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

Division of Public Health

Provider Participation Enrollment Form

READ INSTRUCTIONS BEFORE COMPLETING. SIGNATURE REQUIRED.

By completing and signing this Participation Enrollment Form, the Provider agrees to provide services as needed to Nebraska Department of Health and Human Services (hereinafter "DHHS") approved clients in accordance with the terms and conditions of the Every Woman Matters and Nebraska Colon Cancer Screening Programs (hereinafter EWM/NCCP).

Section A: Type of Provider Participation Enrollment Form

1. **Check Type of Provider Enrollment:**
   - ☐ New EWM/NCCP Provider or Facility
   - ☐ Existing EWM/NCCP Provider or Facility
   - ☐ Add Individuals to Provider Group

2. **Check Type of Provider:**
   - ☐ Primary Care Setting
   - ☐ Hospital Setting
   - ☐ OB/GYN Specialty
   - ☐ Surgery Center
   - ☐ Surgeon (Specialty):_____
   - ☐ Anesthesiology
   - ☐ Radiology/Mammography ***FDA Certification required- Please include a copy.***
   - ☐ Laboratory/Pathology ***CLIA#:_____***
   - ☐ Other:_____

3. **Effective Dates:** The Signed **Provider Participation Enrollment Form** shall be effective **July 1, 2022** and shall continue in effect until **June 30, 2027** or in the event of termination or suspension.
4. **Is provider a Medicaid Provider? Yes_____ N0_____**

Section B: Provider Information

5. **Federal Taxpayer Identification Name and Number (FTIN):**

   Issued to:_____ Number:_____

6. **Provider Name and Physical Address:**

   *Legal Name:*_____

   Doing Business as Name: (if applicable)_____

   *Contract Contact Name and Title:*_____

   Physical Street Address (P.O. Box not accepted):_____

   City, State, Zip +4:_____

   Phone Number:_____ *Fax Number*:_____

   E-Mail for Provider Contact:_____

Section C: Billing Information

A completed Form W-9 is required to be returned with this signed Provider Participation Enrollment Form. See attached form for completion.

7. **Third Party Billing Service?** ☐ Yes ☐ No

8. **Type of Billing Fee:** ☐ Global Fee ☐ Professional Fee ☐ Technical Fee

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

   Name: _____

   Address: _____

   City, State, Zip +4: _____

   E-mail: _____ Fax: _____

10. **Contact for Billing Related Inquiries:**

    Name: _____ Phone Number: _____

    Address: _____

    City, State, Zip +4: _____

    E-mail: _____ Fax: _____

Section D: Provider Scope of Services:

11. **Primary Contact for Office Manager:**

    Name: _____ Phone Number: _____

    Address: _____

    City, State, Zip +4: _____

    E-mail: _____ Fax: _____

12. **Related Program Services *Performed* At This Facility** (please check all that apply)**:**

    ☐ Clinical Breast Exams ☐ Breast Biopsy ☐ Breast Fine Needle Aspiration ☐ Breast Ultrasound ☐ Mammography

    ☐ Pelvic/Pap Tests ☐ Colposcopy ☐ Laboratory ☐ Colonoscopy ☐ Radiology

13. ***Will Accept Referrals* For the Following Program Services** (please check all that apply)**:**

    ☐ Clinical Breast Exams ☐ Breast Biopsy ☐ Breast Fine Needle Aspiration ☐ Breast Ultrasound ☐ Mammography

    ☐ Pelvic/Pap Tests ☐ Colposcopy ☐ Laboratory ☐ Colonoscopy ☐ Radiology

14. **Translation Services Available** (please check all that apply)**?** ☐ Yes ☐ No ☐ N/A

    ☐ Spanish ☐ Vietnamese ☐ Other(s): _____

    ☐ On-Site Translation ☐ Language Line Services

15. **Accepting New EWM/NCCP Clients?** ☐ Yes ☐ No ☐ N/A

    * All EWM/NCCP Participating Providers Will Appear on Web-Based Listing Available to Clients Seeking Care.

Section E: Affiliated/Satellite Locations Operating Under This Contract and FTIN:

This section is for Providers who offer Program services at multiple sites under this Provider Participation Enrollment Form and corresponding FTIN.
Sites listed will receive a separate request for additional information. Additional sites will not be added to the system until we have obtained the information requested.

Please complete for each site and attach additional pages or directory as necessary.

1. **Site Name:**_____ **NPI#**_____

   Address:_____

   City, State, Zip +4:_____

   Primary Contact for Clinical Related Services or Concerns:

   Name:_____ Phone Number:_____

   E-mail:_____ Fax:_____

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2. **Site Name:**_____ **NPI#**_____

   Address:_____

   City, State, Zip +4:_____

   Primary Contact for Clinical Related Services or Concerns:

   Name:_____ Phone Number:_____

   E-mail:_____ Fax:_____

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3. **Site Name:**_____ **NPI#**_____

   Address:_____

   City, State, Zip +4:_____

   Primary Contact for Clinical Related Services or Concerns:

   Name:_____ Phone Number:_____

   E-mail:_____ Fax:_____

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4. **Site Name:**_____ **NPI#**_____

   Address:_____

   City, State, Zip +4:_____

   Primary Contact for Clinical Related Services or Concerns:

   Name:_____ Phone Number:_____

   E-mail:_____ Fax:_____

Section F: Individual Professionals Part of 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.

1. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

2. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

3. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

4. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

5. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

6. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

7. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

8. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

9. Name:_____ Primary Specialty: _____

   Credentials:_____ License/Certification Number:_____

10. Name:_____ Primary Specialty: _____

    Credentials:_____ License/Certification Number:_____

Provider Participation Enrollment Form for DHHS Women's and Men's Health Programs

This **Provider Participation Enrollment Form** between the Nebraska Department of Health and Human Services, Division of Public Health (hereinafter the Department) and the approved service provider governs the provision of the service(s) indicated in this **Provider Participation Enrollment Form.**

As a provider for the Every Woman Matters or Nebraska Colon Cancer programs 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 and in submitting claims for payment as described in the Every Woman Matters and Nebraska Colon Cancer Program Provider Manual at https://dhhs.ne.gov/Documents/EWM-NCP-Provider-Manual.pdf; The manual and its amendments are incorporated by this reference as though fully set out herein. The Department reserves the right to amend the provider manual as needed. Authorized services and resulting charges are subject to review and approval by the Department. Payments for services shall be in accordance with program billing guidelines in effect at the time services are provided.

- Full compliance with all applicable State and Federal statutory and regulatory law;

- 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. Payment shall not be required or requested from clients for authorized services covered by this **Provider Participation Enrollment Form.** The Provider shall have the right to bill clients for services not covered under this **Provider Participation Enrollment Form.** The Department shall not pay the co-pay portion of any public or private compensation programs in which the client is enrolled, unless so specified in the provider manual;

- 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);

- That federal, state, or local offices responsible for program administration or audit will be allowed to review service records, in accordance with 45 CFR 74.20-74.24. Inspections, reviews, and audits may be conducted on site as it relates to services provided to clients enrolled for clinical services under the Women's and Men's Health Programs (Every Woman Matters and Nebraska Colon Cancer Program);

- Operation of a drug free workplace;

- Understanding that provider participation does not constitute employment by the State of Nebraska or guarantee referrals;

- This **Provider Participation Enrollment Form** 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;

- That this **Provider Participation Enrollment Form** may be terminated at any time upon mutual written consent or by either party for any reason upon submission of written notice to the other party at least Thirty (30) days prior to the effective date of termination. The Department may also terminate this **Provider Participation Enrollment Form**, in whole or in part, in the event funding is no longer available. The Provider shall be entitled to receive just and equitable compensation for any authorized services which have been satisfactorily provided as of the termination date. If the Provider is in violation of this **Provider Participation Enrollment Form** or any other law, rule or regulation of the Department, the State of Nebraska, or Federal Government, this **Provider Participation Enrollment Form** may be terminated immediately upon mailing of a written notice from the Department. In the event of termination, the Provider shall be paid only for services provided as of the termination date.

- That the Provider has and will maintain the necessary qualifications and licensure, certification, or registration required by state and federal law to provide services under the **Provider Participation Enrollment Form**.

My signature certifies I have read and understand the Terms of the Provider Participation Enrollment Form as referenced above and the information on the form is true, accurate and complete.

Authorized Signature for Provider:

_____

Printed Name and Title of Provider/ Authorized Official

_____ _____

Signature Name and Title of Provider/ Authorized Official **Date**

*** NOTE: It is the provider's responsibility to retain a copy of the complete Provider Participation Enrollment Form.**

Authorized Signature For DHHS/EWM/NCCP:

_____ _____

Sara Morgan, Interim Deputy Director **Date**
Prevention and Promotion
Department of Health and Human Services

PROGRAM USE ONLY

○ Approved ○ Denied

○ Med It Database Entry Complete_____(Initials) ○ Date:_____