

Eligible Professional (EP) EHR Incentive Program Enrollment and Attestation

Contact information for all inquiries and responses

First Name	M.I.	Last Name	Suffix	Job Title
<input type="text"/>				
Phone number (include area code)	E-mail address			
<input type="text"/>				

Provider Information

First Name	M.I.	Last Name	Suffix	
<input type="text"/>				
Address Line 1	Address Line 2	City	State	Zip
<input type="text"/>				
NPI (National Provider Identifier) Number	If not enrolled in Medicaid, please provide your license number	CMS EHR Certification Number(s) for your EHR system		
<input type="text"/>				

Payee Information

Do you want to reassign your incentive payment to go to a payee other than yourself? Yes No

Practice NPI	Name			
<input type="text"/>				
Address Line 1	Address Line 2	City	State	Zip
<input type="text"/>				

Eligibility Information

Provider Type (select one)

<input type="checkbox"/> Physician Are you a Pediatrician? <input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> Certified Nurse Midwife <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Dentist	<input type="checkbox"/> Physician Assistant* *If Physician Assistant was selected, please make a selection below <input type="checkbox"/> The PA is the primary provider in the qualifying FQHC/RHC <input type="checkbox"/> The PA is a clinical or medical director at the qualifying FQHC/RHC <input type="checkbox"/> The PA is an owner of the qualifying RHC
---	---

Do you provide 90% or more of your professional services in a hospital setting (Place of Service is 21 or 23)? Yes No

Do you have any sanctions with Medicare or Medicaid in any state? Yes No

If yes, which states

Please indicate the stage of your EHR system.

<input type="checkbox"/> Adopted	<input type="checkbox"/> Implemented	<input type="checkbox"/> Upgraded	<input type="checkbox"/> Demonstrating Meaningful Use
----------------------------------	--------------------------------------	-----------------------------------	---

Patient Volume Information

Patient volume is being submitted for	If at a group/clinic: Group NPI number	If at a group/clinic: Group NE Medicaid number
<input type="checkbox"/> Individual Practitioner <input type="checkbox"/> Group/Clinic	<input type="text"/>	<input type="text"/>

Please provide the following patient encounter numbers

90-day or 3 month reporting period		Total Medicaid patient encounters during the reporting period	Total patient encounters during the reporting period
From:	To:		

FQHC/RHC

Do you practice predominately in either a FQHC or RHC? Yes No

Please indicate a six-month period in the most recent calendar year in which this may be demonstrated

From:	To:

90-day reporting period

From:	To:	Total Medicaid patient encounters during the reporting period

Total uncompensated care encounters during the reporting period (include services provided at no cost or at a reduced costs based on sliding scale determined by the patient's ability to pay)

Total patient encounters during reporting period

--	--

Managed Care

If you are a Medicaid Managed Care Primary Care Physician (PCP) and are submitting based on patient panel, please complete the following:

90-day reporting period

From:	To:	Total patients assigned during the reporting period which had a least one encounter in the previous calendar year

Total of all encounters in 90-day reporting period (not included in above)

Total Medicaid patients assigned during the reporting period which had at least one encounter in the previous calendar year

--	--

Total Medicaid encounters during 90-day reporting period (not included in above)

Total needy patient panel (see instructions)

--	--

Were any of the above Medicaid patient encounters provided to an individual covered by a medicaid program other than Nebraska? Yes No

If yes, which states

Percentage of patient volume in the other states

--	--

Terms of Attestation and 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 electronic health records final rule issued by the Centers for Medicare and Medicaid Services (CMS-0033-F), the EHR Incentive Program Manual, Nebraska Administrative Code (NAC) Titles 465 and 471, 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. A complete Agreement is effective, upon acceptance by the Department, by formal notification to a provider that the Agreement has been accepted.

As a provider participating in the Electronic Health Record Incentive Program for the Medicaid & Long-Term Care programs specified in this agreement, the Provider assures:

1. 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. <http://www.dhhs.ne.gov/Medicaid/> and http://dhhs.ne.gov/Pages/reg_t471.aspx;
2. Full compliance with all applicable Federal statutory and regulatory law;
3. Full compliance with the State's audit process;
4. Full compliance with requirement found at 42 CFR 455.432 specifying 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;
5. Full compliance with requirement found at 42 CFR 455.434 specifying 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;

6. 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 satisfaction of program requirements, and the amount paid will be accepted as payment in full and that no additional payment will be claimed.
7. 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);
8. That service records will be retained as are necessary to fully disclose satisfaction of program requirements and the extent of the services provided to support and document all claims, for a minimum period of six years as required under HIPPA Section 164.530(j); The State can request supporting documentation.
9. It will 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.
10. Provider understands that provider enrollment does not constitute employment by the State of Nebraska or guarantee referrals;
11. This agreement will not be transferred to any other person or entity;
12. Provider understands that any payment is made with federal funds and is contingent upon availability of those funds and federal requirements for disbursement;
13. That all information will be disclosed to Nebraska Department of Health and Human Services as required by policies of the Department;
14. 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); and any incentive payments paid to the EP or hospital later found to have been made based on fraudulent or inaccurate information or attestation may be recouped by the State
15. The EHR incentive payments will be treated like all other income and are subject to Federal and State laws regarding income tax, wage garnishment and debt recoupment.
16. This form and any required addenda, and/or attachments must be completed and submitted prior to a request for payment being considered complete.
17. By signing this Agreement, the provider is agreeing to be bound by the appeals process set forth in Nebraska's Regulations

I have read and understand the terms of this agreement and attestation. I attest that the foregoing information is true, accurate and complete. I understand that Medicaid EHR Incentive payments submitted under this provider number will be from Federal funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Printed Name of Provider

Signature of Provider

Date