

# Nebraska Provider Screening and Enrollment

## Pharmacy Enrollment and Revalidations






Note: If the Pharmacy's Tax ID does not have a username and password, see the appropriate Account Creation Instructions.

This will be completed at the [Provider Data Management Site \(PDMS\) for Nebraska Medicaid Provider Screening and Enrollment.](#)

The steps below will guide you through filling out or updating an application for Pharmacies.

**All applications must be submitted for review when completed or when a change is made.**

Symbols to watch for:

	A pencil symbol represents the option to EDIT information. Click on the symbol to open the box and allow edits.
	The asterisk symbol represents when a field is REQUIRED.
	The circle with a question mark symbol represents that there is HELP TEXT when you hover over the symbol.
	The plus mark symbol represents the option to ADD information. Click on the symbol to open the box and add information.
	The ex or cross mark symbol represents the option to DELETE information. Click on the symbol to remove the information.

## Pharmacy New Enrollment

Avoid creating new enrollments. Always update existing enrollments instead of creating a New Provider Location what possible. See the Provider Management Home Screen Instructions for assistance.

If this is a new Pharmacy or a Pharmacy new to Medicaid select **“Add New Provider Location.”**

Complete and confirm all Required Fields.

- All information will be specific to this location. (Provider Type, Specialty, Taxonomy, Name, EIN, Type 2 NPI, Zip and Zip Extension)
- New Pharmacies need to pay close attention to the Requested Effective Date.

**Provider Management Home**

[Update My Profile](#) Questions? Contact MAXIMUS Provider Customer Service at 1-844-374-5022

**Provider Summary**

Tax ID: [REDACTED]

**My Providers**

Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	Location	Effective Date	Submit Date	Revalidation Due Date
No providers found.									

[Add New Provider Location](#)

**My Group Member Profiles**

Provider	Status	Provider Type	NPI	Specialty	Effective Date	Submit Date
No group member profiles found.						

Create a Group Member Profile if you are or will be part of a Group Practice.

[Add Group Member Profile](#)

**Other Providers with same TaxID**

Provider	Status	Provider Type	NPI	Medicaid ID	Taxonomy Code	Location	Revalidation Due Date	Assigned User
[REDACTED]	Not Submitted	[REDACTED]	1234567890		208D00000X	08509 - 5026		[REDACTED]

[Manage](#)

Select a provider to begin managing its registration.

**New Registration** \* Designates a required field

Category\* Pharmacy

Provider Type\* Pharmacy (PHCY)

Specialty\* All Other

Taxonomy\* Pharmacy (333800000X)

Type of Practice\* Independent Pharmacy

Name of Business Entity\* Pharmacy Name  
Business Name as it appears on your IRS Assignment letter

Tax ID Type\*  EIN  SSN

Tax ID\* 123456789

NPI(if applicable) 1259966888

Requested Effective Date\* 4/20/2016 [What is this?](#)

Zip Code\* 68522

Zip Code Extension\* 1037

[Save](#) [Cancel](#)

Click **Save**. This will take you to the application.

## Viewing the Provider Enrollment

If you want to return to the home page at any time, you need to re-enter this application or Edit a Key Provider Identifier, see the Business/Provider Location Provider-Management Home Resource.

On the Bottom left side of the application, you will see a list of all the pages you need to complete. Each blue bullet point will change to a green checkmark when it is completed.




## Identification Page


### Identification

[Save](#) [Next](#)

**Provider Information**

Legal Name	DBA NPI	Tax ID	Provider Type	Effective Date
				

**Primary Contact Information**

Primary Contact Name	Title	Phone Number	EmailAddress
			

**Uploaded Documents**

Name	Description	File Name	Page Name	Username
No uploaded documents found.				

[Browse...](#)

Name

Description

[Upload file](#)

Complete the Provider Information section by selecting **Edit**. The following box will open:



The screenshot shows a web form titled "Provider Information". The form contains the following fields and values:

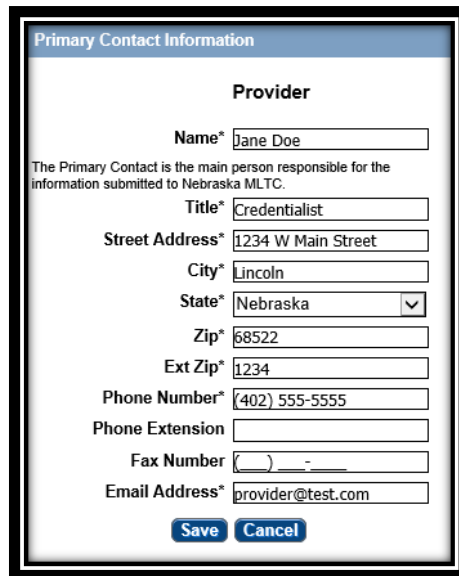
- Name of Business Entity\*: Pharmacy Name
- Business Name as it appears on your IRS assignment letter. (Note)
- DBA: (empty)
- Tax ID\*: 123456789
- NPI: 1259966888
- NPI Start Date: 4/20/2016
- NPI End Date: (empty)
- Provider Type\*: Pharmacy (PHCY)
- Type of Practice\*: Independent Pharmacy
- Requested Effective Date\*: 4/20/2016
- Revalidation Date: Not Set Yet
- Enrollment Status: Not Set Yet

At the bottom of the form are "Save" and "Cancel" buttons.

Complete all required fields and ensure all the information is correct and select **Save**.

See the Business/Provider Location Provider-Management Home Resource if a Key Provider Identifier is incorrect.

Primary Contact Information on the Identification page, select **Add** or **Edit**. The following box will open:



The screenshot shows a web form titled "Primary Contact Information". The form contains the following fields and values:

- Provider (Section Header)
- Name\*: Jane Doe
- The Primary Contact is the main person responsible for the information submitted to Nebraska MLTC. (Note)
- Title\*: Credentialist
- Street Address\*: 1234 W Main Street
- City\*: Lincoln
- State\*: Nebraska
- Zip\*: 68522
- Ext Zip\*: 1234
- Phone Number\*: (402) 555-5555
- Phone Extension: (empty)
- Fax Number: ( ) - -
- Email Address\*: provider@test.com

At the bottom of the form are "Save" and "Cancel" buttons.

Complete all required fields and select **Save**. Name should include First and Last.

On the Identification page you will not be required to upload any documents unless a new pharmacy requests a retro effective date.

Click **Next** to proceed to the next page.

## License and Clasifications Page

### Licenses & Classifications

Provider Type: Pharmacy (PHCY)(50)

Save Previous Next

#### Specialties and Taxonomies

Primary Specialty	Primary Taxonomy	Taxonomy Name
All Other(87)	3336C0002X	Clinic Pharmacy

You must bill using the Primary Taxonomy. Other Taxonomies are used for information only.

No additional records found

#### Licenses

License Number	License Type	License State	Issue Date	Expiration Date
1234	Pharmacy - Home Therapy, Independent, Professional, Small or Large Chain,	NE	6/1/2023	9/1/2026

#### Miscellaneous

No Medicare Enrollment found

No Other State Medicaid Number found

No NCPDP, Rebate Exemption, and 340 B

The Specialties and Taxonomies are listed.

- You may add a secondary Specialty by clicking **Add**.
- New Locations can change the Specialties and Taxonomies prior to be active. See the Business/Provider Location Provider-Management Home Resource if a Key Provider Identifier is incorrect. Once active the Primary Specialty and Taxonomy cannot be changed.

Pharmacies may also be required to enter or update license information. Select the **Add** or **Edit** button to enter and confirm the pharmacies license if required on this page.

If applicable, in the **Miscellaneous** section select **Add** or **Edit** to enter or confirm the Medicare Enrollment information and Other State Medicaid Enrollment Information.

Pharmacies are required to enter or update their Pharmacy information. Select the **Add** or **Edit** button to enter and confirm the NCPDP number. The NCPDP start date entered here should not be prior to the Effective date of this enrollment. This does not represent when the NCPDP number was initially received. It is specific to this enrollment.

**Edit Pharmacy and Dispensing Physicians**

NCPDP Number\*  \*

NCPDP Start Date\*  \*

NCPDP End Date  \*

Rebate Exemption Start Date

Rebate Exemption End Date

340 B Participant  Yes  No

**Save** **Cancel**

On the Licenses & Classifications page you will only be required to upload a document if you have an out of state license.

Click **Next** to proceed to the next page.

## Practice Locations Page

**Practice Locations** **Save** **Previous** **Next**

**Provider Physical Address**

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext
1234 W Main Street			Lincoln	NE	68501	7470

**Billing / Payment Contact Information**

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext

**Correspondence Information**

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	Phone Number

**Uploaded Documents**

Name	Description	File Name	Page Name	Username
No uploaded documents found.				

No file chosen

Name

Description

**Upload file**

**Practice Locations (43127)** **Save** **Previous** **Next**

Provider Physical Address, Bill/Payment Contact Information and Correspondence Information are required sections that need to be completed.

### Provider Physical

The physical address CANNOT be a PO BOX and should be where the services are physically being provided.

Click the edit symbol. The following box will open:

**Edit Provider Physical Address**

Physical Street\* 1234 W Main Street

Address Line 2

Address Line 3

City\* Lincoln

State\* Nebraska

County\* Lancaster

Zip\* 68801 ?

Ext Zip\* 7470 ?

Phone Number\* (402) 555-5555

Fax Number ( ) -

Save Cancel

Complete All required fields, confirm all information is correct, and select Save.

See the Business/Provider Location Provider-Management Home Resource if a Key Provider Identifier is incorrect.

### Billing/Payment Contact Information

Click the **Add** or **Edit**. The following box will open:

**Edit Billing / Payment Contact Information**

Same as Practice Location

Pay To / Check Payable To Name\* Jane Doe

Address\* 1234 W Main Street

Address Line 2

Address Line 3

City\* Lincoln

State\* Nebraska

Zip\* 68801

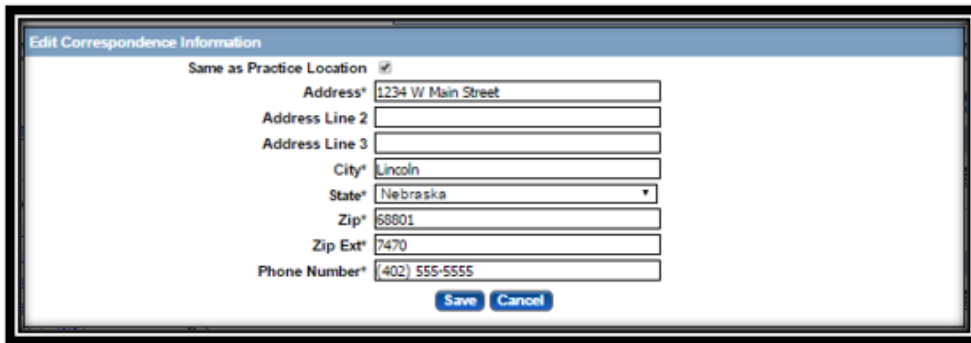
Zip Ext\* 7470

Save Cancel

Complete all required fields, confirm all information is correct, and select Save.

## Correspondence Information

Click the **Add** or **Edit**. The following box will open: Complete All required fields, confirm all information is correct, and select Save.



The screenshot shows a dialog box titled "Edit Correspondence Information". It contains the following fields and options:

- Same as Practice Location
- Address\*: 1234 W Main Street
- Address Line 2: [Empty]
- Address Line 3: [Empty]
- City\*: Lincoln
- State\*: Nebraska (dropdown menu)
- Zip\*: 68801
- Zip Ext\*: 7470
- Phone Number\*: (402) 555-5555

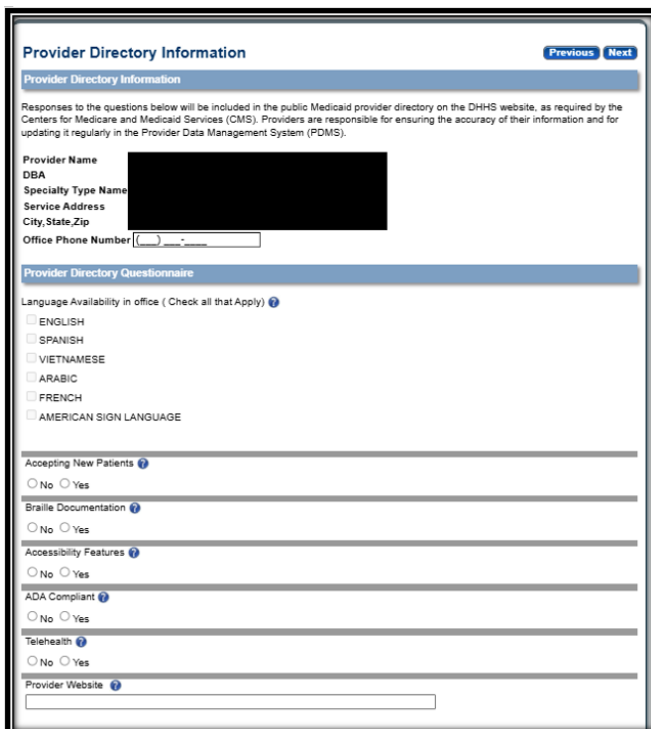
At the bottom of the dialog box are two buttons: "Save" and "Cancel".

You will not be required to upload any documents on the Practice Locations page.

Select **Next** to proceed to the next page.

## Provider Directory Information Page

The Provider Screening and Enrollment system now collects Provider Directory information. Responses to the questions will be included on [the public Medicaid Provider Directory on the DHHS website](#), as required by the Centers for Medicare and Medicaid Services (CMS). Questions are optional, but providers are responsible for ensuring the accuracy of their information and for updating it regularly in the Provider Data Management System (PDMS).



The screenshot shows the "Provider Directory Information" page. It includes the following sections:

- Provider Name**: [Redacted]
- DBA**: [Redacted]
- Specialty Type Name**: [Redacted]
- Service Address**: [Redacted]
- City, State, Zip**: [Redacted]
- Office Phone Number**: [Redacted]

**Provider Directory Questionnaire**

- Language Availability in office ( Check all that Apply )
  - ENGLISH
  - SPANISH
  - VIETNAMESE
  - ARABIC
  - FRENCH
  - AMERICAN SIGN LANGUAGE
- Accepting New Patients
  - No  Yes
- Braille Documentation
  - No  Yes
- Accessibility Features
  - No  Yes
- ADA Compliant
  - No  Yes
- Telehealth
  - No  Yes
- Provider Website
  - [Empty text input field]

## Individual Providers Associated with Your Group Page

**Individual Providers Associated with Your Group** Save Previous Next

Individual Providers Associated with Your Group

In the table below, please enter or confirm each individual provider that is associated with your group.

Name	Tax ID	NPI	Start Date	End Date	Specialty	License	Affiliation Status	Medicaid ID
No affiliations found.								

Partial or Full search using Name and/or NPI. When both fields are used to search, the grid will be filtered by both Name and NPI.

Name

Tax ID

NPI

Search Associated Providers Clear Search Filter

Pharmacists that are proving Tobacco Cessation must be added as group members. No other affiliations are required. See the Group Enrollment Guide for more detailed information on this page.

Select **Next** to proceed to the next page.

## Ownership and Controlling Interest and Conviction Disclosure Page

Expand and collapse each section by clicking on the small white plus or minus.

**Ownership/Controlling Interest and Conviction Disclosure** Save Previous Next


Click on the section header to expand or collapse the panel.

**- Instructions**

Completion of this form is required as mandated by the Centers for Medicare and Medicaid Services, Department of Health and Human Services and applicable regulations as found at 42 CFR 455.100 through 42. CFR 455.106. Disclosure must be made at the time of enrollment or contracting with the Department, at the time of survey, or within 35 days of a written request from the Department. It is the provider's responsibility to ensure all information is accurate and to report any changes as required by law by completing a new Ownership and Disclosure form.


**+ Definitions**

**- Owner Information**

*No owner information found.* 

List the name, address, Federal Tax Identification Number (FTIN) (for corporations) or Social Security Number (SSN) and Date of Birth (DOB) (for persons) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. If you are an Individual Billing Provider enrolling with an SSN, please list yourself.

**- Managing Employee**

*No managing employee information found.* 

List any person(s) who holds a position of managing employee within the disclosing entity. If you are an Individual Billing Provider enrolling with an SSN, please list yourself.

**+ Additional Addresses**

**- Questions**


Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling?  
 Yes  No

Does any person, business, organization or corporations with an ownership or control interest have an ownership or controlling interest of 5% or more in any other Nebraska Medicaid Provider?  
 Yes  No

Does any person have ownership or control interest in the disclosing entity(provider), or is an agent or employee of the disclosing entity (provider) who has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Waivers, CHIP or the Title XX services since the inception of these programs.  
 Yes  No

Complete the Ownership Information by selecting **Add** or **Edit**. You can edit existing information or delete it using the RED X.

**- Owner Information**

*No owner information found.* 

List the name, address, Federal Tax Identification Number (FTIN) (for corporations) or Social Security Number (SSN) and Date of Birth (DOB) (for persons) with an ownership or control interest in the disclosing entity including any person who holds a position of managing employee within the disclosing entity.

Owner Information			
Type	Name	Title	Percentage
Person	[REDACTED]		100

List the name, address, Federal Tax Identification Number (FTIN) (for corporations) or Social Security Number (SSN) and Date of Birth (DOB) (for persons) with an ownership or control interest in the disclosing entity including any person who holds a position of managing employee within the disclosing entity.

Owner Information

Provider

Owner Type\*

Name of Individual or Organization\*

Birth Date\*

SSN\*

Percentage of Ownership\*

Title

Address\*

Suite/Dept/Floor

City\*

State\*

Zip\*

Ext Zip

Make all necessary changes and select **Save**.

It is common to have multiple owners and managing employees. Listing at least one Managing Employee is required

Complete the **Additional Addresses** section if necessary.

Complete the Questions section and click **Next**.

Note: If only one owner is listed, the first question will be answered "No."

You will not be required to upload any documents on the Ownership and Controlling Interest page.

### Substitute W9 Page

Pharmacies are required to complete a Substitute W9 Form.

**Substitute W9 Form** Save Previous Next

Information from the Identification page displayed below.  
Corrections to this information must be made in the Organization/Individual Identification and Primary Contact sections of the Identification page.

Legal Business Name Pharmacy Name

\*\*Please visit <http://www.irs.gov> to obtain a copy of the W9 with instructions.

**Tax Classification**

Select the most appropriate category below:

- 1. Individual/Sole Proprietor or LLC
- 2. Corporation
- 3. S Corporation
- 4. Partnership
- 5. Trust/Estate
- 6. Limited Liability Corporation
- 7. Limited Liability S Corporation
- 8. Limited Liability Partnership
- 9. State, County or City (Government Entity)

**Profit Status**

Select the most appropriate category below:

- 01 - 501(C)(3) Non-Profit
- 02 - For Profit, Closely Held
- 03 - For Profit, Publicly Traded
- 04 - Other
- 99 - Unknown

Select the appropriate Tax Classification and Profit Status.

Click **Next**.

You will not be required to upload any documents on the Substitute W9 page.

## ACH Authorization Page

Only select the Check Box in the Direct Deposit section if your bank is outside the United States. The State will not provide any payment to any financial institution or entity located outside the United States.

To assist in fraud mitigation, US Bank performs account validation on new and updated ACH information to ensure it is legitimate and active. Please be aware that this validation process may take additional time, resulting in a delay in payments.

**ACH Authorization** Save Previous Next

**Instructions**

**READ INSTRUCTIONS BEFORE COMPLETING**

- Electronic Fund Transfer (EFT) enrollment is required for a provider to enroll with Nebraska Medicaid.
- Medicaid providers must submit this form to receive payment via EFT (Electronic Fund Transfer). It is also the responsibility of the Medicaid provider to ensure this information is updated, as necessary.
- Nebraska Medicaid transmits the EFT via the NACHA standard CCD + format.
- It is the responsibility of the Provider to contact their financial institution to request the receipt of all data contained within the ACH information field (including the RTN Reassociation Trace Number) of the CCD + Addenda Record. This Trace Number uniquely identifies the transaction set and aids in reassociating payments and remittance advices.
- To assist in fraud mitigation, US Bank performs account validation on new and updated ACH information to ensure it is legitimate and active. Please be aware that this validation process may take additional time resulting in a delay in payments.

Check here if the bank is outside of the United States. Per 1902(a)(80) of the Social Security Act, the State shall not provide any payment to any financial institution or entity located outside the United States.

Please enter your banking information below.

**Banking Information**

Financial Institution Name	City	Account Number	Account Type
US BANK	Lincoln	*****8**	Checking

**Confirm**

By selecting the confirmation box below, the submitting individual is attesting and acknowledging on behalf of the Nebraska Medicaid Provider listed above that:

- He or she is authorized to complete and submit this Enrollment Form.
- The information provided is accurate and true.

I confirm the information provided is true and accurate.

Click **Add** or **Edit** to enter your checking or saving information for deposits. Complete all required fields and click **Save**.

**Banking Information**

**Provider**

Trading Partner ID

Financial Institution Name\*

Street\*

City\*

State\*

Zip Code/Postal Code

Zip Code Extension

Financial Institution Phone Number\* ( ) -

Financial Institution Extension

Financial Institution Routing Number\*

Confirm Financial Institution Routing Number\*

Account Number\*

Confirm Account Number\*

Account Type\*  Checking  Savings

Account Type Entity\* 1 - Individual

Name as it Appears on Account\*

**Save Cancel**

Check the "I confirm the Information provided is true and accurate" and click **Next**.

You will not be required to upload any documents on the ACH Authorization page.

## Agreements Page

Click on each “Click here to view the entire agreement”. A separate tab will show on your web browser that contains each agreement.

Place a check mark in the “I agree’ or “I attest” box.

Note: The check box is only accessible after clicking the web link.

### Agreements

[Save](#) [Previous](#)

#### Provider Participation Agreement

By signing the Provider Participation Agreement, the applicant agrees to adhere to all Terms of Agreement listed and is aware that the applicant may be denied entry to or terminated from the program if any conditions are violated.

[Click here to view the participation agreement.](#)  I agree to the Terms of Agreement in the Participation Agreement.

#### Ownership Disclosure Acknowledgement

By checking 'I accept' I certify that I have read the Ownership Disclosure Acknowledgement on behalf of myself or the entity that I represent and by this certification agree to bind myself or said entity by these provisions.

[Click here to view the ownership disclosure acknowledgement.](#)  I attest I can legally bind this Provider Entity, and that all the information provided in the Ownership section of this application is true and accurate to the best of my knowledge.

#### Nebraska Medicaid Excluded Provider

I understand that it is the provider's responsibility to screen all employees, providers, contractors and sub-contractors for Medicaid exclusion status on the Nebraska Medicaid Exclusion Provider List through the DHHS Nebraska Medicaid website.  
[Link to Nebraska Exclusion Provider List](#)

#### State Employee Acknowledgement

No employee of the Department and its subdivisions, and Department contractors, except clinical consultants, may serve as providers under Medicaid or as paid consultants to enrolled providers without the express written approval of the Medicaid Director.

I am not currently employed with the State of Nebraska, and I understand that as a provider of this service I am ineligible for state employment, due to potential overtime liability.

I will not accept employment with the State of Nebraska unless I have first ended this provider agreement.

Answer all questions on the Agreements page.

**Questions**

Is the provider an entity identified on the System for Award Management (SAM) website as debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits?

No  Yes

If 'YES' a comment is required.

\_\_\_\_\_

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Is the provider, any facility, employee or contractor providing services under this Agreement identified on the OIG list of Excluded Individuals/Entities website as excluded from receiving payment by a Federal health care program?

No  Yes

If, 'YES' a comment is required.

\_\_\_\_\_

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Has there ever been disciplinary action against this provider license by a licensing board in any state?

No  Yes

If 'YES' a comment is required.

\_\_\_\_\_

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Has the provider ever been sanctioned or terminated by Medicare, Nebraska Medicaid, or any state health program as defined in 42 U.S.C. § 1320a-7?

No  Yes

If, 'YES' a comment is required.

\_\_\_\_\_

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In compliance with Title 8 U.S.C. § 1324a, has employment eligibility been verified for all employees of this provider OR for individual providers, do you attest that you are in the United States legally and eligible to work per Pub.L. no. 104-193 (1997)?


No  Yes

If 'NO' a comment is required.

\_\_\_\_\_

---

**Signature**



Please enter the characters in the image above:

Enter password:

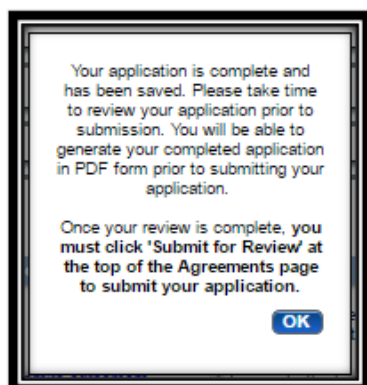
The password requested is your user login password.

In the Signature section, enter the characters in the image (if applicable)

Note: characters are not case sensitive.

Enter the password and click **Save**.

This message will be displayed when the application is successfully saved:

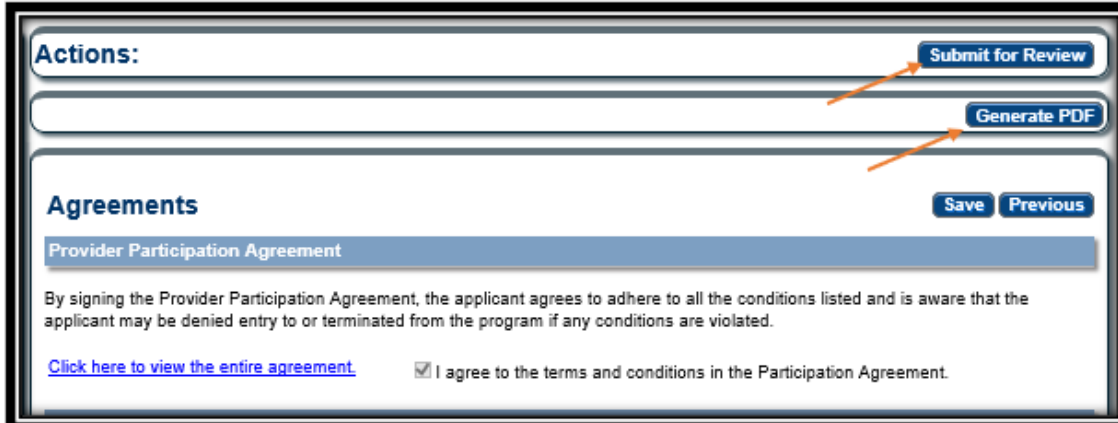


Click **OK**.

## Submit for Review

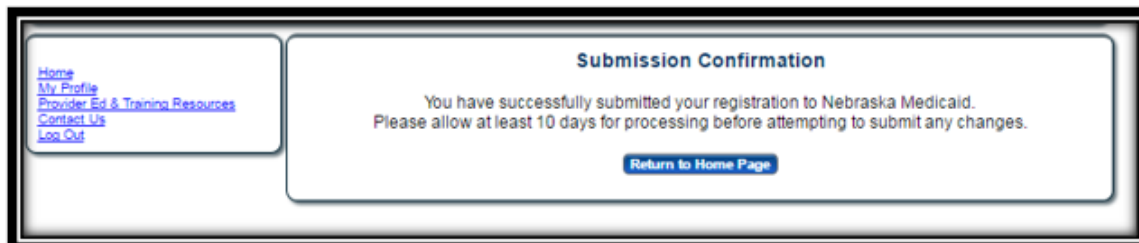
Click **“Generate a PDF”** if you wish to save or print a PDF of the application.

You MUST hit **“Submit for Review”** to successfully complete the application process.



The screenshot shows a web interface with a header section titled "Actions:" containing two buttons: "Submit for Review" and "Generate PDF". Below this is a section titled "Agreements" with "Save" and "Previous" buttons. Under "Agreements", there is a sub-section for "Provider Participation Agreement" with a paragraph of text and a checkbox labeled "I agree to the terms and conditions in the Participation Agreement." which is checked. A link "Click here to view the entire agreement." is also present. Two orange arrows point from the text above to the "Submit for Review" and "Generate PDF" buttons.

When finished the following screen will be displayed: Changes to your registration are not permitted while the enrollment is being reviewed. New Enrollments and Revalidations are not completed until fully processed. This will result in a Welcome Email and a new Revalidation Date. Watch for email communication.



The screenshot shows a "Submission Confirmation" screen. On the left, there is a navigation menu with links: "Home", "My Profile", "Provider Ed & Training Resources", "Contact Us", and "Log Out". The main content area contains the text: "You have successfully submitted your registration to Nebraska Medicaid. Please allow at least 10 days for processing before attempting to submit any changes." Below this text is a button labeled "Return to Home Page".