

Nebraska Provider Screening and Enrollment






Home Care Based Services (HCBS)

Updating Information

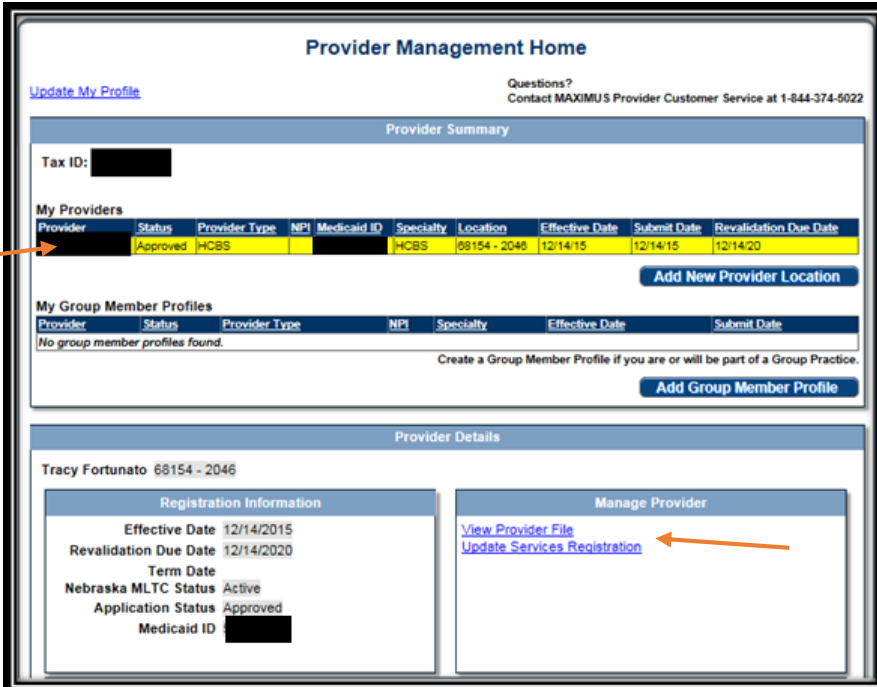
<https://www.nebraskamedicaidproviderenrollment.com>

The steps below will guide you through updating information for HCBS providers.
All applications must be submitted for review when completed.

Symbols to watch for:

	Edit		Required		Add
	Key Provider Identifier		Delete		

1. Log into the Portal. See Account Creation for Instructions.
2. The provider name must be highlighted by selecting the Provider's **NAME**.
 1. 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	[REDACTED]	[REDACTED]	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

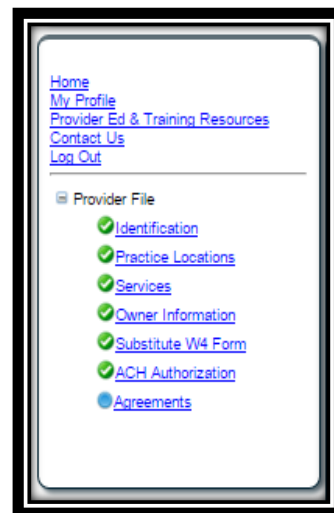
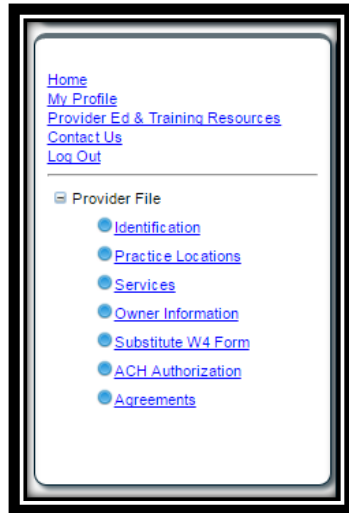
Tracy Fortunato 68154 - 2046

<p>Registration Information</p> <p>Effective Date 12/14/2015 Revalidation Due Date 12/14/2020 Term Date Nebraska MLTC Status Active Application Status Approved Medicaid ID [REDACTED]</p>	<p>Manage Provider</p> <p>View Provider File Update Services Registration</p>
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➤ 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 HCBS Provider Management Home Resource.

➤ On the Bottom left side of the page 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.



3. Identification:

The screenshot shows the "Identification" form. At the top right, there are "Save" and "Next" buttons. The form is divided into three main sections: "Provider Information", "Primary Contact Information", and "Uploaded Documents".

Provider Information

Legal Name	DBA NPI	Tax ID	Provider Type	Effective Date
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

Primary Contact Information

Primary Contact Name	Title	Phone Number	EmailAddress
[Redacted]	[Redacted]	[Redacted]	[Redacted]

Uploaded Documents

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

Below the table is a "Browse..." button. Underneath, there are input fields for "Name" and "Description". At the bottom of the form is an "Upload file" button.

Orange arrows in the image point to the "Save Next" buttons, the delete icons in the Provider and Primary Contact tables, and the "Browse..." button.

1. Complete the Provider Information section by selecting the edit symbol. The following box will open:

Provider Information

Entity Type Individual Organization

Citizenship Status I am a Citizen of the United States
 I am a qualified alien under the Federal Immigration and Nationality Act, my immigration status and alien number are as follows:

First Name* [Redacted]

Middle Initial [Redacted]

Last Name* [Redacted]

Tax ID* [Redacted] ?

Tax ID Type ?

Gender* Female Male Unknown

Date of Birth*

Date of Death

Provider Type* ?

Effective Date*

Revalidation Date

Enrollment Status

2. Select the appropriate citizen status, complete all required fields, ensure all the information is correct and select **Save**.
 - If you are a qualified alien under the Federal Immigration and Nationality Act, select the applicable immigration Status and prove your alien number.
 - See the HCBS Provider Management Home Resource if a Key Provider Identifier is incorrect.
3. Primary Contact Information. On the Identification page, select 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.

Street Address*

City*

State*

Zip*

Ext Zip*

Phone Number*

Phone Extension

Fax Number

Email Address*

4. Ensure all of the information is correct and select **Save**.

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

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

4. Practice Locations:

Practice Locations Save Previous Next

Provider Physical Address

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
			Omaha	NE	68154	2046	

Billing / Payment Contact Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
			Omaha	NE	68154	2046	

Correspondence Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	Phone Number	
			Omaha	NE	68154	2046		

Uploaded Documents

No uploaded documents found.

Browse...

Name

Description

Upload file

Practice Locations (55782) Save Previous Next

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

Note: If you provide services in a client's home **do not enter the client's address**. Enter the address of your primary residence.

1. Provider Physical Address:
 - 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.

2. Correspondence Information:

- Click the 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.

3. Correspondence Information:

- Click the edit symbol.
- The following box will open:

➤ 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.

4. Select **Next** to proceed to the next page.
5. Services:
 1. The Program Services Code(s) the provider is authorized to provide will be present on this page. No action is required.

2. Select **Next**.

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

6. Household Members: NOT ALL PROVIDERS WILL HAVE THIS PAGE.
 1. Some HCBS providers are required to list Household Members living in their home. You do not have to list the provider (yourself) or the client. List or confirm ALL other people that live at the Provider's Physical Address.

2. Select **Add** or **Edit** to make necessary changes to household members.
3. When all Household Members have been entered click **Next**.

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

7. Ownership/Controlling Interest and Conviction Disclosure:

1. Expand the "Owner Information" section by clicking on the small white plus.

2. Select **Add** or **Edit** to make necessary changes.
Note: Most 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

3. Select **Save**.
4. Complete the Additional Addresses section if necessary.

- 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

Uploaded Documents

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

No file chosen

Name

Description

Ownership/Controlling Interest Info (43127)

5. 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.

8. Substitute W4 Form or W9 Form:

1. Individuals will have a Substitute W4 Form.

- Fill out all Applicable fields. Marital Status and Allowances are required.
- 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

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

2. Organizations will complete a Substitute W9 Form.

- Confirm 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.

9. ACH Authorization:
 1. Select your payment method.

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

Provider File

- [Identification](#)
- [Practice Locations](#)
- [Services](#)
- [Owner Information](#)
- [Substitute W4 Form](#)
- [ACH Authorization](#)
- [Agreements](#)

ACH Authorization

Save Previous Next

Please mark your choice:

- Direct Deposit
- ReliaCard

Uploaded Documents

No uploaded documents found.

Choose File No file chosen

Name

Description

[Upload file](#)

ACH Authorization (43127)

Save Previous Next

- If you select Direct Deposit:
 - Only select the Check Box in the Direct Deposit section if you bank is outside the United State.

ACH Authorization Save Take Action 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
			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 confirm or change your checking or saving information for deposits. Complete all required fields and click **Save**.
- Select “I confirm the information provided is true and accurate” and click **Next**.

- If you select ReliaCard:
 - Click **ADD** or **EDIT** to confirm the ReliaCard Authorization information.
 - Complete all required fields and click **Save**.

- 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.

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.

Uploaded Documents

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

No file chosen

Name

Description

ACH Authorization (43127)

10. Agreements:

1. Click on each “Click here to view the entire agreement”. A separate tab will show on your web browser that contains each agreement.
2. If you agree with the contents of the agreement, place a checkmark in the “I agree’ or “I attest” box.
Note: The check box is only accessible after clicking the web link.
3. Place a checkmark in the Provider Release of Information section.

Agreements

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 MIC-100 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.

4. Answer all of 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



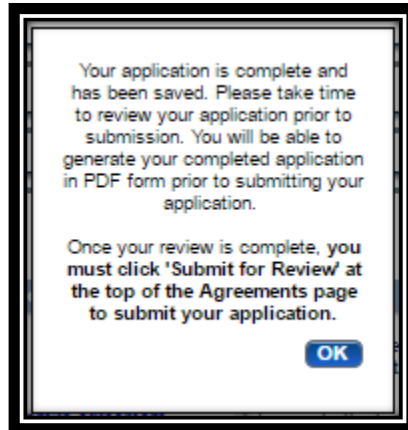
Please enter the characters in the image above:

Enter password:

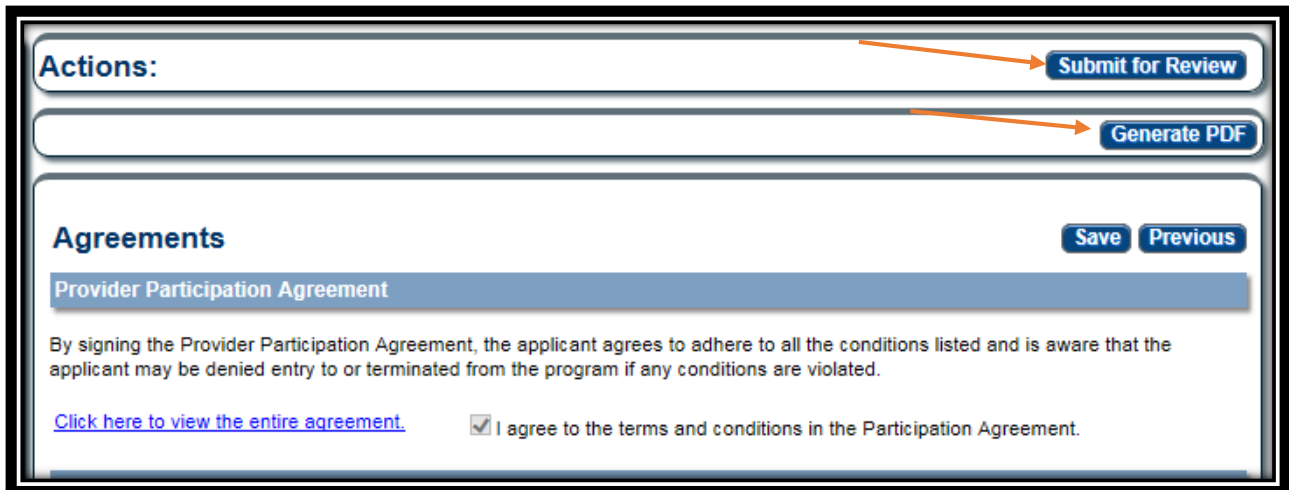
The password requested is your user login password.

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

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



8. Click **OK**.
11. Click "**Generate a PDF**" if you wish to save or print a PDF of the application.
12. You MUST hit "**Submit for Review**" to successfully complete the application process and submit all changes.



13. When finished the following screen will be displayed:

