Supplier (OPTC)		MS-84
6	Medicaid	Optometrist		Copy of License; MS-84
65	Medicaid	Orthopedic Device Supplier (ORTH)		MS-84
50	Medicaid	Pharmacy - Home Therapy, Independent, Professional, Small or Large Chain, Nursing Facility, or Other	MC-202	Copy of License; MS-84
49	Medicaid	Pharmacist-Tobacco Cessation Counselor	MC-202	Copy of License; MS-84
22	Medicaid	Physician Assistant (PA)		Copy of License; MS-84
2	Medicaid	Physician, DO		Copy of License; MS-84
1	Medicaid	Physician, MD		Copy of License; MS-84
7	Medicaid	Podiatrist (DPM)		Copy of License; MS-84
58	Medicaid	Provisionally Licensed Drug & Alcohol Counselors (PDAC)		Copy of License; MS-84;
57	Medicaid	Provisionally Licensed PHD - PPHD	MC-204, MC-205	Copy of License; MS-84;
30	Medicaid	Registered Nurse (RN)		Copy of License; MS-84
32	Medicaid	Registered Physical Therapist (RPT)		Copy of License; MS-84
62	Medicaid	Rental & Retail Supplier		MS-84
46	Medicaid	Residential Rehabilitation (REST)	MC-208	MS-84;
87	Medicaid	Psychiatric Residential Treatment Facility (PRTF)	MC-205, MC-208	MS-84;
20	Medicaid	Rural Health Clinic - Independent		MS-84
23	Medicaid	Rural Health Clinic - Provider Based (Over 50 Beds)		MS-84; CMS Documentation of Status; Out of State rate letter
19	Medicaid	Rural Health Clinic-Provider Based (Less than 50 beds)		MS-84; CMS Documentation of Status; Out of State rate letter
64	Medicaid	Specially Licensed PHD/Psychology Resident (SPHD)	MC-204, MC-205	Copy of License; MS-84;
68	Medicaid	Speech Pathologist		Copy of License; MS-84
47	Medicaid	Substance Abuse Treatment Center (SATC)	MC-204, MC-205, MC-208	MS-84;
79	Medicaid	Treatment Crisis Intervention (TCI)	MC-204, MC-205, MC-208	MS-84;
86	Medicaid	Professional Resource Family Care	MC-204, MC-205, MC-208	MS-84;
81	Medicaid	Therapeutic Group Home (TRGH)	MC-204, MC-205, MC-208	MS-84;
26	Medicaid	Tribal 638 Clinic (T638)		MS-84

Type Code (field 7a)	Program	Type of Provider (field 7b)	Addendum Required	Required Attachments
	Medicaid	Personal Assistance Services	MC-190, MC-195, MC-199	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - AD Waiver	Adult Day Health	MC-190, MC-196, MC-199	FA-84
	Medicaid - AD Waiver	Child Care for Children with Disabilities	MC-190, MC-192AD, MC-199	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - AD Waiver	Home Care/Chore	MC-190, MC-195, MC-199	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - AD Waiver	Home Delivered Meals	MC-190, MC-197, MC-199	FA-84
	Medicaid - AD Waiver	Independence Skills Management	MC-190, MC-199	FA-84 - Agencies; FA-100 - Individuals
61	Medicaid - AD Waiver	Non-Emergency Transportation (NET)	MC-190, MC-199, MC-211	MS-84
	Medicaid - AD Waiver	Nutrition Services	MC-190, MC-199	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - AD Waiver	Personal Emergency Response System	MC-190, MC-193AD, MC-199	FA-84
	Medicaid - AD Waiver	Respite Care	MC-190, MC-198, MC-199	FA-84 - Agencies; FA-100 - Individuals
11	Medicaid - AD/TBI Waiver	Assisted Living	MC-190, MC-191AD, MC-199	MS-84
	Medicaid - DD Waiver	Assisted Technology	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - DD Waiver	Community Living & Day Support	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - DD Waiver	Home Modification	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - DD Waiver	Homemaker	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - DD Waiver	Personal Emergency Response System	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - DD Waiver	Respite	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - DD Waiver	Specialized Residential Services	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - DD Waiver	Specialized Day Services	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
	Medicaid - DD Waiver	Vehicle Modifications	DD-213, DD-214	FA-84 - Agencies; FA-100 - Individuals
13	MHCP	Medically Handicapped Children's Program (MHCP) Provider	MC-210	MS-84
61	SSAD	Non-Emergency Transportation (NET)	MC-190, MC-199, MC-211	FA-84 - Agencies; FA-100 - Individuals
	SSAD	SSAD - Adult Day Care	MC-190, MC-196, MC-199	FA-84 - Agencies; FA-100 - Individuals
	SSAD	SSAD - Chore	MC-190, MC-195, MC-199	FA-84 - Agencies; FA-100 - Individuals

Type Code (field 7a)	Program	Type of Provider (field 7b)	Addendum Required	Required Attachments
	SSAD	SSAD - Congregate Meals	MC-190, MC-197, MC-199	FA-84 - Agencies; FA-100 - Individuals
	SSAD	SSAD - Home Delivered Meals	MC-190, MC-197, MC-199	FA-84 - Agencies; FA-100 - Individuals
	SSAD	SSAD - Homemaker	MC-190, MC-195, MC-199	FA-84 - Agencies; FA-100 - Individuals
	SSAD	SSAD - Respite Care	MC-190, MC-198, MC-199	FA-84 - Agencies; FA-100 - Individuals

8a. Primary Specialty Code: Enter the appropriate PRIMARY SPECIALTY CODE from the list below.

8b. Primary Specialty: Enter the appropriate PRIMARY SPECIALTY that corresponds with the Primary Specialty Code entered in 8a.

Primary Specialty Code (8a)	Primary Specialty Description	Primary Specialty Code (8a)	Primary Specialty Description
01	General Practice	48	Podiatrist - Surgical Chiropracist
02	General Surgery	49	Miscellaneous-MIPS, Ambulatory Surgical Center, Etc
03	Allergy	50	Reserved
04	Otology, Laryngology, Rhinology (ENT)	51	Medical Supply Company with Certified Orthotist (CO) Certification
05	Anesthesiology	52	Medical Supply Company with Certified Prosthetist (CP) Certification
06	Cardiovascular Disease	53	Medical Supply Company with Certified Orthotist-Prosthetist (CPO) Certification
07	Dermatology	54	Medical Supply Company not included in 51, 52, or 53
08	Family Practice	55	Individual Certified Orthotist (CO)
09	Reserved	56	Individual Certified Prosthetist (CP)
10	Gastroenterology	57	Individual Certified Orthotist-Prosthetist (CPO)
11	Internal Medicine (Includes Geriatrics & Nephrology)	58	Individual not included in 55, 56, or 57
12	Internal Medicine (Restricted to group with multi specialties)	59	Ambulance
13	Neurology	60	Public Health or Welfare Agencies (Federal, State & Local)
14	Neurological Surgery	61	Voluntary Health or Charitable Agencies
15	Reserved	62	Licensed Psychologist (Clinical)
16	OB/GYN	63	Portable X-ray supplier (Billing Independently)
17	Ophthalmology, Otology, Laryngology, Rhinology (EENT)	64	Audiologists (Billing Independently)
18	Ophthalmology	65	Physical Therapist (Billing Independently)
19	Oral Surgery (Dentist only)	66	Hospitals
20	Orthopedic Surgery	67	Urgent Cared Health Plan (OPHP)
21	Reserved	68	Dialysis
22	Pathology - Lab	69	Independent Laboratory (Billing Independently)
23	Peripheral Vascular Disease or Surgery	70	Clinic
24	Plastic Surgery	71	Diagnostic X-ray Clinic
25	Physical Medicine & Rehabilitation	72	Diagnostic Laboratory Clinic
26	Psychiatry/Mental Health/Substance Abuse	73	Physiotherapy
28	Proctology	74	Occupational Therapy
29	Pulmonary Disease	75	Assisted Living Services

Primary Specialty Code (8a)	Primary Specialty Description	Primary Specialty Code (8a)	Primary Specialty Description
30	Radiology - X-ray	76	Other Physician Specialist for HEALTH CHECK Follow-up
32	Radiation Therapy	77	Other Provider (non-MD) for HEALTH CHECK Follow-up
33	Thoracic Surgery	78	Screening Physician & Other Physician Specialist for HEALTH CHECK Follow-up
34	Urology	79	Adult Day Care
35	Chiropractor	80	Rehab Providers (MRO) (DPI)
36	Nuclear Medicine (MD only)	81	Rehab Acute Hospital
37	Pediatrics	82	Hospice
38	Endocrinology, Diabetes	87	All Other-Including SSAD, AD Waiver, MHCP
39	Gerontology	88	Unknown - Suppliers
40	Hand Surgery	89	Chemical Dependency
41	Oncology/Hematology	90	Nurse Midwife
42	Epidemiology/Infectious Disease	91	Nurse Practitioner
43	Certified Registered Nurse Anesthetist (CRNA)	94	PSC Exempt (Public Transportation)
44	Nephrology	95	Commercial NET (Licensed by the Public Service Commission)
45	Neonatology	96	Individual NET (Friend, neighbor or family member who is not legally responsible for the client or in the business of transportation for hire).
46	Rheumatology	99	Unknown - Practitioners
47	Physiological Labs (Independent)		

9. NCPDP #: (For pharmacy and dispensing physicians only). Enter the National Council for Prescription Drug Program (NCPDP) number issued to the provider identified in Field 5.

10. License/Certification Number: Enter the license or certification number, if applicable. Providers are required to attach a copy of their licensure or certification.

11. Medicare Number/(CMS Certification Number [CCN]): Enter the Medicare/CCN Provider number, if applicable. Attach a copy of the Medicare/CCN Certification.

12a. Primary Organizational NPI #: Enter the National Provider Identification (NPI) number issued to the provider identified in Field 5. If enrolling as a group practice, enter group NPI number. **“For providers NOT eligible for NPI (atypical),** leave this section blank.” Certain “atypical” or non-healthcare providers do not qualify for a National Provider Identifier (NPI) and taxonomy. Nebraska Medicaid defines “atypical” providers as: MHCP (Medically Handicapped Children’s Program) clinics, MIPS (Medicaid in Public Schools), Personal Care Aides, Mental Health Personal Care Aides/Community Treatment Aides, Mental Health Home Health Care Aides and Non-Emergency Transportation providers. Not applicable for SSAD, MHCP and DPFS.

12b. Primary Taxonomy Number: Enter the Primary Taxonomy Number for the provider identified in Field 5, if applicable.

12c. Secondary Taxonomy Number: Enter the Secondary Taxonomy Number for the provider identified in Field 5, if applicable.

Healthcare Provider Taxonomy Codes are a Health Insurance Portability and Accountability (HIPAA) standard code set used to report the type/classification/specialization of a health care provider. Information regarding the NPI, how to apply, who qualifies, taxonomies, and other pertinent information may be obtained from the Centers for Medicare and Medicaid Services (CMS) at <http://www.cms.gov/NationalProvdentStand/>.

13. CLIA # (Laboratory services only): If laboratory services are provided, enter the CLIA number assigned to the provider identified in Field 5.

14. Type of Practice: Check the appropriate type of practice.

- Check "Individual/Sole Proprietor" to enroll as an individual or solo practice requesting payment to that individual or entity.
- Check "Group" to enroll as a group practice requesting payment to a group provider number for all members of the group.
- Check "Facility" to enroll as a Hospital, Nursing Facility, or Assisted Living Facility.
- Check "Pharmacy" to enroll as a licensed Pharmacy.

15. It is the provider's responsibility to monthly screen all employees, and subcontractors for exclusion status through the General Services Administration (GSA) website located at <https://www.epls.gov/>. The Excluded Parties List System (EPLS) includes information regarding entities 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 pursuant to the provisions of 31 U.S.C. 6101, note, E.O. 12549, E.O. 12689, 48 CFR 9.404. The EPLS contains actions taken by various Federal agencies. Check "Yes" and provide an explanation if the provider is identified on the EPLS website.

16. It is the provider's responsibility to screen facilities, providers, employees and contractors for OIG exclusion status on the List of Excluded Individuals/Entities database through the HHS-OIG website located at www.oig.hhs.gov/fraud/exclusions.asp. No payment will be made by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan). This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person. For exclusions implemented prior to August 4, 1997, the exclusion covers the following Federal health care programs: Medicare (Title XVIII), Medicaid (Title XIX), Maternal and Child Health Services Block Grant (Title V), Block Grants to States for Social Services (Title XX) and State Children's Health Insurance (Title XXI) programs. Check "Yes" and provide an explanation if the provider is identified on the OIG website.

17. Check "yes" if there has ever been disciplinary action against this provider license by a licensing board in any state, and an explanation must be provided.

18. Check "yes" if the provider has ever been sanctioned or terminated by Medicare or any state health program as defined in 42 U.S.C. 1320a-7, and an explanation must be provided.

19. Check "Yes" if the provider has verified employment eligibility of all employees.

Section B: Individual Professionals, Part of a Provider Group

Complete information for each member of a provider group.

- 1. Licensee Full Name and Title:** Enter the full name of group member that matches licensure or certification (e.g. MD, PHD, APRN, DDS, etc.).
- 2. Provider Type:** Enter the appropriate PROVIDER TYPE CODE and PROVIDER TYPE from the list provided on pages 2-4). Choose only ONE.
- 3. Provider Specialty:** Enter the appropriate PRIMARY SPECIALTY CODE and PRIMARY SPECIALTY from the list provided on page 5. Choose only ONE.
- 4. Requested Date of Enrollment:**
- 5. NPI #:** Enter each group member's NPI number, required.
- 6. Social Security Number:** Enter each group member's social security number, required to identify the service rendering provider.
- 7. Primary Professional License or Certification Number:** Enter each group member's license number. Providers are required to attach a copy of their licensure or certification.
- 8.** Check "yes" if there has ever been disciplinary action against this provider by a licensing board in any state, and an explanation must be provided.

9. Check "yes" if the provider has ever been sanctioned or terminated by Medicare or any state health program as defined in 42 U.S.C. 1320a-7, and an explanation must be provided.
10. Check "Yes" if the member is identified on the General Services Administration Excluded Parties List System (EPLS).
11. Check "yes" if the member is identified on the Health and Human Services, Office of Inspector General List of Excluded Individuals/Entities (LEIE) database.
12. : Check "Yes" if the employment eligibility of this individual has been verified.

Terms of Agreement

It is the provider's responsibility to read and understand the terms of agreement within Section C.

1. Printed Name and Title of Provider/Authorized Official Completing this Form: The provider or authorized representative/agent must type or print their name and title legibly on the Provider Agreement.
2. Signature of Provider/Authorized Official: The provider or authorized representative/agent must sign and date the Provider Agreement, certifying provider has read and understands the terms of this agreement, and information provided on the agreement by the provider is true, accurate and complete. A stamped signature will not be accepted.

NOTE: It is the provider's responsibility to notify the Nebraska Department of Health and Human Services contact if information provided on this form changes,

It is the provider's responsibility to retain a copy of the completed Agreement.