Provider Enrollment Checklist for Provider Type 93 Specialty 704

Substance Use Treatment: Group Specialty 704, Residential Substance Use Treatment in an Institution for Mental Disease (IMD)

The following is a list of required enrollment documents for this provider type. A copy of each document listed below, along with this completed checklist, must be included with your provider enrollment application or revalidation.

Original signatures and initials are required on this form.

If you have any questions, please contact Provider Customer Service at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Group Name: _____ Date: _____

National Provider Identifier (NPI): _____

Please check one of the following boxes. Updates to Clinical Supervisors of the agency are reported using this form and the appropriate change application.

- ☐ New Enrollment, Re-enrollment, Revalidation or Change of Ownership
- ☐ Clinical Supervisor of the agency Update

Attachments (please check the box indicating that a copy of the specified item is attached):

- ☐ Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9).
- ☐ Current Substance Abuse Prevention and Treatment Agency (SAPTA) certificate/endorsement as a Co-Occurring Capable or Co-Occurring Enhanced Program.
- ☐ Current SAPTA certificate/endorsement showing certified American Society of Addiction Medicine (ASAM) Levels of Care.
- ☐ Attestation on business letterhead from the owner, signed and dated, that the bed count is more than 16 beds and more than 50% of care is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, and also provides for medical attention, nursing care and related services.
- ☐ Nevada Secretary of State Business License.
- ☐ Appropriate Clinical Laboratories Improvement Act (CLIA) certification for the level of testing performed, as applicable.
- ☐ If receiving state funding from Nevada Department of Health and Human Services, Division of Public Behavioral Health, please attach first page of your subgrant award.
- ☐ Associated Providers List with original provider signature(s).
- ☐ Current copy of the license for the Clinical Supervisor of the agency.
- ☐ Electronic Funds Transfer (EFT) form and voided check/bank letter.

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Select all subspecialties (ASAM levels of care that you are SAPTA certified to provide) for which you are enrolling:

☐ 713 (ASAM Level 3 Residential)

Note: *Groups who are certified as ASAM Level 3.1, 3.5 or 3.7WM should select 713.

Clinical Supervisor

Clinical Supervisor of the agency Name: _____

Professional Title: _____

NPI: _____ Phone: _____

Clinical Supervisor Signature: _____ Date:_____

Policy Declaration

I hereby declare that I have read the current Medicaid Services Manual (MSM) Chapters 100, 400 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 400.

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 name: _____ Signature: _____

Date:_____

Resources:

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