

Eligible Hospital (EH) EHR Incentive Program Enrollment and Attestation

Contact information for all inquiries and responses

First Name	M.I.	Last Name	Suffix	Job Title
Phone number (include area code)		E-mail address		

Provider Information

Name of Hospital	NPI (National Provider Identifier) Number	Medicaid Number
CCN Number	Provider Type (please select one)	
	<input type="checkbox"/> Acute Care Hospital (including Critical Access Hospital) <input type="checkbox"/> Children's Hospital	

Patient Volume Information

What is the continuous 90 day or 3 month period for which you are reporting patient volume?

From: _____ To: _____

Medicaid Patient Encounters

Total Medicaid patient encounters during the reporting period	Total patient encounters during the reporting period

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

If yes, which states _____ Percentage of patient volume in the other states _____

Please indicate the stage of your EHR system.

Adopted
 Implemented
 Upgraded
 Demonstrating Meaningful Use

Provide the CMS EHR Certification Number for your EHR system

Medicare Cost Report Information

Please complete the column indicating the year the fiscal year ends as well as the reported data column.

Data Element	Fiscal Year from which the data is pulled	If data is drawn from CMS 2552-96:	If data is drawn from CMS 2552-10:	Reported Data Please complete
Total Discharges - Base Fiscal Year *		Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14	
Total Discharges - 1st Prior Fiscal Year		Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14	
Total Discharges - 2nd Prior Fiscal Year		Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14	
Total Discharges - 3rd Prior Fiscal Year		Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14	
Total Medicaid Days	Base fiscal year	Worksheet S-3, Part I, Column 5, Lines 1, 6-10	Worksheet S-3, Part I, Column 7, Lines 1, 8-12	
Medicaid HMO Days	Base fiscal year	Worksheet S-3, Part I, Column 5, Line 2	Worksheet S-3, Part I, Column 7, Line 2	
Total Hospital Days	Base fiscal year	Worksheet S-3, Part I, Column 6, Lines 1, 2, 6-10	Worksheet S-3, Part I, Column 8, Lines 1, 2, 8-12	
Total Charity Charges	Base fiscal year	Worksheet S-10, Line 30	Worksheet S-10, Line 20	
Total Hospital Charges	Base fiscal year	Worksheet C, Part I, Column 8, Line 101	Worksheet C, Part I, Column 8, Line 200	

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 recoument.
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/Authorized Official Completing this Form

Job Title

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Signature

Date