OBAT NAVIGATOR PROVIDER ADDENDUM

For DXC Technology Internal Use Only

Provider Name: _____ Provider ID #: _____

Doc Type: **CHNGREQ** Provider Type: _____ Provider Specialty: _____

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

NOTE: THE OBAT PRACTICE IS REQUIRED TO COMPLETE PARTS 1 THRU 4 OF THIS PROVIDER ADDENDUM AS A PREVIOUSLY ENROLLED MEDICAID BILLING PROVIDER. THE NAVIGATOR IS REQUIRED TO COMPLETE PART 5 OF THIS PROVIDER ADDENDUM.

OBAT NAVIGATOR PROVIDER ADDENDUM

Billing Provider Name **Billing Provider ID** **Billing Provider NPI Number**

Navigator

Navigator Legal Name **Professional Title** **Social Security Number** **DOB**

Navigator Medicare Provider No. (If applicable) **Navigator UPIN No. (if applicable)**

Navigator NPI Number

PART 1 - CONFIRMATION OF NAVIGATOR QUALIFICATIONS

To request participation as a Navigator in an Office-Based Addiction Treatment (OBAT) practice, an individual must either be 1) a Registered Nurse (RN), 2) a Licensed Practical Nurse (LPN) with two years of lived experience*; 3) an individual with a baccalaureate (BA) degree and two (2) years of lived experience*; or 4) an individual with an associate's degree and four (4) years of lived experience* or 5) a Certified Medical Assistant with four (4) years of lived experience*.
Physicians, APNs and PAs may not serve as a Navigator.

***Lived experience is defined as having knowledge of substance use disorders or mental illness gained through direct, personal experience through one's own successful recovery process as well as individuals who have gained direct experience with successful treatment of substance use disorder and/or mental illness through either a personal relationship or professional contact with individuals suffering from substance use disorder or mental illness.**

OBAT NAVIGATOR PROVIDER ADDENDUM

Please indicate your qualifications as a Navigator below:

Provider Specialty	Qualifications (*Copy of License. College Degree or Attestation Required)*
1) Registered Nurse	License No./State
2) Licensed Practical Nurse with 2 years Lived experience	License No./State **Must complete enclosed attestation**
3) Baccalaureate (BA) degree with 2 years lived experience	**Copy of college degree** **Must complete enclosed attestation**
4) Associate degree with 4 years of lived experience	**Copy of college degree** **Must complete enclosed attestation**
5) Certified Medical Assistant with 4 years of lived experience	Certification No./State **Must complete enclosed attestation**

PART 2 – PROVIDER QUESTIONS/ AGREEMENT

Effective Date Requested _____

1. **Have you ever been approved as a provider of services under the Medicaid/NJ FamilyCare program or the Medicaid program of any other state or jurisdiction? _____ Yes _____No. If Yes, list the types of services provided and current status. If you were approved as a provider at one time and you no longer participate, please explain below.**

2. **Have you ever been the subject of any past or pending license or certification suspension, revocation or other adverse action by any licensing or certifying authority, including but not limited to any fine, penalty, reprimand, disciplinary action or probationary period (even if paid and/or resolved) imposed by any licensing authority (excluding motor vehicle violations) in this State or any other jurisdiction?**
   _____ Yes _____No If Yes, please explain:

3. **Have you ever been indicted, charged, convicted of or pled guilty or no contest to any federal or state crime or disorderly persons offense in this State or any other jurisdiction (even if this resulted in pre-trial intervention)?**
   _____Yes _____No If Yes, please explain:

4. **Have you ever been the subject of any past or pending suspensions, debarments, disqualifications, recovery actions or criminal convictions involving Medicaid, Medicare, any other federally-funded or state-funded health care program, any private or non-profit health insurance plan or program in this State or any other jurisdiction or any other programs administered in whole or in part by DMAHS?**
   _____Yes _____No If Yes, explain and indicate current status of action:

5. **Has any person (or any member of such person's immediate family) or entity required to be named in response to any questions in this application ever owned or had an interest in, or any relationship (including an employment relationship) with, any other person or entity providing services under Medicaid, Medicare, any other federally or state-funded health care program or any private or non-profit health insurance plan or program in this State or in any other jurisdiction?**
   _____Yes _____No If Yes, explain:

6. **Are you employed by the State of New Jersey in any capacity? _____Yes _____No**
   If Yes, please explain:

OBAT NAVIGATOR PROVIDER ADDENDUM

7. **NOTE: There are federal and State statutes and regulations governing kickbacks and referral practices which may apply to you, as the applicant, and to those individuals and entities listed in this application. These statutes and regulations include, but are not limited to: the Federal Medicare and Medicaid Anti-Kickback Statute (42 USC 1320a-7b(b)); the Federal Safe Harbor Regulations (42 CFR 1001.952: the Stark Laws (42 USC 1395nn, 42 USC 1396b(s) and implementing regulations); the State Medicaid Anti-Kickback Statute (NJS 30:4D-17(c)); and the Codey Law (NJS 45:9-22.4 et. seq.) and its implementing regulations (NJAC 13:35-6.17)). Applicants should carefully review and understand these legal requirements and prohibitions, because signing this Agreement is a representation that there is full compliance with all of these statutes and regulations.**

I have read and understand the above paragraph. _____ (Please Initial)

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8. FOR THE PURPOSE OF ESTABLISHING ELIGIBILITY TO RECEIVE DIRECT PAYMENT FOR SERVICES TO BENEFICIARIES UNDER THE NEW JERSEY MEDICAID (TITLE XIX) PROGRAM AND THE OTHER PROGRAMS ADMINISTERED IN WHOLE OR IN PART BY THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS), I CERTIFY ON BEHALF OF THE APPLICANT THAT THE INFORMATION FURNISHED IN THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE. I AM AWARE, AND BY SIGNING THIS APPLICATION GIVE CONSENT ON BEHALF OF THE APPLICANT THAT I REPRESENT, THAT DMAHS AND/OR THE MEDICAID FRAUD DIVISION (MFD) OF THE OFFICE OF THE STATE COMPTROLLER MAY VERIFY THE ACCURACY OF ANY AND ALL INFORMATION AND DOCUMENTATION SUBMITTED IN CONNECTION WITH THIS APPLICATION, INCLUDING, BUT NOT LIMITED TO, CONDUCTING A CIVIL AND/OR CRIMINAL BACKGROUND INVESTIGATION RELATING TO ANY OF THE INDIVIDUALS OR ENTITIES MENTIONED IN THIS APPLICATION OR IN ANY SUPPORTING DOCUMENTS. I AM AWARE THAT IF ANY OF THE STATEMENTS MADE BY ME IN THIS APPLICATION ARE FALSE OR FRAUDULENT, OR IF THE RESULTS OF THE BACKGROUND INVESTIGATION ARE UNSATISFACTORY, THIS APPLICATION MAY BE DENIED, AND I AND THE APPLICANT ARE SUBJECT TO PUNISHMENT, INCLUDING BUT NOT LIMITED TO: CRIMINAL PROSECUTION UNDER APPLICABLE STATUTES, INCLUDING N.J.S. 30:4D-17 AND N.J.S. 2C:28-3; SUSPENSION, DEBARMENT OR DISQUALIFICATION FROM THE NEW JERSEY MEDICAID PROGRAM AND ALL OTHER PROGRAMS ADMINISTERED IN WHOLE OR IN PART BY DMAHS IN ACCORDANCE WITH N.J.A.C. 10:49-11.1(D)22; TERMINATION OF ANY PROVIDER AGREEMENT UNDER N.J.A.C. 10:49-3.2(F); AND RECOVERY UNDER APPLICABLE STATUTES AND REGULATIONS, INCLUDING N.J.S. 30:4D-7.H. AND N.J.S. 30:4D-17. I ALSO UNDERSTAND THAT ALL OF THE QUESTIONS IN THIS APPLICATION MUST BE ANSWERED, AND THAT FAILURE TO DO SO MAY RESULT IN DENIAL OF THIS APPLICATION. I FURTHER UNDERSTAND THAT IF THIS APPLICATION IS DENIED, A NEW APPLICATION CANNOT BE RESUBMITTED FOR A PERIOD OF ONE YEAR FROM THE DATE OF THE DENIAL. I AGREE TO NOTIFY (IN WRITING) THE FISCAL AGENT'S PROVIDER ENROLLMENT UNIT IMMEDIATELY OF ANY UPDATES OR CHANGES TO ANY OF THE INFORMATION THAT ARE BEING PROVIDED IN THIS APPLICATION AND IN ANY SUPPORTING DOCUMENTS.

_____	_____	_____	
Signature	Print Name	Title	Date

OBAT NAVIGATOR PROVIDER ADDENDUM

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

_____

PROVIDER NAME

PROVIDER AGREES:

1. To comply with all applicable State and Federal laws, policies, rules and regulations promulgated pursuant thereto;

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the programs administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), and to provide any authorized DMAHS employee or agent with copies of requested records free of all copy fees and related duplication charges;

3. To furnish the DMAHS, the Secretary of the U.S. Department of Health and Human Services and the Medicaid Fraud Section of the Division of Criminal Justice with such information as may be requested from time to time, regarding any payments claimed for providing services under the programs administered in whole or in part by DMAHS;

4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 2428 which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/ agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106.

6. To accept Title XIX payments as payment in full, and not institute collection activities, including but limited to, billing, balance billing and litigation, against Title XIX beneficiaries for the payment of claims that have been denied in whole or in part by DMAHS or its fiscal agent, except as permitted by NJSA 30:4D-6.c., or otherwise permitted or required by State or Federal Law.

The provider or DMAHS may, on 60 days written notice to the other party, terminate this Agreement without cause.

_____ _____

DATE SIGNATURE OF NAVIGATOR PROVIDER

_____

PRINT NAME AND TITLE

PART 3 - PLEASE ATTACH A COPY OF THE NAVIGATOR'S LICENSE, CERTIFICATION OR COLLEGE DEGREE AND COMPLETED ATTESTATION (IF APPLICABLE).

PART 4 - OBAT NAVIGATOR ENTITY LIVED-EXPERIENCE ATTESTATION

I {_____} on behalf of our group practice, {_____

_____}, on this date {_____} attest that {_____

_____}, our staff navigator, has the educational and lived experience required to qualify and practice as a Navigator in our Office-Based Addiction Treatment (OBAT) practice and shall comply with all federal and State statutes and regulations applicable to a provider serving NJ Medicaid/NJ FamilyCare beneficiaries. I fully understand the consequences for non-compliance which may result in recovery of payments, actions against the practice, or other penalties being assessed by the New Jersey Division of Medical Assistance and Health Services or other State or federal authorities.

_____ _____

Print Name Signature

_____ _____

Title Date

PART 5: - NAVIGATOR LIVED EXPERIENCE ATTESTATION

I {_____}, a Navigator for the OBAT group practice

{_____}, on this date {_____} attest that **I have the following lived experience**[1] required to qualify and practice as a Navigator in the above-referenced Office-Based Addiction Treatment (OBAT) practice (**please specify your Lived Experience**):

_____

_____

_____I further attest that I shall comply with all federal and State statutes and regulations applicable to a provider serving Medicaid/NJ FamilyCare beneficiaries. I fully understand the consequences of non-compliance, which may result in penalties being assessed by the New Jersey Division of Medical Assistance and Health Services or other State or federal authorities. I certify that the information provided on this Attestation is accurate and that my failure to provide accurate information could result in penalties being assessed including exclusion from the program, denial or recovery of claims, or other actions against me or the provider practice.

_____ _____

Print Name Signature

_____

Date

[1] **Lived experience is defined as having knowledge of substance use disorders or mental illness gained through direct, personal experience with one's own successful recovery process as well as individuals who have gained direct experience with successful treatment of drug addiction and/or mental illness through either a personal relationship or professional contact with individuals suffering from drug addiction and/or mental illness.**