



## Provider Enrollment Checklist

### Provider Type 17: Special Clinics

### Specialty 188: Certified Community Behavioral Health Center (CCBHC)

Please refer to the Provider Enrollment Information Booklet for guidance and to the applicable Medicaid Services Manual (MSM) Chapter for enrollment requirements. In addition, the following are required for your provider type and specialty. In the online application, upload specified documents where prompted and additional documents in the Miscellaneous Attachment section.

If you have any questions, please call the Gainwell Technologies Contact Center at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Pacific Time Monday through Friday.

#### Notes:

- Providers must complete and submit, as instructed, the [Certified Community Behavioral Health Center \(CCBHC\) Enrollment Criteria](#) prior to submitting an application to enroll as a Nevada Medicaid CCBHC provider.
- Providers must have rates established by Nevada Medicaid prior to enrolling as a Nevada Medicaid CCBHC provider.
- CCBHC providers enrolling an Access location must complete the attestation on page 2 of this Enrollment Checklist and submit the attestation with their enrollment or revalidation request.

#### Documents:

- ☐ Document of Certification as a Certified Community Behavioral Health Center (CCBHC) issued by the Nevada Health Authority (NVHA) Division of Public and Behavioral Health (DPBH).
- ☐ Providers must have a separate National Provider Identifier (NPI) specifically for CCBHC services.
- ☐ Substance Abuse Prevention and Treatment Agency (SAPTA) certificate/endorsement as a Co-Occurring Capable or Co-Occurring Enhanced Program.
- ☐ Substance Abuse Prevention and Treatment Agency (SAPTA) certificate/endorsement showing certified Levels of Care.

*You do not need to submit page 1 of this checklist with your enrollment or revalidation.*



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**Access Site Attestation**

*(This attestation is required for CCBHC providers enrolling an Access location and must be submitted with enrollment or revalidation request.)*

I attest that the information provided below is accurate to the best of my knowledge.

I understand that further documentation may be requested to verify the information provided below.

Access Site Location Address: \_\_\_\_\_

Access Site Telephone Number: \_\_\_\_\_

Local Business License Number and Expiration date (If exempted from obtaining a business license, provide proof of exemption with this form.):  
\_\_\_\_\_

Last inspection by local or State Fire Authority date and outcome: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Facility Representative

Date

Printed Name of Facility Representative

CCBHC Program Name

Certification #