Nebraska Provider Screening and Enrollment

<u>Groups</u>

<u>Revalidations</u> for Existing Groups

Note: If the group does not have a username and password, see the appropriate Account Creation Instructions.

The steps below will guide you through filling out or updating an application for Groups and adding Group Members.

See Step 5: Individual Providers to Add and Confirm Group Members or the Adding a Group Member to a Group instructions

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

Symbols to watch for:

 <u>Edit</u>

 <u>Required</u>

 <u>Add</u>

 <u>Key Provider Identifier</u>

 <u>Delete</u>
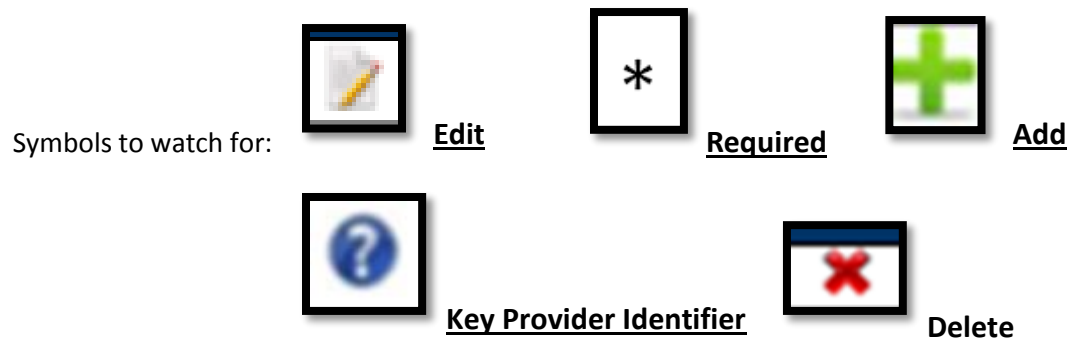
1. Select the appropriate action:

   o If this location needs to update information select the name of the location under "My Providers". Select Continue or Update in the Mange Provider section of the Provider Management Home Screen. Go to step 2.

   o If this is an existing, converted location click on **Manage** in the "Other providers with the same TaxID" section on the appropriate location. This should be done instead of creating a New Provider Location.

- o   Confirm all Information and complete all Required Fields.
  - ➢ All information will be specific to this location. (Provider Type, Specialty, Taxonomy, Name, Business EIN, Organizational NPI, Zip and Zip Extension)

- o   Click **Save**.

This will take you to the application.

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.

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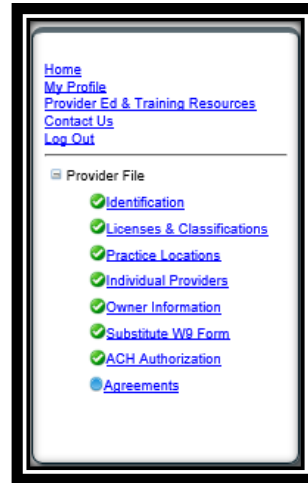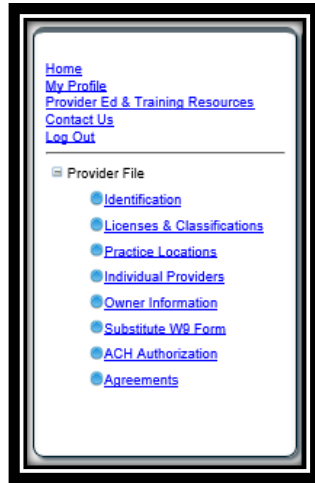
On the Bottom left side of the application you will see a list of all of the pages you need to complete. Each blue bullet point will change to a green checkmark when it is completed.

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

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

o   Complete all required fields and select **Save**.

On the Identification page you will not be required to upload any documents.

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

3. Licenses & Classifications:
    o   The Specialties and Taxonomies are listed in this section and cannot be changed. You
        may add a secondary Specialty by clicking **Add**.
    o   If applicable, in the **Miscellaneous** section select **Add** or **Edit** to enter or confirm the
        Medicare Enrollment information and Other State Medicaid Enrollment Information. If
        the provider is a Billing Provider for Medicare or any other state Medicaid you need to
        fill out this section.

On the Licenses & Classifications page you will not be required to upload any documents.

    o   Click **Next** to proceed to the next page.
4. Practice Locations:

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

- o Provider Physical Address: This is the actual physical address where services are provided.
    - ➢ Click the edit symbol.
    - ➢ The following box will open:

    - ➢ 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.

- o Billing / Payment Contact Information:
    - ➢ Click the **Add** or **Edit**.
    - ➢ The following box will open:

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

- o Correspondence Information: This is where general communication materials will be sent.
    - ➢ Click the **Add** or **Edit**.
    - ➢ 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.

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

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

5. Individual Providers:

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		
Jane Doe	*****4555	1254889999	4/20/2016				Member Profile not 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**

o Click **Add** to add group members to this group.
   ➢The following box will open:

Add Group Member

First Name*		Last Name*	
NPI		Tax ID*	
Start Date*	4/20/2016 What is this?		
Provider Type*			

Save **Cancel**

- o Enter the Group Member's information.
  - ➢ The Tax ID MUST be the Group Member's Individual SSN. The NPI is the Group Member's Individual NPI.
    - ➢ All of this information must match the Group Member's Profile. See the appropriate Group Member Profile resource.
  - ➢ Pay close attention to the start date listed.
    - ➢ If you request a retro start date, a document must be uploaded on the Individual Provider's page explain why this is being requested.
- o Click **Save**.
- o Confirm Group Member if the individual provider has an active group member profile.
  - ➢ Confirm by selecting **Edit**. The system will automatically move to the next step if the provider has a current Group Member Profile.
- o Complete all required fields and answer all questions.
  - ➢ Click **Confirm Association**.

  If the provider needs to be terminated from the group, enter an End Date and End Association.

Affiliation Status Definitions can be found on the Individual Providers Associated with Your Group page.

- o   For large group, use the search option to locate the group member.
  - ➢ Enter information into at least one field and click "Search Associated Providers".

- o   You are required to upload a letter with an explanation for EACH provider this is requesting a retro start date.

Uploaded Documents

No uploaded documents found.

Browse...   No file selected.

Name [   ]
Description [   ]

Upload file

6. Ownership/Controlling Interest and Conviction Disclosure:
    o 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

+ Additional Addresses

+ Questions

Uploaded Documents

No uploaded documents found.

Choose File   No file chosen

Name [   ]
Description [   ]

Upload file

Ownership/Controlling Interest Info (43127)   Save Previous Next

    o Complete the Ownership Information by selecting **Add** or **Edit**.

- o Make all necessary changes and select **Save**.
  - ➢ It is common to have multiple owners and managing employees.
- o Complete the Additional Addresses section if necessary.

- o 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.

7. Substitute W9 Form:
    - o Groups will complete a Substitute W9 Form.
        - ➢ Select the appropriate Tax Classification and Profit Status.
        - ➢ Click **Next**.

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 A New Beginning Chiropractic & Acupuncture

**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 W9 page.

8. ACH Authorization:
   o Only select the Check Box in the Direct Deposit section if you bank is outside the United States. Medicaid will not provide any payment to any financial institution or entity located outside the United States.

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.

☐ 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	
▮▮▮▮▮▮	Lincoln	▮▮▮▮▮▮	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.

- o Click **Add** or **Edit** to enter your checking or saving information for deposits. Complete all required fields and click **Save**.
- o Please check your data entry to ensure there are no errors. You want to make sure that your payments go to the correct account. Needing to correct this information will cause a delay with payments.

- o 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.

9. Agreements:
   - o Click on "Click here to view the entire agreement". A separate tab will show on your web browser that contains each agreement. Read the information. You are responsible for following all of the regulations and will be held accountable for them.
   - o Place a checkmark in the "I agree' or "I attest" box.
     Note: The check box is only accessible after clicking the web link.

o   Answer all of the questions on the Agreements page. You are required to answer all of the questions truthfully. Failure to answer these questions completely and accurately may lead to denial, termination, and administrative, civil, or criminal action.

o   In the Signature section, enter the characters in the image
    Note: characters are not case sensitive.
o   Enter the password used to log into the portal and click **Save**.

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

Your application is complete and
has been saved. Please take time
to review your application prior to
submission. You will be able to
generate your completed application
in PDF form prior to submitting your
application.

Once your review is complete, you
must click 'Submit for Review' at
the top of the Agreements page
to submit your application.

OK
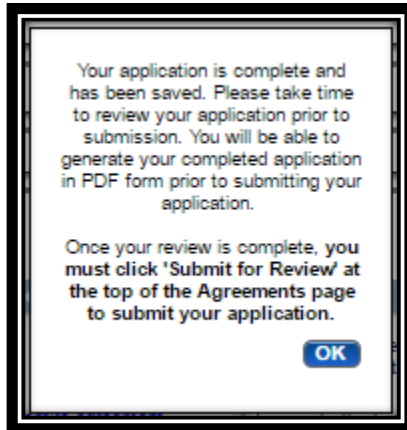
○ Click **OK**.
○ Click "**Generate a PDF**" if you wish to save or print a PDF of the application. This is your only opportunity to save or print a PDF.
○ You MUST hit "**Submit for Review**" to successfully complete the application process.

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:

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