

Nebraska Provider Screening and Enrollment

Individual/Solo Practice Enrollment and Revalidations

Note: If the Individual Provider'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 an Individual or Solo Practice.

NOTE: Individual/Solo providers may use an EIN or SSN and must supply a Type 1 NPI. If an EIN is used, an Individual Provider must also supply their Legal Business Name. If a Type 2 NPI is needed, you must enroll as a GROUP and have your Type 1 NPI listed under your Group Member Affiliation. See the Group Provider Ed and Training Resources.

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.

Individual 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 Individual Provider to Medicaid select “**Add New Provider Location.**”

Complete and confirm all Required Fields.

It is possible for a Solo Provider to also be a group member of a separate group. This provider will have a Solo Provider Location and a Group Member Profile.

- All information will be specific to this Provider. (Provider Type, Specialty, Taxonomy, Name, SSN, Type 1 NPI, Zip and Zip Extension)
- New Solo Providers 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	88509 - 5028		[REDACTED] Manage

Select a provider to begin managing its registration.

New Registration * Designates a required field

Category*

Provider Type*

Specialty*

Taxonomy*

First Name*

Middle Initial

Last Name*

Tax ID Type* EIN SSN

Tax ID*

NPI(if applicable)

Requested Effective Date* [What is this?](#)

Gender* Female Male Unknown

Date of Birth*

Zip Code*

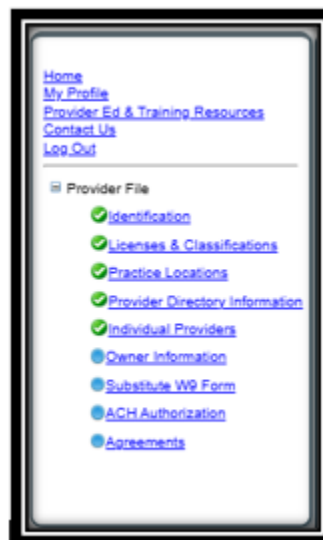
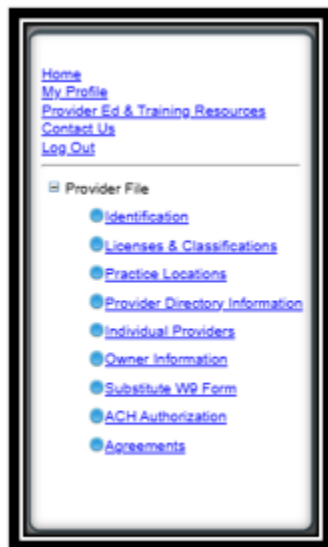
Zip Code Extension* x

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 check mark when it is completed.



Identification Page

The screenshot shows the 'Identification' page with three main sections:

- Provider Information:** A table with columns: Legal Name, DBA NPI, Tax ID, Provider Type, and Effective Date. The rows are redacted with black boxes. An orange arrow points to an 'Edit' icon in the top right corner of the table.
- Primary Contact Information:** A table with columns: Primary Contact Name, Title, Phone Number, and EmailAddress. The rows are redacted with black boxes. An orange arrow points to an 'Edit' icon in the top right corner of the table.
- Uploaded Documents:** A table with columns: Name, Description, File Name, Page Name, and Username. Below the table is a 'Browse...' button and an 'Upload file' button.

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

The 'Provider Information' edit form contains the following fields and options:

- Citizenship Status:** Radio buttons for 'I am a Citizen of the United States' and 'I am a qualified alien under the Federal Immigration and Nationality Act, my immigration status and alien number are as follows:'.
- Immigration Status:** A dropdown menu.
- Alien Number:** A text input field.
- Title:** A text input field.
- First Name*:** Text input with 'Jane' entered.
- Middle Initial:** Text input field.
- Last Name*:** Text input with 'Doe' entered.
- Tax ID*:** Text input with '123456789' and a help icon.
- NPI:** Text input with '1234567855' and a help icon.
- NPI Start Date:** Text input with '4/20/2016'.
- NPI End Date:** Text input field.
- Gender*:** Radio buttons for 'Female' (selected), 'Male', and 'Unknown'.
- Date of Birth*:** Text input with '5/25/1980'.
- Date of Death:** Text input field.
- Provider Type*:** Dropdown menu with 'Doctor Of Dental Surgery - Dentist (DE)' selected and a help icon.
- Requested Effective Date*:** Text input with '4/20/2016' and a 'What Is this?' link.
- Revalidation Date:** Text input with 'Not Set Yet'.
- Enrollment Status:** Text input with 'Not Set Yet'.

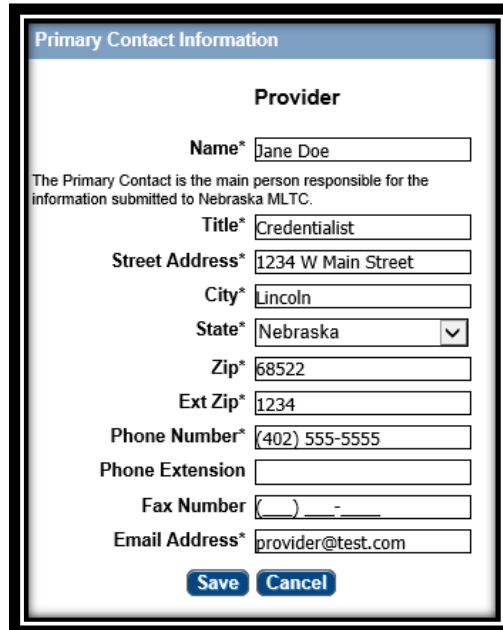
Buttons: Save, Cancel

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

Your Citizen Status will determine if an Immigration Status and Alien Number are required. It is recommended that documentation is uploaded to help expedite immigration status screening. Useful information includes Alien Number, SEVIS Identifier, I-94 Number, Passport Number, Naturalization/Citizen Number, Card Number (Green Card, Receipt Number, Permanent Resident Number), or Visa number.

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" with a sub-header "Provider". The form contains several input fields, some marked with an asterisk to indicate they are required. The fields are: Name* (Jane Doe), Title* (Credentialist), Street Address* (1234 W Main Street), City* (Lincoln), State* (Nebraska), Zip* (68522), Ext Zip* (1234), Phone Number* ((402) 555-5555), Phone Extension, Fax Number (with a placeholder for area code and dashes), and Email Address* (provider@test.com). At the bottom of the form are two buttons: "Save" and "Cancel". A note below the Name field states: "The Primary Contact is the main person responsible for the information submitted to Nebraska MLTC."

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 solo provider requested a retro effective date.

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

License and Classifications Page

Licenses & Classifications

Provider Type: Anesthesiologist (ANES)(15)

Save Previous Next

Specialties and Taxonomies

Primary Specialty	Primary Taxonomy	Taxonomy Name
Anesthesiology(05)	207L00000X	Anesthesiology

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	Anesthesiologist	NE	6/1/2023	9/1/2026

Miscellaneous

No Medicare Enrollment found

No Other State Medicaid Number found

The Specialties and Taxonomies are listed.

- You may add a secondary Specialty by clicking **Add**.
- New Locations can change the Specialties and Taxonomies. See the Business/Provider Location Provider-Management Home Resource if a Key Provider Identifier is incorrect.

Solo Providers must enter or update license information. Select the **Add** or **Edit** button to enter and confirm the 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.

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

The screenshot shows the 'Practice Locations' page. On the left is a navigation menu with links: Home, My Profile, Provider Ed & Training Resources, Contact Us, and Log Out. Below this is a 'Provider File' section with a tree view containing: Identification (checked), Practice Locations (selected), Services, Owner Information, Substitute W4 Form, ACH Authorization, and Agreements.

The main content area is titled 'Practice Locations' and has 'Save', 'Previous', and 'Next' buttons at the top right. It contains three tables for address information:

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext
1234 W Main Street			Lincoln	NE	68801	7470

Below this is a 'Billing / Payment Contact Information' table with the same columns as above, but it is empty.

Next is a 'Correspondence Information' table with columns: Address 1, Address 2, Address 3, City, State, Zip, Zip Ext, and Phone Number. It is also empty.

At the bottom is an 'Uploaded Documents' section with a table header: Name, Description, File Name, Page Name, Username. Below the header, it says 'No uploaded documents found.' There is a 'Choose File' button, a text input for 'Name', a larger text area for 'Description', and an 'Upload file' button.

At the bottom right of the main content area, there are 'Save', 'Previous', and 'Next' buttons. An orange arrow points to the 'Save' button in the top right, and another orange arrow points to the 'Save' button in the bottom right.

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:

The screenshot shows the 'Edit Provider Physical Address' form. It contains the following fields:

- Physical Street*: 1234 W Main Street
- Address Line 2: (empty)
- Address Line 3: (empty)
- City*: Lincoln
- State*: Nebraska (dropdown menu)
- County*: Lancaster (dropdown menu)
- Zip*: 68801 (with a help icon)
- Ext Zip*: 7470 (with a help icon)
- Phone Number*: (402) 555-5555
- Fax Number: () - ()

At the bottom are 'Save' and 'Cancel' buttons.

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:

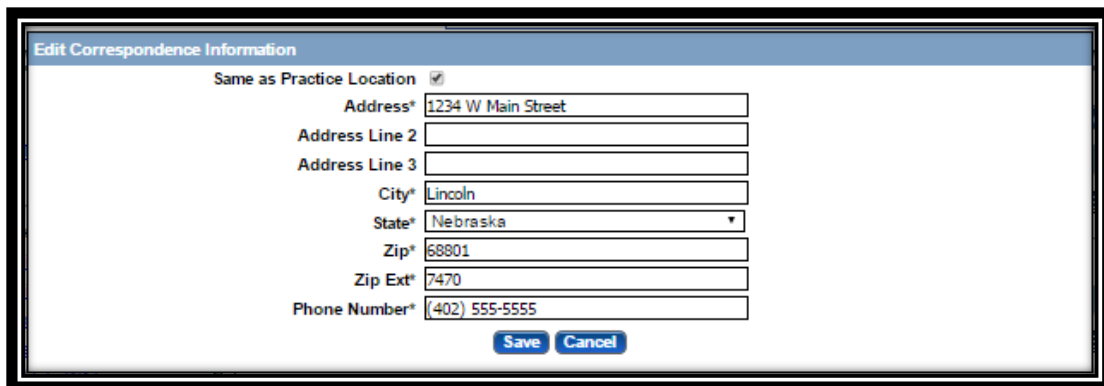


The screenshot shows a web form titled "Edit Billing / Payment Contact Information". At the top, there is a checkbox labeled "Same as Practice Location" which is checked. Below this are several input fields: "Pay To / Check Payable To Name*" with the value "Jane Doe", "Address*" with "1234 W Main Street", "Address Line 2", "Address Line 3", "City*" with "Lincoln", "State*" with a dropdown menu showing "Nebraska", "Zip*" with "68801", and "Zip Ext*" with "7470". At the bottom right of the form are two buttons: "Save" and "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:



The screenshot shows a web form titled "Edit Correspondence Information". At the top, there is a checkbox labeled "Same as Practice Location" which is checked. Below this are several input fields: "Address*" with "1234 W Main Street", "Address Line 2", "Address Line 3", "City*" with "Lincoln", "State*" with a dropdown menu showing "Nebraska", "Zip*" with "68801", "Zip Ext*" with "7470", and "Phone Number*" with "(402) 555-5555". At the bottom right of the form are two buttons: "Save" and "Cancel".

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

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).

Provider Directory Information

[Previous](#) [Next](#)

Provider Directory Information

Responses to the questions below will be included in the public Medicaid provider directory on the DHHS website, as required by the Centers for Medicare and Medicaid Services (CMS). Providers are responsible for ensuring the accuracy of their information and for updating it regularly in the Provider Data Management System (PDMS).

Provider Name
DBA
Specialty Type Name
Service Address
City, State, Zip
Office Phone Number () - -

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 ?

Ownership and Controlling Interest and Conviction Disclosure Page
Expand the "Owner Information" section by clicking on the small white plus.

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* Person

Name of Individual or Organization* Jane Doe

Birth Date* 05/29/1980

SSN* 123455678

Percentage of Ownership* 100

Title

Address* 1234 W Main Street

Suite/Dept/Floor

City* Lincoln

State* Nebraska

Zip* 68522

Ext Zip

Save **Cancel**

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](#)

Solo Providers 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 you bank is outside the United State. 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 checkmark 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.

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.

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.

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.

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:

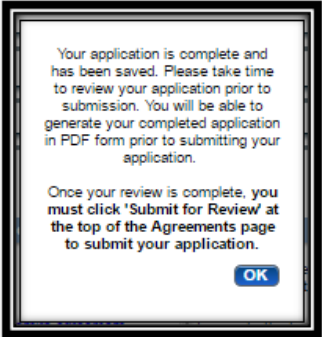
The password requested is your user login password.

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:

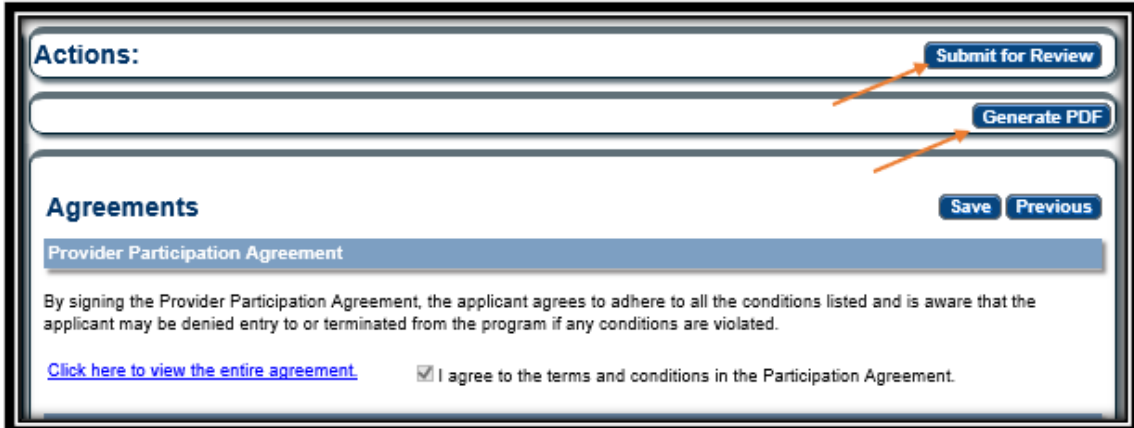


Click **OK**.

Submit for Review

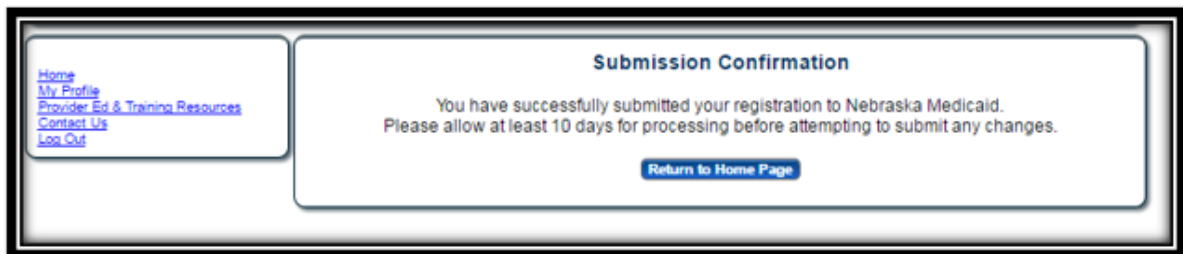
Click **“Generate a PDF”** if you wish to save or print a PDF of the application.

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 explanatory 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.

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 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." and a "Return to Home Page" button.