

Nebraska Provider Screening and Enrollment

Facility

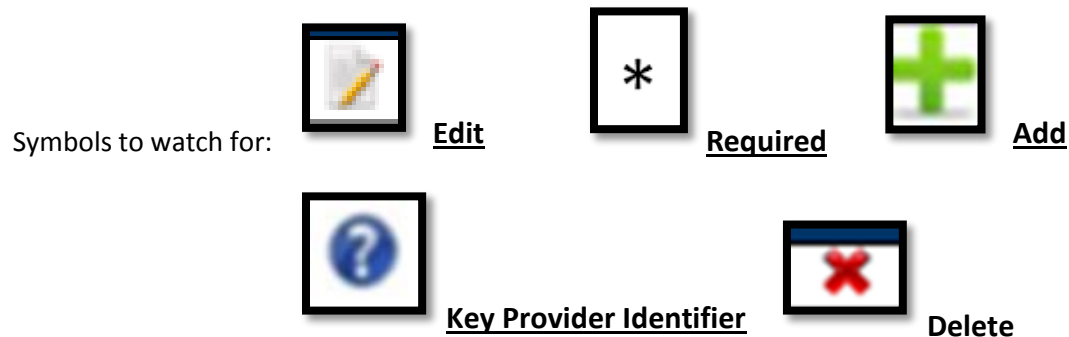
Enrollment and Revalidations

Note: If the Facility'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 a Facility.

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

Note: Individual Transportation Providers with Provider Type 61 (Transportation) and Specialty 96 (Individual Net) should enter their name as Last Name, First Name.



1. Select the appropriate action:
 - 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.
 - 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.
 - If this is a new Facility or a Facility new to Medicaid select "**Add New Provider Location**".
 - 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 Facilities 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*

Name of Business Entity*

Business Name as it appears on your IRS Assignment letter

Tax ID Type* EIN SSN

Tax ID*

NPI(if applicable)

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

Zip Code*

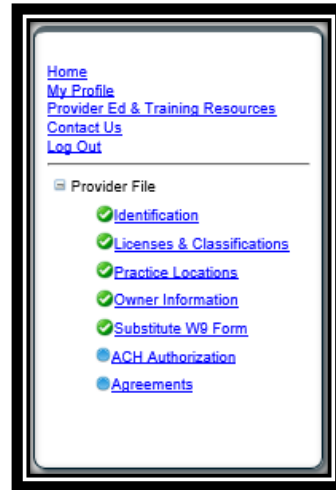
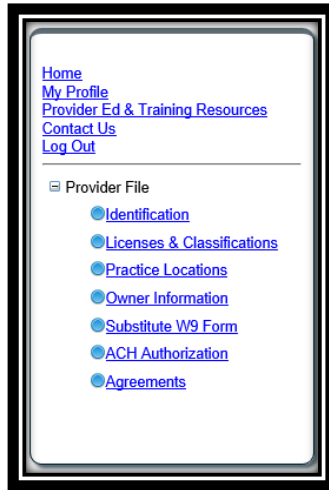
Zip Code Extension*

- 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 is titled 'Identification' and has 'Save' and 'Next' buttons in the top right corner. It is divided into three main sections: 'Provider Information', 'Primary Contact Information', and 'Uploaded Documents'.
1. 'Provider Information' section contains a table with columns: Legal Name, DBA NPI, Tax ID, Provider Type, and Effective Date. The 'Effective Date' column has a small yellow icon with a red arrow pointing to it.
2. 'Primary Contact Information' section contains a table with columns: Primary Contact Name, Title, Phone Number, and EmailAddress. The 'EmailAddress' column has a small yellow icon with a red arrow pointing to it.
3. 'Uploaded Documents' section contains a table with columns: Name, Description, File Name, Page Name, and Username. Below the table is a 'Browse...' button and a form with 'Name' and 'Description' fields. At the bottom of the form is an 'Upload file' button.

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

Provider Information

Name of Business Entity*

Business Name as it appears on your IRS assignment letter.

DBA

Tax ID* ?

NPI ?

NPI Start Date

NPI End Date

Provider Type* ?

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

Revalidation Date

Enrollment Status

- 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.
- Complete the Primary Contact Information on the Identification page, select **Add** or **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.

Title*

Street Address*

City*

State*

Zip*

Ext Zip*

Phone Number*

Phone Extension

Fax Number

Email Address*

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

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

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

3. Licenses & Classifications:

Licenses & Classifications

Save
Previous
Next

Provider Type: Hospitals (HOSP)

Specialties and Taxonomies

Primary Specialty	Primary Taxonomy
Hospitals (Defined By Department Of Social Services)	282E00000X

No additional records found

Number of Certified Beds

No beds 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.
- Facilities may also be required to enter the Number of Certified Beds. Select **Add** or **Edit** to enter and confirm the Number of Certified Beds.
- Facilities may also be required to enter or update license information. Select the **Add** or **Edit** button to enter and confirm the facilities 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 a Key Provider Identifier is incorrect.
- Billing / Payment Contact Information: This is where EOBs 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:

➤ 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.

- 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* Person

Name of Individual or Organization* Jane Doe

Birth Date* 05/29/1980

SSN* 123455678

Percentage of Ownership* 100

Title

Address* 1234 W Main Street

Suite/Dept/Floor

City* Lincoln

State* Nebraska

Zip* 68522

Ext Zip

Save Cancel

- 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:

- Facilities 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 Facility Name

Fiscal Year End

**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

- Enter the Facilities Fiscal Year End.
- 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 you 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

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 for deposits. 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.

- 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 “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.

- 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



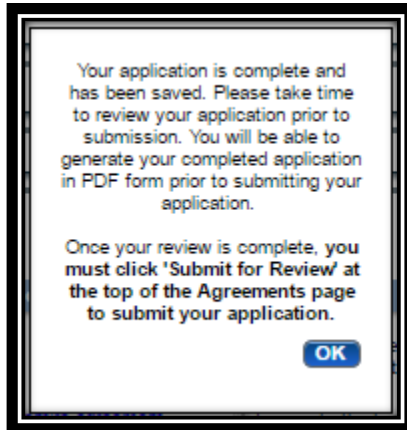
Please enter the characters in the image above:

Enter password:

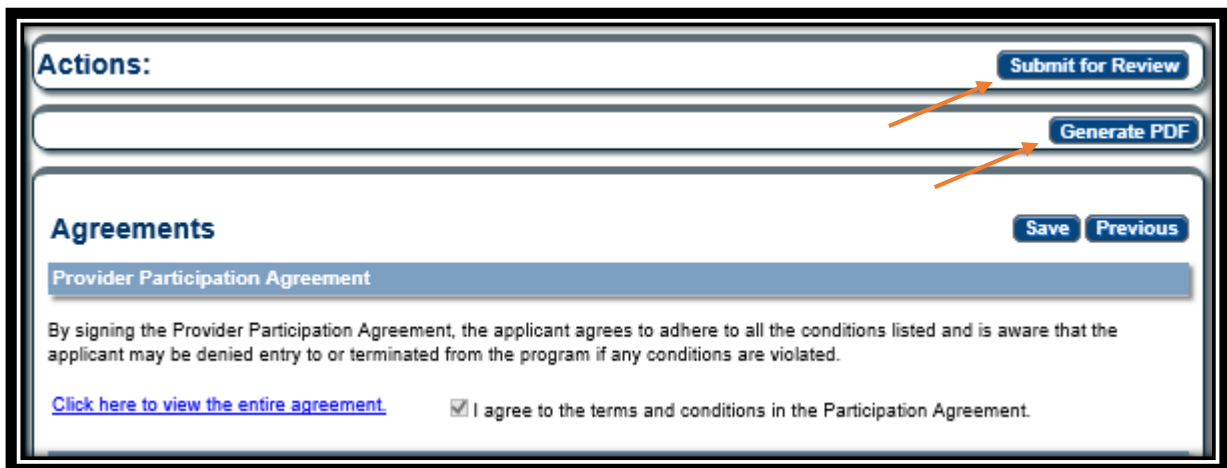
The password requested is your user login password.

- 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** hit **“Submit for Review”** to successfully complete the application process.



When finished the following screen will be displayed:

