Provider Type 33/Specialty 933: Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS)

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.

Out-of-state providers seeking full or Medicare Crossover enrollment only must complete/return page 2 of this checklist.

Providers dispensing diabetic supplies must enroll as a Pharmacy provider (provider type 28) and bill those products through the Pharmacy program — not through the DMEPOS program (provider type 33).

Provider Type 33/Specialty 933: Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS)

For Out-of-State DMEPOS Providers Seeking Full or Medicare Crossover Enrollment Only

All out-of-state DMEPOS providers seeking full enrollment must return this completed page with their provider enrollment or revalidation and documents specified on the previous page.

Currently, DMEPOS providers are readily available in Nevada. If you are not providing one of the following four services, your application will be denied per Medicaid Services Manual (MSM) Chapter 100, Section 102.3.

Indicate each service you wish to provide:

1. Medicare Crossover ☐ Yes ☐ No
   and/or
2. Catchment Area ☐ Yes ☐ No
   and/or
3. Providing an item/supply that is not readily available within the state of Nevada by a current provider. ☐ Yes ☐ No
   and/or
4. Recipient is temporarily receiving inpatient services in an institution/facility outside of Nevada:
   ☐ Yes ☐ No If you checked yes, you must complete the following recipient and institution/facility information. If you checked yes and you do not supply the information, your application will be returned. Attach one sheet for each recipient.

Recipient Name (*first and last*):		
Recipient Medicaid ID Number:		
Institution/Facility Name:		
Institution/Facility Address:		
City:	State:	Zip Code:
Recipient Date of Admission:		

If you did not answer yes to at least one of the above three questions, **please go no further**; if you answered yes to at least one of the questions, **please continue**.

Please check the box next to each medical supply/equipment you wish to provide:

☐ Enteral Tube Feeding Supplies	
☐ Ostomy Supplies	
☐ Other Equipment: (*specify*)	
☐ Other Supplies: (*specify*)	

How will the recipient be provided with instruction in the care and use of equipment, set-up and follow-up for these items?

_____

Do you have a storefront (*either in Nevada or out-of-state*)? ☐ Yes ☐ No

Check each of your intended sources of delivery:

☐ Mail Order (*only reimburses for Medicare crossovers*)	☐ Delivery
☐ Other: (*specify*)	