

# Nebraska Provider Screening and Enrollment






## Facility Enrollment and Revalidations

Note: If the Facility'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 Facilities. **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.

## Facility 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 Facility Provider 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 Facilities 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 - 5026		[REDACTED] <a href="#">Manage</a>

Select a provider to begin managing its registration.

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

Category\*

Provider Type\*

Specialty\*

Taxonomy\*

Name of Business Entity\*

Business Name as it appears on your IRS Assignment letter

Tax ID Type\*  EIN  SSN

Tax ID\*

NPI(if applicable)

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

Zip Code\*

Zip Code Extension\*

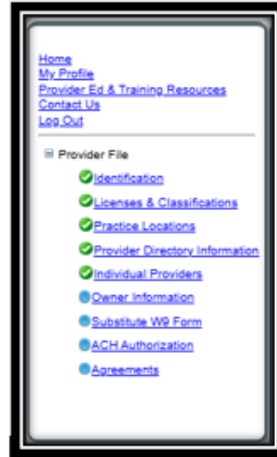
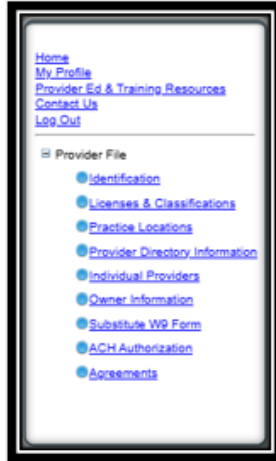
[Save](#) [Cancel](#)

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

## Viewing the Provider Enrollment

If at any time you want to return to the home page, 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. Most Facility Enrollments will not have an Individual Providers Page.




## 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:

**Provider Information**

Name of Business Entity\*

*Business Name as it appears on your IRS assignment letter.*

DBA

Tax ID\*

NPI

NPI Start Date

NPI End Date

Provider Type\*

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

Revalidation Date

Enrollment Status

Complete all required fields and ensure all the information is correct and select **Save**. Some Facilities will have to select their Type of Practice.

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

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

**Primary Contact Information**

**Provider**

Name\*

The Primary Contact is the main person responsible for the information submitted to Nebraska MLTC.

Title\*

Street Address\*

City\*

State\*

Zip\*

Ext Zip\*

Phone Number\*

Phone Extension

Fax Number

Email Address\*

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 facility requests a retro effective date.

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

## License and Clasifications Page

### Licenses & Classifications

Provider Type: Hospitals (HOSP) Save Previous Next

#### Specialties and Taxonomies

Primary Specialty	Primary Taxonomy
Hospitals (Defined By Department Of Social Services)	282E00000X

*No additional records found*

#### Number of Certified Beds

*No beds found*

#### 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.

Some Facilities may also be required to indicate if this is a teaching hospital or Add or Edit the Number of Certified Beds.

Some Facilities may also be required to enter or update license information. Select the **Add** or **Edit** button to enter and confirm the facilities 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

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	68801	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				

Choose File 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:

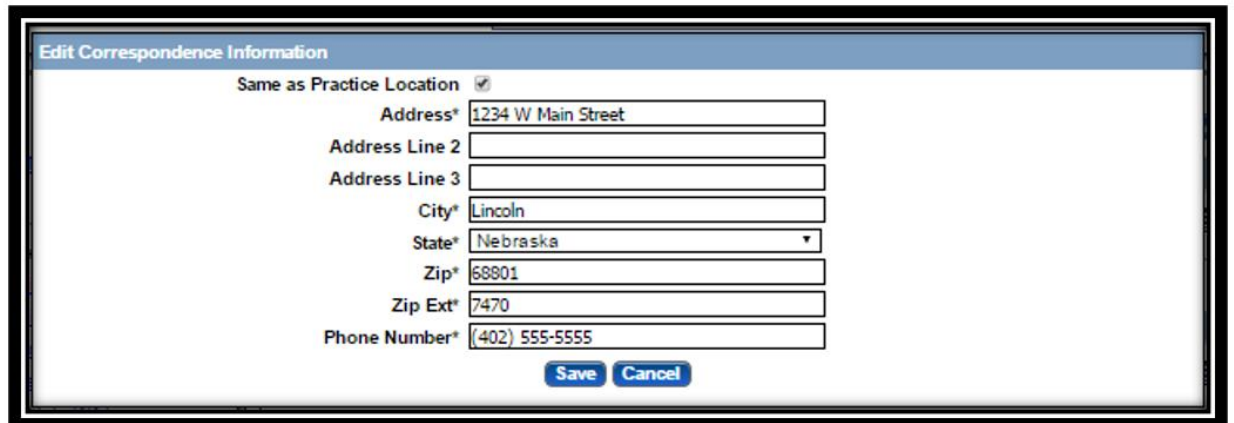


The screenshot shows a web form titled "Edit Billing / Payment Contact Information". At the top, there is a checkbox labeled "Same as Practice Location" which is checked. Below this are several input fields: "Pay To / Check Payable To Name\*" with the value "Jane Doe", "Address\*" with "1234 W Main Street", "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

## 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	Attribution 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

Some Facilities will have this page. If the page is visible, this enrollment type may be required to supply group members to adjudicate claims. In other cases, it is optional. The system will not let you move past this page if they 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 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\*

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

Facilities are required to complete a Substitute W9 Form.

The screenshot shows a web form titled "Substitute W9 Form" with "Save", "Previous", and "Next" buttons in the top right. Below the title is a text box containing the following text: "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." Below this text box is a label "Legal Business Name Pharmacy Name" followed by a text input field. At the bottom of the text box is a note: "Please visit <http://www.irs.gov> to obtain a copy of the W9 with instructions." Below the text box is a blue header for "Tax Classification". Underneath is the instruction "Select the most appropriate category below:" followed by a list of radio button options: 1. Individual/Sole Proprietor or LLC, 2. Corporation (selected), 3. S Corporation, 4. Partnership, 5. Trust/Estate, 6. Limited Liability Corporation, 7. Limited Liability S Corporation, 8. Limited Liability Partnership, and 9. State, County or City (Government Entity). Below this is another blue header for "Profit Status". Underneath is the instruction "Select the most appropriate category below:" followed by a list of radio button options: 01 - 501(C)(3) Non-Profit, 02 - For Profit, Closely Held (selected), 03 - For Profit, Publicly Traded, 04 - Other, and 99 - Unknown.

Enter the Facilities Fiscal Year End.

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	*****0**	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\*

Name as it Appears on Account\*

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**

**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 the 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.



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**Signature**



Please enter the characters in the image above:

Enter password:

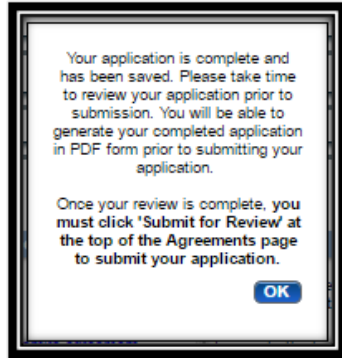
The password requested is your user login password.

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:

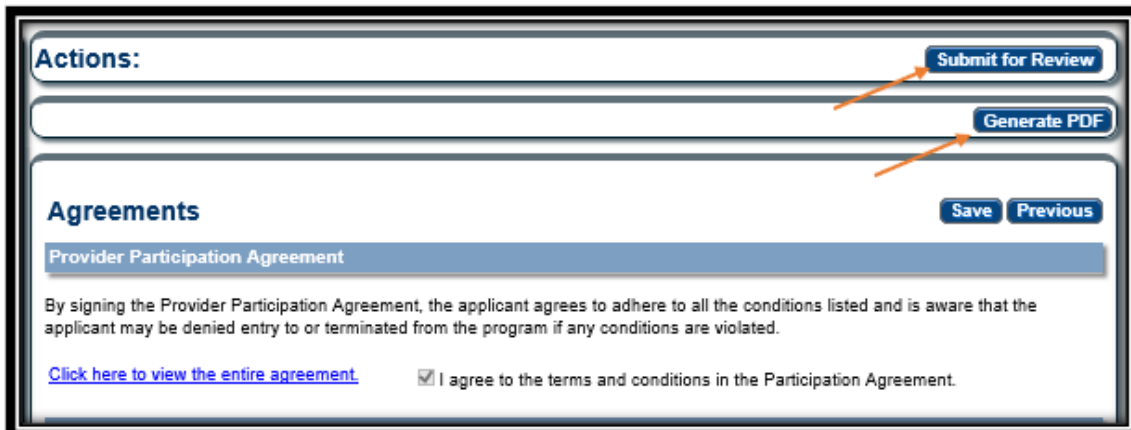


Click **OK**.

## 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.



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.

