NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Medicaid Provider Disenrollment Form

Nebraska Provider Screening and Enrollment
P.O. Box 81890 Lincoln, Nebraska 68501-1890
Fax: 844-374-5026
Email: NebraskaMedicaidPSE@MAXIMUS.com

To officially request disenrollment of your entire provider agreement or select service(s), please fill out this form and mail, fax, or email to Nebraska Provider Screening and Enrollment.

Today's Date: _____

Provider Name: _____

Medicaid ID: _____

NPI (if applicable): _____

Requested Disenrollment Date: _____

Select One:

- ☐ Disenroll Provider Agreement with Medicaid ID listed above (For Home and Community Based Services (HCBS) providers this will include all services)
- ☐ Close only specific service(s) (Home and Community Based Services (HCBS) provider only). This will not close the Provider Agreement.
  Must list all services to be closed.

Please specify service, service type code, and service name:

Reason for Disenrollment:

I have verified that this Medicaid Provider ID is not currently receiving payments, has not received any payments for services performed after the requested disenrollment date, and understand that payments will not be made to this Medicaid Provider ID for services performed after the requested disenrollment date. I understand if I am an HCBS provider the same applies to closed service codes.

_____ Provider or Authorized Staff Signature

_____ Email Address

_____ Provider or Authorized Staff Name

_____ Phone Number