

# Nebraska Provider Screening and Enrollment

## Home Care Based Services (HCBS) Updates

### Updating Information for HCBS Providers

Note: If you do 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 updating an application for HCBS providers.

**All applications must be submitted for review when completed.**

Note: HCBS Provider Locations using an EIN are considered Agencies and must have a Type 2 NPI. HCBS Provider Locations using an SSN are considered Individual HCB Providers and must have a Type 1 NPI.

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.

### Accessing Your Provider Enrollment

Log into the Portal. See Account Creation for Instructions.

The provider name must be highlighted by selecting the Provider's **NAME**.

Click **Update Services Registration** to update enrollment information.

**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
[REDACTED]	Approved	HCBS		55752395	HCBS	68154 - 2046	12/14/15	12/14/15	12/14/20

[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](#)

**Provider Details**

Tracy Fortunato 68154 - 2046

**Registration Information**

Effective Date 12/14/2015  
Revalidation Due Date 12/14/2020  
Term Date  
Nebraska MLTC Status Active  
Application Status Approved  
Medicaid ID 55752395

**Manage Provider**

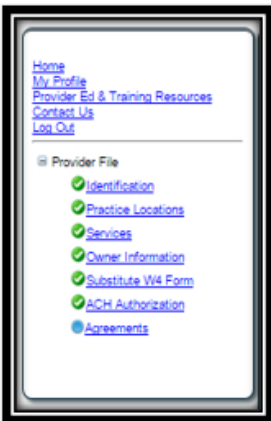
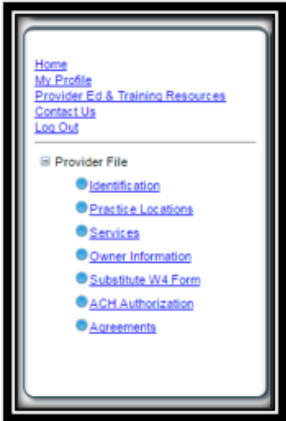
[View Provider File](#)  
[Update Services Registration](#)

This will take you to the application.

### Viewing the Provider Enrollment

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

On the Bottom left side of the page, 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

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 Effective Date column has an edit icon (pencil) and a delete icon (trash).
- Primary Contact Information:** A table with columns: Primary Contact Name, Title, Phone Number, and EmailAddress. The EmailAddress column has an edit icon (pencil) and a delete icon (trash).
- 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 the edit symbol. The following box will open:

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

- Entity Type:** Radio buttons for Individual (selected) and Organization.
- Citizenship Status:** Radio buttons for I am a Citizen of the United States (selected) and I am a qualified alien under the Federal Immigration and Nationality Act, my immigration status and alien number are as follows:.
- First Name\*:** Text input field.
- Middle Initial:** Text input field.
- Last Name\*:** Text input field.
- Tax ID\*:** Text input field with a help icon.
- Tax ID Type:** Dropdown menu set to SSN with a help icon.
- Gender\*:** Radio buttons for Female (selected), Male, and Unknown.
- Date of Birth\*:** Text input field with value 5/29/1980.
- Date of Death:** Text input field.
- Provider Type\*:** Dropdown menu set to HCBS with a help icon.
- Effective Date\*:** Text input field with value 06/14/2010.
- Revalidation Date:** Text input field with value 05/31/2016.
- Enrollment Status:** Text input field with value Not Set Yet.

Buttons: Save, Cancel

Individuals must select the appropriate citizen status, 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" for a "Provider". The form contains the following fields and values:

- Name\***: Jane Doe
- Title\***: Credentialist
- Street Address\***: 1234 W Main Street
- City\***: Lincoln
- State\***: Nebraska (dropdown menu)
- Zip\***: 68522
- Ext Zip\***: 1234
- Phone Number\***: (402) 555-5555
- Phone Extension**: (empty)
- Fax Number**: ( ) - (empty)
- 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**.

On the Identification page you will not be required to upload any documents unless you are requesting a retro effective date.

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

## License and Clasifications Page on Some HCBS Registrations

**Licenses & Classifications** Save Previous Next

Provider Type: HCBS

**CPR and First Aid**

No CPR and First Aid found +

**TBI Training**

I certify that I have completed TBI Training. A TBI Training Verification has been uploaded

**Education and Training**

Abuse, Neglect, and Exploitation and State Law Reporting is required to provide services. Verification requirements include a Certificate of completion or Training verification through previous employer.

Complete professional experience, life experience, or a combination of education, professional, and life experience as a qualification for habilitation service provision.

**A total of four years of education, professional, or life experience (or any combination thereof) is required, unless applicant possesses a Bachelor's Degree in an acceptable field.**  
Certified Transcripts must be uploaded if using any education as a qualification.

**Training**

I certify that I have completed the Abuse, Neglect, and Exploitation and State Law Reporting training. A Certificate of completion or Training Verification thru a previous employer will be uploaded.

**Education**

No Education Details Found +

**Professional Experience**

Please list all relevant experience. Experience may be used in lieu of or in combination with education equaling 4 or more years. A minimum of 15 hours per week constitutes employment. Volunteer positions such as Sunday School Teachers, 4-H or Scout leaders, etc. can also be applied in this sections.

No Professional Experience Details Found +

**Life Experience**

Please describe any meaningful, relevant life experience in teaching or supporting individuals with disabilities. Descriptions of life experience may include 1:1 interactions or regular interactions in a group setting (school club, family friend, family member, etc.). Include number of years for each life experience listed.

No Life Experience Details Found +

This page is displayed based on specific service requirements. Fill out all required information. Ensure all certifications are current.

- **License** – Issued by DHHS and should be current
- **CPR and First Aid** - Must be from an approved source. CPR must include hands on skills assessment. They do not have to be from the same course or source
- **Abuse and Neglect Training** - Must be from an approved source. You can also complete the free [DHHS Abuse and Neglect Training Online](#) and upload the certification. The certification does not expire.
- **Education, Life and or Work Experience** - It must total 4 years or 48 months of experience.
  1. **Education** (no degree required, based on credits on an official transcript with classes in psychology, social work, sociology, human services, or related field. Copy of Certified Transcripts required, 8 credits = 1 year
  2. **Work Experience** in a related industry (can include volunteer work)
  3. **Life Experience** must be related to Developmental Disability (can include volunteer experience)
- **TBI Training** can complete the [DHHS Training](#) and upload the Certification. Does not expire

- **Driver's License** information is not required on this page, but you may be required to supply this if you have an out of state address. If you are Out of State College Student in Nebraska, you may have to supply your driver's license and a copy of you student ID. You will receive notification if this is required or you can upload it now.

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

## Practice Locations Page

The screenshot shows the 'Practice Locations' page. On the left is a sidebar with navigation links: Home, My Profile, Provider Ed & Training Resources, Contact Us, and Log Out. Below these is a 'Provider File' section with links for Identification, Practice Locations, 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 several sections: 'Provider Physical Address' with a table containing '1234 W Main Street', 'Lincoln', 'NE', '68801', and '7470'; 'Billing / Payment Contact Information' with an empty table; 'Correspondence Information' with an empty table including a 'Phone Number' column; and 'Uploaded Documents' with a table showing 'No uploaded documents found' and a file upload area with 'Name' and 'Description' fields and an 'Upload file' button. Orange arrows point to the 'Save', 'Previous', 'Next' buttons at the top and bottom right, and the 'Upload file' button.

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. If you provide services in a client's home **do not enter the client's address**. Enter the address of your Individual Primary Residence or Agency address. Ensure this phone number is current.

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 HCBS Provider Management Home Resource if a Key Provider Identifier is incorrect, including the Zip Code.

### Billing/Payment Contact Information

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

**Edit Correspondence Information**

Same as Practice Location

Address\* 1234 W Main Street

Address Line 2

Address Line 3

City\* Lincoln

State\* Nebraska

Zip\* 68801

Zip Ext\* 7470

Phone Number\* (402) 555-5555

Save Cancel

Complete All required fields, confirm all information is correct, and select **Save**. Ensure this phone number is current.

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

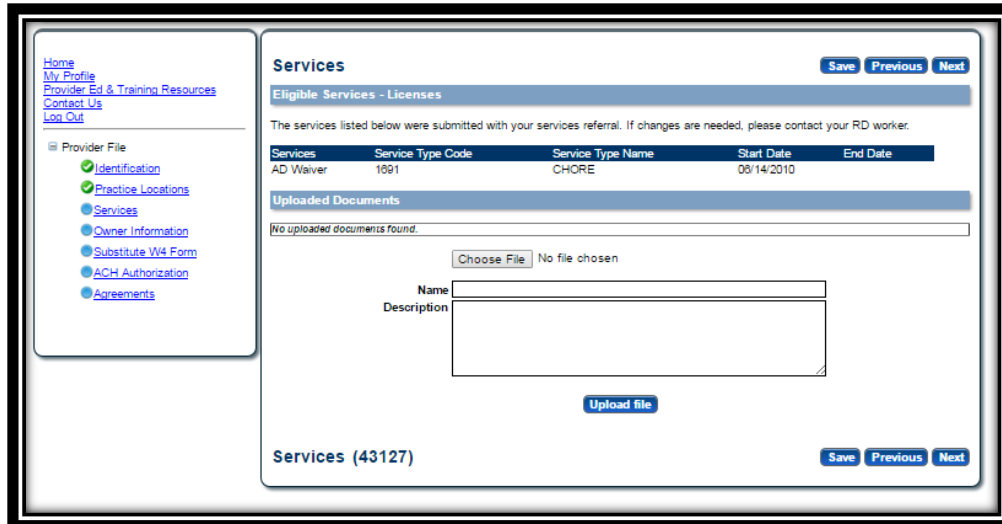
ADA Compliant  
 No  Yes

Telehealth  
 No  Yes

Provider Website

## Services Page

The Program Service Code(s) that the provider is authorized to provide will be present on this page. No action is required. Select **Next**.



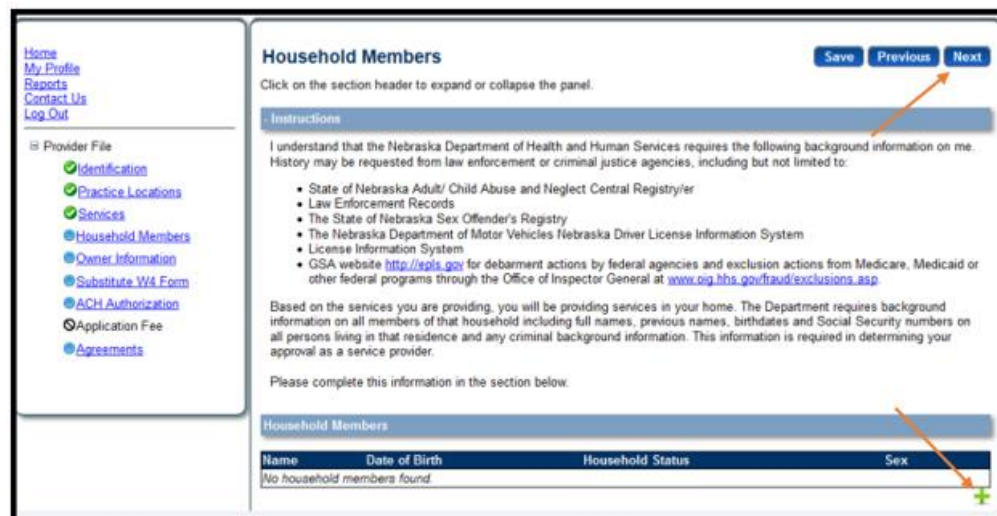
You will not be required to upload any documents on the Services page.

## Household Members Page

NOT ALL PROVIDERS WILL HAVE THIS PAGE.

Some INDIVIDUAL HCBS providers are required to list Household Members living in their home. You do not have to list the provider. You do not need to list the client if you only have one client in the home. If more than one client is in the home, you must list all clients that are 13 years of age or older.

List ALL other people that live at the Provider's Physical Address by selecting **ADD**.



Select **Add** or **Edit** to make necessary changes to household members.

When all Household Members have been entered click **Next**.

You will not be required to upload any documents on the Household Members page.

## Ownership and Controlling Interest and Conviction Disclosure Page

Expand the "Owner Information" section by clicking on the small white plus or minus as needed.

### 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.

Notes: Individual HCBS will list themselves as the owner at 100%.

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. 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."

Other sections are optional. Use your own discretion. You will not be required to upload any documents on the Ownership and Controlling Interest page.

## Substitute W4 or W9 Form

**Individuals** will have a Substitute W4 Form.

Fill out all Applicable fields. Marital Status and Allowances are required. Contact your Resource Development worker If you have questions about withholdings.

Click **Next**.

### Substitute W4 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 [REDACTED]  
 Tax ID [REDACTED]  
 DBA

\*\*Please visit <http://www.irs.gov> to obtain a copy of the W4 with instructions.

Marital Status Married

Note: If married, but legally separated, or spouse is a nonresident alien, select "Single".

If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.

Total number of allowances you are claiming 2

Additional amount, if any, you want withheld from each paycheck \_\_\_\_\_

I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption.

- Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and
- This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, indicate "Exempt" here.  Exempt

**Organizations/Agencies** will complete a Substitute W9 Form.

Select the appropriate Tax Classification and Profit Status.

Click **Next**.

### Substitute W9 Form

Save Take Action 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 Wendy Andorf-Blum

\*\*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

You will not be required to upload any documents on the Substitute W4 or W9 page.

# ACH Authorization Page

Select your payment method.

The screenshot shows the 'ACH Authorization' page. On the left is a navigation menu with links for Home, My Profile, Provider Ed & Training Resources, Contact Us, and Log Out. Below this is a 'Provider File' section with links for Identification, Practice Locations, Services, Owner Information, Substitute W4 Form, ACH Authorization (highlighted), and Agreements. The main content area is titled 'ACH Authorization' and contains a 'Please mark your choice:' section with radio buttons for 'Direct Deposit' and 'ReliaCard'. Below this is an 'Uploaded Documents' section with a 'Choose File' button and a table for listing documents. At the bottom right, there are 'Save', 'Previous', and 'Next' buttons. An orange arrow points to the 'Direct Deposit' radio button.

## Direct Deposit

If you select Direct Deposits: Only select the Check Box in the Direct Deposit section if your bank is outside the United States.

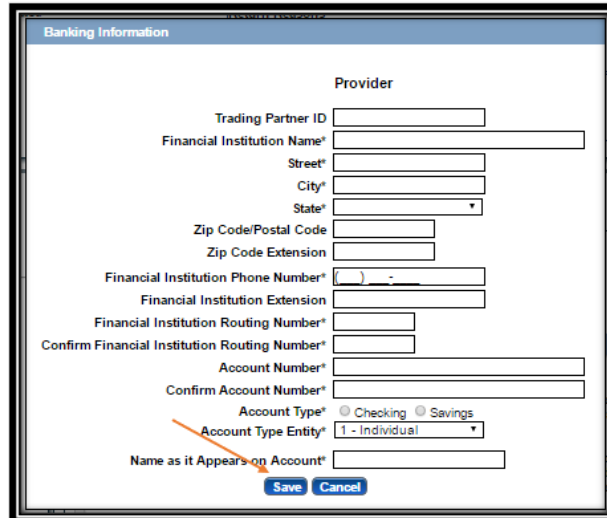
The screenshot shows the 'ACH Authorization' page with the 'Banking Information' section. It includes a table with the following data:

Financial Institution Name	City	Account Number	Account Type
US BANK	Lincoln	*****9**	Checking

Below the table is a 'Confirm' section with a checkbox for 'confirm the information provided is true and accurate.' which is checked. An orange arrow points to this checkbox. There are also 'Save', 'Previous', and 'Next' buttons at the top right of the page.

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

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

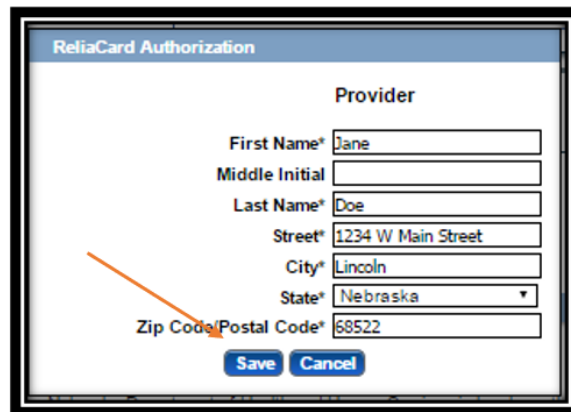


The image shows a screenshot of a web form titled "Banking Information". The form is divided into a "Provider" section and an "Account" section. The "Provider" section includes fields for Trading Partner ID, Financial Institution Name\*, Street\*, City\*, State\* (a dropdown menu), Zip Code/Postal Code, Zip Code Extension, Financial Institution Phone Number\* (with a format ( ) - -), Financial Institution Extension, Financial Institution Routing Number\*, and Confirm Financial Institution Routing Number\*. The "Account" section includes fields for Account Number\*, Confirm Account Number\*, Account Type\* (with radio buttons for Checking and Savings), Account Type Entity\* (a dropdown menu showing "1 - Individual"), and Name as it Appears on Account\*. At the bottom of the form are "Save" and "Cancel" buttons. An orange arrow points to the "Name as it Appears on Account\*" field.

## ReliaCard

If you select ReliaCard: Click Add to enter the ReliaCard Authorization information.

Complete all required fields and click **Save**.



The image shows a screenshot of a web form titled "ReliaCard Authorization". The form is divided into a "Provider" section. The "Provider" section includes fields for First Name\* (filled with "Jane"), Middle Initial, Last Name\* (filled with "Doe"), Street\* (filled with "1234 W Main Street"), City\* (filled with "Lincoln"), State\* (a dropdown menu showing "Nebraska"), and Zip Code/Postal Code\* (filled with "68522"). At the bottom of the form are "Save" and "Cancel" buttons. An orange arrow points to the "Zip Code/Postal Code\*" field.

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” boxes.

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 the conditions 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 entire agreement.](#)  I agree to the terms and conditions 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 entire agreement.](#)  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.

**United States Citizenship Attestation**

By checking 'I accept' I certify that I have read the US Citizenship 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 entire agreement.](#)  I attest that my response and the information provided regarding my status as either a United States citizen or a qualified alien under the federal Immigration and Nationality Act and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

**Provider Release of Information Felony/Misdemeanor Statement**

I agree that information provided can be used to obtain information to complete background checks which are required for approval as a provider. Form MC-199 is used to obtain information to complete background checks which are required for approval as a provider. This form is used to allow potential and renewing providers and/or their employees to self-disclose any current charges, pending indictments or any convictions they have had. Individual providers must complete the form every 12 months before their provider service agreement may be signed or renewed. For providers who provide the service in their home, each household member must also complete the form at the same time. Assisted Living providers must have each employee complete this form annually.

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.

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:

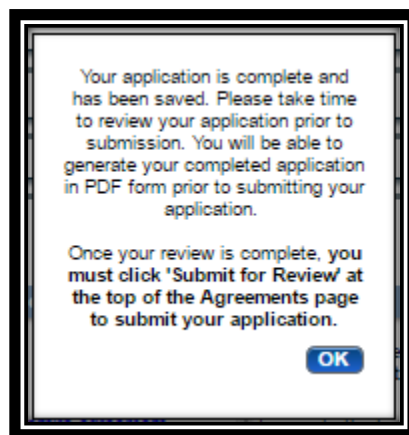
The password requested is your user login password.

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

Note: characters are not case sensitive.

Enter the password used to log into the portal 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 and submit all changes.

**Actions:**

[Submit for Review](#) [Generate PDF](#)

**Agreements** [Save](#) [Previous](#)

**Provider Participation Agreement**

By signing the Provider Participation Agreement, the applicant agrees to adhere to all the conditions 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 entire agreement.](#)  I agree to the terms and conditions in the Participation Agreement.

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.

[Home](#)  
[My Profile](#)  
[Provider Ed & Training Resources](#)  
[Contact Us](#)  
[Log Out](#)

**Submission Confirmation**

You have successfully submitted your registration to Nebraska Medicaid.  
Please allow at least 10 days for processing before attempting to submit any changes.

[Return to Home Page](#)