Provider Enrollment Checklist for Provider Type 28

Pharmacy

The following is a list of required enrollment and revalidation documents for this provider type followed by a short questionnaire for out-of-state providers who are not located in a catchment area. This completed checklist must be submitted with your enrollment request. If you have any questions, please contact the Provider Enrollment Unit at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Resources:

The Provider Enrollment webpage provides instruction materials that will assist providers with enrolling in Nevada Medicaid.

All providers:

Please indicate which type of provider you are enrolling as, and include this checklist with your enrollment documents.

- ☐ Pharmacy
- ☐ Dispensing Practitioner

In-State providers and providers located in a catchment area:

Submit a copy of each of the following documents with your provider enrollment or revalidation.

- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9)
- ☐ Nevada State Board of Pharmacy License
- ☐ Copy of your Pharmacy License from your home state (catchment area providers)
- ☐ Nevada Secretary of State Business License or business license in your home state

For Dispensing Practitioners:

The Dispensing Practitioners' office must be located in the State of Nevada.

Submit a copy of each of the following documents with your provider enrollment or revalidation.

- ☐ Dispensing Practitioner Certificate (NRS 639.070 and NAC 639.390)
- ☐ Drug Enforcement Administration (DEA) License and Controlled Substance License (if dispensing controlled substances)

Out-of-State providers requesting full enrollment:

Submit a copy of each of the following documents with your provider enrollment or revalidation. See page 2 of this checklist for Out-of-State and Out-of-Catchment Urgent/Emergent Enrollment instructions.

- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9)
- ☐ Copy of your Pharmacy License from your home state

Questionnaire for Out-of-State providers:

Out-of-state pharmacies may be enrolled only when enrollment is for one of the reasons below. Check and complete each item below that applies and return this checklist with your enrollment or revalidation documents.

- ☐ To support a recipient who has been placed in an inpatient facility outside the state of Nevada

  Name of Institution: _____

  Name of Recipient(s): _____

- ☐ To provide diabetic supplies to recipients when Medicare is the primary payer

Pharmacy

☐ To provide a specialty drug that is not currently available in the state of Nevada (attach a separate page, if applicable):

Name and National Drug Code (NDC) of Product:_____

Name and National Provider Identifier (NPI) of referring Physician:

_____

Out-of-State and Out-of-Catchment Urgent/Emergent Enrollment

Full Nevada Medicaid enrollment is not required for out-of-state, out-of-catchment providers that render urgent/emergent services to recipients outside of Nevada borders.

If you are enrolling to be reimbursed for urgent/emergent services provided to a Nevada Medicaid recipient, please complete an Urgent/Emergent enrollment.

The following documentation will need to be submitted along with the urgent/emergent enrollment.

☐ Proof of Medicaid Enrollment in Home State
The proof must show the rendering provider's name and NPI and your State's Medicaid name and be dated within 5 years from the date of service.

☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9)

☐ Voided Check or Bank Letter to Confirm Electronic Funds Transfer (EFT) Information

☐ Letter of intent including information on recipient such as name, Nevada Medicaid ID number, dates of service, NDC/CPT/HCPCS/revenue codes, etc.

Policy Declaration

I hereby declare that I have read the current MSM Chapters 100, 800 and 3300 as of the date above and understand this policy and how it relates to my scope of practice. I acknowledge that, as a Nevada Medicaid-contracted provider, I am responsible for complying with the MSM, with any updates to this policy as may occur from time to time and with applicable state and federal laws. This entity meets all provider qualifications outlined in MSM Chapters 100 and 800. I also understand that I am responsible for ensuring that all owners, administrators, managing employees, and all other employees providing direct services have a fingerprint-based criminal background check through the Department of Public Safety and Federal Bureau of Investigation. Failure to comply may result in administrative action including recoupment of Medicaid reimbursement and/or termination from the Medicaid program.

Owner/Provider/Managing Employee signature: _____Date: _____

Changes in Medicaid Information

If there are any pertinent information changes from what is presented above and on your enrollment application, you are required to notify Nevada Medicaid in compliance with Medicaid Services Manual (MSM) Chapter 100, Section 103. Changes in business ownership must be reported by resubmitting a new enrollment application and indicating ownership change. All ownership changes must include documentation of the purchase agreement. All other changes must be reported by using the Provider Web Portal at https://www.medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx. After logging in, click on the "Revalidate – Update Provider" link under Provider Services. The Online Provider Enrollment User Manual Chapter 3 Revalidation and Updates on the Provider Enrollment webpage at https://www.medicaid.nv.gov provides instructions on navigating the Update Provider tool. (Per MSM Chapter 100, Medicaid providers, and any pending contract approval, are required to report, in compliance with Medicaid Services Manual (MSM) Chapter 100, Section 103, any change in ownership, address,

Pharmacy

or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery.) I hereby accept Nevada Medicaid's change notification requirements:

Owner/Provider/Managing Employee signature: _____Date: _____

Reporting Fraud

Providers have an obligation to report to the Division of Health Care Financing and Policy (DHCFP) any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers (MSM Chapter 3300). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405. I understand that Nevada Medicaid payments are made from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws. I hereby agree to abide by Nevada Medicaid's fraud reporting requirements:

Owner/Provider/Managing Employee signature: _____Date: _____

Owner/Provider/Managing Employee Attestation

I certify under penalty of perjury under the laws of the State of Nevada, that the information I have provided is true and correct and that I have read, understood, and agree to comply with all parts of this Provider Enrollment Checklist.

Owner/Provider/Managing Employee signature: _____Date: _____