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

Pete Ricketts, Governor

Nebraska Medicaid NMEP Removal/Reactivation Questionnaire

This questionnaire must be submitted in order to be considered for removal from the Nebraska Medicaid Excluded Providers list and reactivation as a Nebraska Medicaid-enrolled provider. Responses and information supplied with this form will aid the Department in determining whether or not reactivation is appropriate. The completed form must be returned within 30 days.

PLEASE NOTE: If your termination/exclusion was time-limited or was indicated in your sanction letter as having an exclusionary time period of any kind, your request will not be approved unless and until that time period has passed.

Name of Excluded Provider/Individual: _____ NPI: _____
Tax ID/SSN of Excluded Provider/Individual: _____

Instructions: All initials must be handwritten and not typed. If the statement applies, handwrite your initials at the end of each statement.

If the statement requires additional clarification or you wish to provide information, do so in the space provided AND handwrite your initials at the end of the statement. Attach additional sheets if necessary for clarification.

I affirm that:

1. To my knowledge, I am not the subject of any investigation, either criminal or civil, being conducted by an authority of a local, state or federal government and am not the subject of an investigation conducted by any state licensing authority. Clarification:	_____ Initials
2. I have not been convicted of any crime during the exclusion period. Clarification:	_____ Initials
3. I have met or am meeting all the terms and conditions of any court ordered probation. Clarification:	_____ Initials
4. If applicable, I have paid in full all debts to Nebraska Medicaid (e.g., overpayments, interim payments, civil monetary penalties, interest). Clarification:	_____ Initials
5. I am not currently federally excluded by Department of Health and Human Services, Office of Inspector General, or excluded or terminated by any other state Medicaid program. Clarification:	_____ Initials

6. During the exclusion period, I did not work as an employee or a contractor in any capacity for any entity receiving Medicaid funds. Clarification:	Initials
7. I certify that I did not submit claims or cause claims to be submitted for Medicaid reimbursement for services/supplies provided, rendered, ordered, or prescribed by me during my exclusion period. Clarification:	Initials
8. There are no limitations/restrictions/conditions on my certification/license. (If yes, describe and attach documentation.) Clarification:	Initials
9. I certify that the circumstances which led to my exclusion from the Medicaid program will not recur. Clarification:	Initials
10. Listed below is my complete employment history from the effective date of my exclusion to the present. It includes all health care employment, non-health care employment, self-employment and any periods of unemployment. (Attach additional sheets if necessary.)	Initials

Employment Date (MM/YYYY-MM/YYYY) *Place of Employment*

Employer's Address *Employer's Phone Number* *Contact Person*

Job Title/Responsibilities

Employment Date (MM/YYYY-MM/YYYY) *Place of Employment*

Employer's Address *Employer's Phone Number* *Contact Person*

Job Title/Responsibilities

Employment Date (MM/YYYY-MM/YYYY) *Place of Employment*

Employer's Address *Employer's Phone Number* *Contact Person*

Job Title/Responsibilities

I have used/am using the following NPI numbers for myself or entities I have ownership in:

Individual/Entity Name	*NPI*
Individual/Entity Name	*NPI*

Listed below are all other names I have used since my exclusion.

First/Last Name	*Date of Name Change*
First/Last Name	*Date of Name Change*

*** Narrative: Please use this space to provide any additional information that you believe would be useful to the Department in determining whether or not removal/reinstatement is appropriate at this time.

I understand my request for reinstatement may be denied if I have submitted claims or caused claims to be submitted during the period of my exclusion. I have not reproduced, altered or modified this application in any way.

CERTIFICATION: I, having made all inquiries necessary to ascertain the truth, hereby certify that the contents of the statements made and information provided herein are true and accurate.

_____ _____

Signature *Please **PRINT** Full Name*

_____

Signature Date (MM/DD/YYYY)

_____

Street Address

_____

City/State/Zip

_____

Daytime Phone Number

_____

Email

Return completed form to Nebraska Medicaid Program Integrity by email at DHHS.MedicaidProgramIntegrity@nebraska.gov

Or by mail at:

Program Integrity
P.O. Box 95026
Lincoln, NE 68509