

Nebraska Provider Screening and Enrollment

Individual/Solo Practice

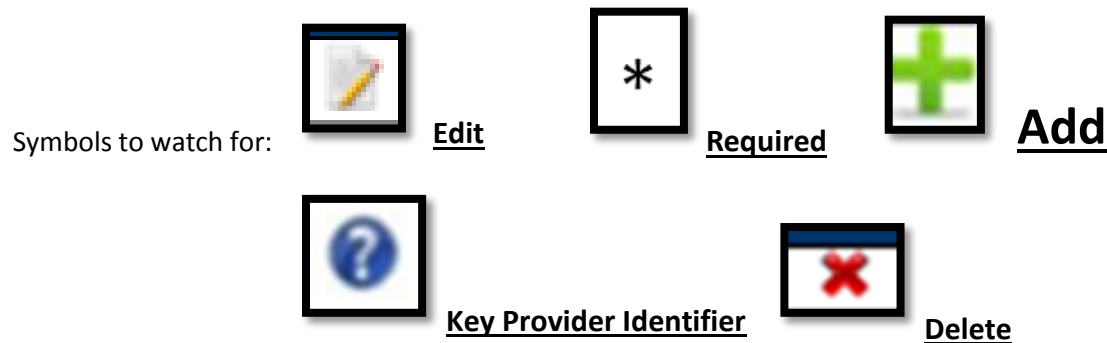
Enrollment and Revalidations

Note: If the Individual Provider's Tax ID 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 an Individual or Solo Practice.

NOTE: An Individual or Solo Practitioner can use their EIN or SSN but must use their Individual Type 1 NPI. If you must be enrolled with an Organization Type 2 NPI you will need to enroll as a group. See the Group Provider Ed and Training Resources.

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



1. Select the appropriate action:

- 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.
- If this is a new Solo Provider or a Solo Provider new to Medicaid select "**Add New Provider Location**".
- If this location needs to update information select the name of the location under "My Providers". Select Continue or Update in the Manage Provider section of the Provider Management Home Screen. Go to step 2.

It is possible for a Solo Provider to also be a group member of a separate group. This provider will have a Solo Provider Location and a Group Member Profile on the Provider Management Home Screen.

- Complete and confirm all Required Fields.
 - All information will be specific to this location. (Provider Type, Specialty, Taxonomy, Name, Business EIN, Organizational NPI, Zip and Zip Extension)
 - New Solo Providers need to pay close attention to the Requested Effective Date.

Provider Management Home

Questions?
Contact MAXIMUS Provider Customer Service at 1-844-374-5022

[Update My Profile](#)

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	68509 - 5026		[REDACTED] Manage

Select a provider to begin managing its registration.

New Registration

* Designates a required field

Category*

Provider Type*

Specialty*

Taxonomy*

First Name*

Middle Initial

Last Name*

Tax ID Type* EIN SSN

Tax ID*

NPI(if applicable)

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

Gender* Female Male Unknown

Date of Birth*

Zip Code*

Zip Code Extension* x

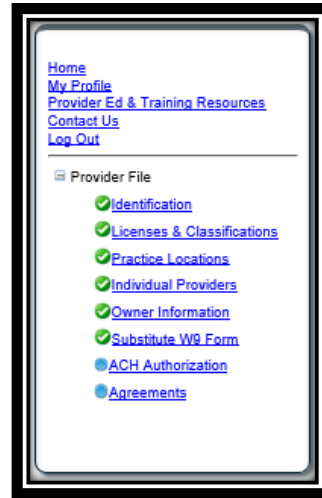
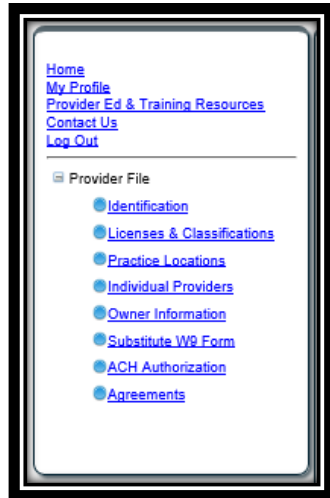
[Save](#) [Cancel](#)

- 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.

A screenshot of the 'Identification' form in the application. The form has a title bar with 'Save' and 'Next' buttons. It is divided into three main sections: 'Provider Information', 'Primary Contact Information', and 'Uploaded Documents'. The 'Provider Information' section contains a table with columns: Legal Name, DBA NPI, Tax ID, Provider Type, and Effective Date. The 'Primary Contact Information' section contains a table with columns: Primary Contact Name, Title, Phone Number, and EmailAddress. The 'Uploaded Documents' section has a table with columns: Name, Description, File Name, Page Name, and Username, and currently shows 'No uploaded documents found.' Below this is a 'Browse...' button and a form with 'Name' and 'Description' fields. At the bottom is an 'Upload file' button. Two orange arrows point to small edit icons in the top right corner of the 'Provider Information' and 'Primary Contact Information' tables.

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

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

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

On the Identification page you will not be required to upload any documents, unless a new solo provider requested a retro effective date.

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

3. Licenses & Classifications:

Licenses & Classifications Save Previous Next

Provider Type: Doctor Of Dental Surgery - Dentist (DDS)

Specialties and Taxonomies

Primary Specialty	Primary Taxonomy
General Practice	1223G0001X

No additional records found

Licenses

No licenses 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 not what is expected.
- Solo Providers must enter or update license information. Select the **Add** or **Edit** button to enter and confirm the 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. 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 only be required to upload a document if you have an out of state license.

- 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.

- Provider Physical Address: This is the actual physical address where services are 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 the Zip or Ext Zip is incorrect.

➤ **Billing / Payment Contact Information:** This is where EOB or similar information should be sent.

- Click the **Add** or **Edit**.
- 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:** 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.

- Select **Next** to proceed to the next page.
5. Ownership/Controlling Interest and Conviction Disclosure:
- 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

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

- 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. . All necessary owners and managing employees should be listed in this section.
- 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)

- 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.

6. Substitute W9 Form:

- Solo Providers are required to complete a Substitute W9 Form.

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 Jane Doe

**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

- Select the appropriate Tax Classification and Profit Status.
- Click **Next**.

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

7. ACH Authorization:

- Only select the Check Box in the Direct Deposit section if your bank is outside the United States. Nebraska 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
[REDACTED]	Lincoln	[REDACTED]	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. Complete all required fields and click **Save**.
- 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.

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*

Save **Cancel**

- 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.

8. Agreements:

- Click on each “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.
- Place a checkmark in the “I agree’ or “I attest” box.

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.

- 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.

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



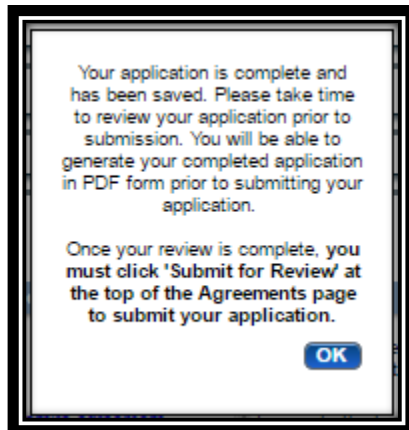
Please enter the characters in the image above: 

Enter password:

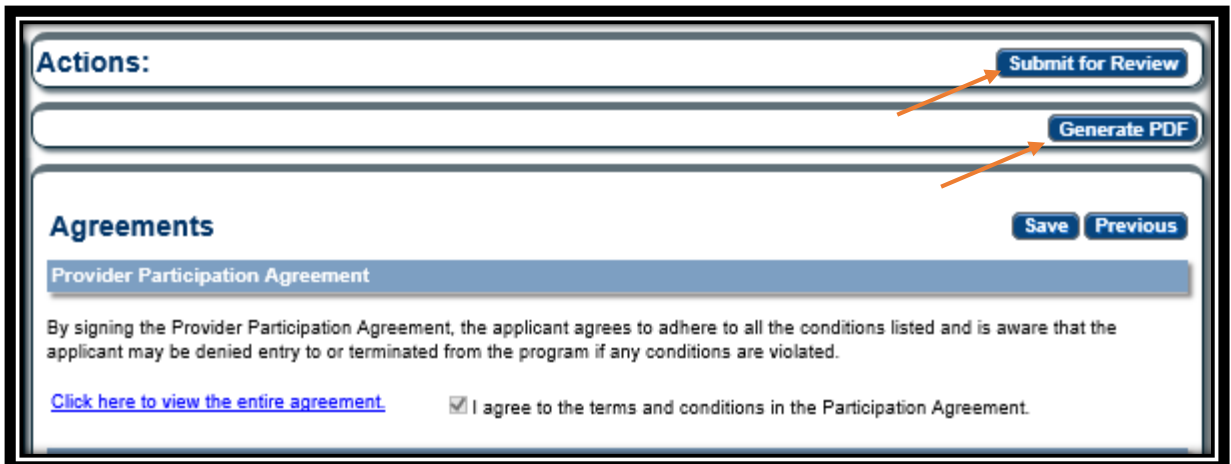
The password requested is your user login password.

- In the Signature section, enter the characters in the image
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**.
9. 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.
 10. You MUST click **"Submit for Review"** to successfully complete the application process.



11. When finished the following screen will be displayed:

