

Medicaid & Long-Term Care Use Only	
Medicaid ID #	
N-Focus 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. Update of Information (General description of what is being updated. Must complete the rest of the form.)

2a. Type of Practice:

- Individual/Solo
- Agency Member

2b. If Agency

- Check here to request a waiver of the application fee payment

3. Provider Name and Physical Address:

Legal Name (per the IRS records):

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:

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

Name:

Address:

City, State, Zip + 4:

5. Correspondence Name and Address (if different from 4 or 5):

Name:

Address:

City, State, Zip + 4:

PROVIDER INFORMATION

6. Federal Taxpayer Identification Name (Attach W9 for EIN and W4 for SSN):

Federal Taxpayer Identification Number:

Indicate Type (check one):

EIN SSN

7. NPI (National Provider Identifier)

8. Provider Profit Status:

- 01 - 501(C)(3) Non-profit
- 02 - For Profit, Closely Held
- 03 - For Profit, Publicly Traded
- 04 - Other

FOR SECTION 8, TABLE 1 PROVIDERS ONLY

89a. Provider Program Name:

9b. Provider Program Code:

10. 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

11. 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

12. It is the provider's responsibility to screen all employees, providers, contractors and sub-contractors for Medicaid exclusion status on the Nebraska Medicaid Exclusion Provider List through the DHHS Nebraska Medicaid website located at <https://dhhs.ne.gov/Documents/Medicaid%20Excluded%20Providers.pdf>. Needs to be added to PDMS under MMIS and NFOCUS billing providers only.

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13. No employee of the Department and its subdivisions, and Department contractors, except clinical consultants, may serve as providers under Medicaid or as paid consultants to enrolled providers without the express written approval of the Medicaid Director. Needs to be added to PDMS under MMIS and NFOCUS billing providers only.
- I am not currently employed with the State of Nebraska, and I understand that as a provider of this service I am ineligible for state employment, due to potential overtime liability.**
 - I will not accept employment with the State of Nebraska unless I have first ended this provider agreement.**
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14. Has there ever been disciplinary action against this provider license by a licensing board in any state?
- Yes No
- IF "YES" ATTACH AN EXPLANATION
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15. 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
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16. 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
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17. Individual Providers (For individual providers, solo practices, and members of provider groups):

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: 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.
<https://dhhs.ne.gov/Pages/Medicaid-Rules-and-Regulations.aspx> 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 REQUIRED

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

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