

Nebraska Provider Screening and Enrollment

Home and Community Based Services (HCBS)

Individuals and Organizations

Web Portal Provider Enrollment Guide

For AD Waiver, CDD Waiver, PAS, DDAC Waiver, and TBI providers, program service authorization information must be entered in the Web Portal prior to enrollment, re-enrollment or revalidation. If you have any questions regarding Service Authorization contact your Resource Development Specialist.

Action Required: You must complete, sign and return an Adult Protective Services/Child Protected Services Release of Information (CFS-5) form to enroll, re-enroll, and prior to your annual service renewal date. Contact MAXIMUS Customer Service at 1-844-374-5022 or by email NebraskaMedicaidPSE@maximus.com to request a copy of the correct CFS-5 form or if you have any questions.

After Referral information has been entered or renewed in the Web Portal by a Nebraska Medicaid Resource Development specialist, you will receive a notification from MAXIMUS containing your Referral Number and a link to the Web Portal to complete your enrollment. You may also submit a paper application.

From: nebraskamedicaidPSE@maximus.com [mailto:nebraskamedicaidPSE@maximus.com]
Sent: Thursday, December 10, 2015 4:27 PM
To: provider@email.com
Subject: Referral NFOCUS-7911 Created

Name: Individual or Organization Name
Issue Date: 12-10-2015

Referral Number: NFOCUS-7911

Provider Name

We have received notice that you have met with your Resource Developer and have now been referred to MAXIMUS to complete your enrollment as a Medicaid provider. You must now access the Nebraska Provider Screening and Enrollment portal to create your user account and begin the enrollment process. No payment for services rendered will be made prior to notification from Maximus that you have been successfully enrolled as a Medicaid provider. You must have your referral number available to begin setting up your enrollment.

The Nebraska Provider Screening and Enrollment portal can be accessed at this link: <https://www.nebraskamedicaidproviderenrollment.com/Account/Login.aspx>

Regards,

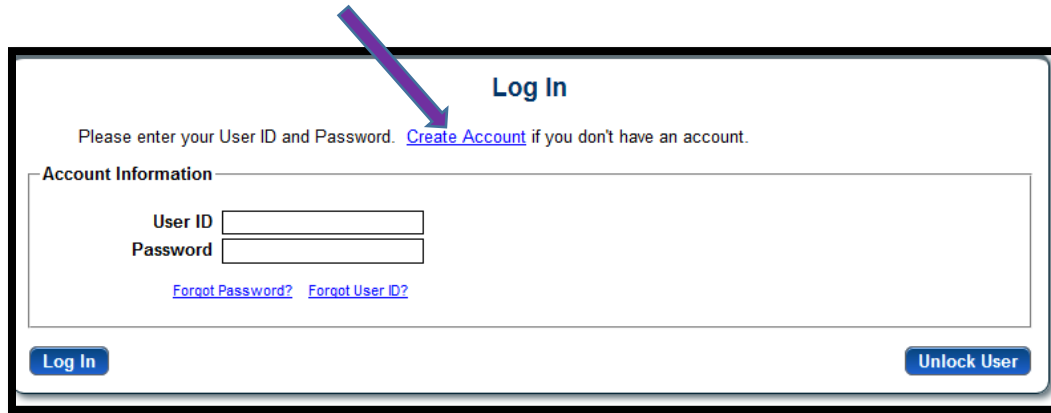
MAXIMUS Provider Screening and Enrollment Customer Service

- ❖ **You will need the Referral Number in the notification to complete your enrollment.**
- ❖ **The entire referral number, “NFOCUS” and the “-“(dash), and the number, must be entered exactly as it appears in the email notification you received. Ex: NFOCUS-6671 or NFOCUS6671**

Creating a User Account in the NE PSE Provider Web Portal

After clicking on the link in the email notification

1. Click on Create Account



Log In

Please enter your User ID and Password. [Create Account](#) if you don't have an account.

Account Information

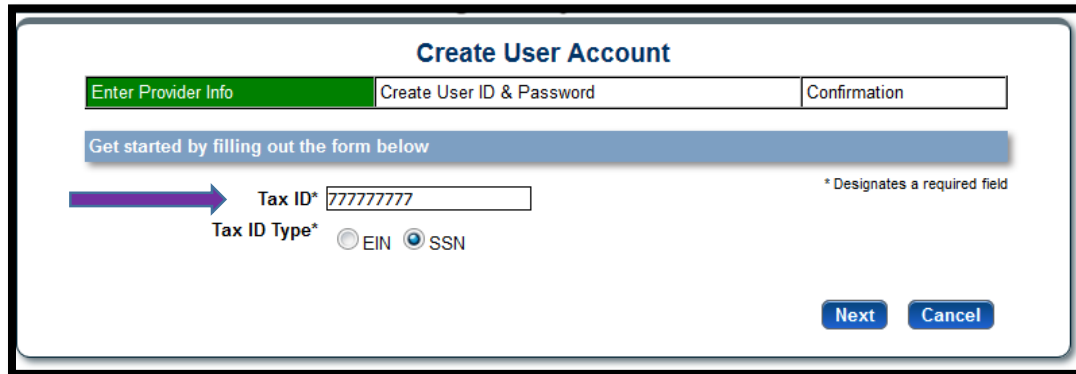
User ID

Password

[Forgot Password?](#) [Forgot User ID?](#)

Log In Unlock User

2. Enter your Tax ID – Either your Social Security Number (Individual) or EIN (Organization)
3. Select the correct Tax ID Type
4. Click Next



Create User Account

Enter Provider Info Create User ID & Password Confirmation

Get started by filling out the form below

Tax ID* * Designates a required field

Tax ID Type* EIN SSN

Next Cancel

Create User Account

5. Enter all required information – see example below
6. Click Register

Create User Account

Enter Provider Info **Create User ID & Password** Confirmation

Please enter your contact information

Contact Name* * Designates a required field
Title*
Phone Number*
Extension
Email Address*
Confirm Email*

Create your user id and password

User ID*
Password*
Confirm Password*

Answer your security question

Security Question*
Answer*
Security Question*
Answer*

After successfully creating your account a notification will appear on your screen.

A confirmation email will be sent to the email address you provided

Create User Account

Enter Provider Info	Create User ID & Password	Confirmation
---------------------	---------------------------	--------------

Confirmation - Next Steps

Your online account creation was successful.

A confirmation email was sent to the email address used during account creation.

Please refer to the email for instructions on activating your account.

[Return to Home Page](#)

7. Check your email account.

You will receive an email with a link taking to the Web Portal to log in to your account using the User Name and Password you created

From: nebraskamedicaidPSE@maximus.com [mailto:nebraskamedicaidPSE@maximus.com]
Sent: Thursday, January 07, 2016 2:28 PM
To: @gmail.com
Subject: Nebraska MLTC Provider Account Created

Welcome to the Nebraska Medicaid Provider Screening and Enrollment Portal!

You have successfully created an account for Nebraska Medicaid Provider Data Management System.

Your user name is:

Please click [here](#) to activate your account.

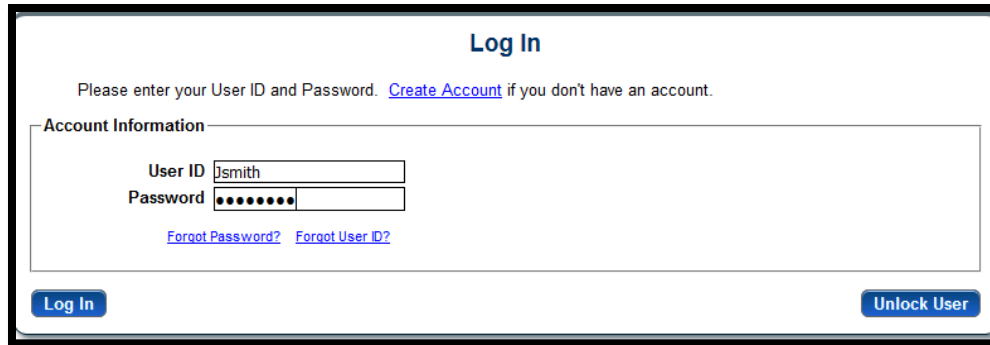
If the link above does not work, please copy <http://www.nebraskamedicaidproviderenrollment.com/Account/Login.aspx?id=55748fcf-09a1-4c9c-ac10-c1fbd0ec58f5> in your browser.

If you have forgotten your password, click the 'Forgot Password' link on the login page.
If you are unable to log in AFTER clicking on the link above, please contact MAXIMUS Provider Customer Service at 1-844-374-5022 or email nebraskamedicaidPSE@maximus.com.

Regards,
MAXIMUS Provider Screening and Enrollment Customer Service

After clicking on the link in the email notification you will return to the Web Portal

8. Enter the User ID and Password you created
9. Click Log In



Log In

Please enter your User ID and Password. [Create Account](#) if you don't have an account.

Account Information

User ID

Password

[Forgot Password?](#) [Forgot User ID?](#)

Provider Management Home Page

To begin the enrollment process

1. Click on "Select" in the "My Outstanding Program Service Referrals" section

User: Jon Smith (Jsmith) Thursday, January 7, 2016 [Home](#) [Logout](#)

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

Provider Management Home

[Update My Profile](#) Questions?
Contact MAXIMUS Provider Customer Service at 1-844-374-5022

Provider Summary

Tax ID: 77777777

My Outstanding Program Service Referrals

Select	Provider	Location	Status	Review Status
Select	Jon Smith	68508 - 4444	Provider Location Not Found	

Select from the list of available referrals to begin the registration process.

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](#)



- 2. Enter information in all required fields.
- 3. Enter the NFOCUS Referral Number exactly as it appears in your email notification

New Registration * Designates a required field

Entity Type* Individual Organization

First Name*

Middle Initial

Last Name*

Tax ID Type* EIN SSN

Tax ID*

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

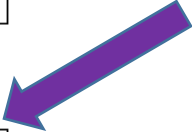
Gender* Female Male Unknown

Date of Birth*

Zip Code*

Zip Code Extension*

Referral Number*



- 4. Click Save


Identification

5. Click on the  symbol in the “Provider Information” section to complete Citizenship questions

Identification

[Save](#) [Next](#)

Provider Information

ProviderName	Tax ID	Provider Type	Effective Date
First Last	505888888	HCBS	

Primary Contact Information

No primary contact information found.

Uploaded Documents

No uploaded documents found.

No file selected.

Name

Description

[Upload file](#)

Identification (73642)

[Save](#) [Next](#)



6. Complete the following fields:

- Entity Type
- Citizenship Status

7. If you are a qualified alien under the Federal immigration and Nationality Act -

- Select applicable Immigration Status
- Provide your Alien Number

Note: After clicking Save you must upload a copy of your USCIS (Immigration) form using the Upload feature at the bottom of this page

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:

Immigration Status

Alien Number

Upload a copy of your USCIS (Immigration) form

First Name*

Middle Initial

Last Name*

Tax ID*

Tax ID Type

Gender* Female Male Unknown

Date of Birth*

Date of Death

Provider Type*

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

Revalidation Date Not Set Yet

Enrollment Status Not Set Yet


8. Click Save


Primary Contact Information

9. Click the '+' to add primary contact information

Primary Contact Information

No primary contact information found.





10. Complete all required fields in the Primary Contact Information section

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*

- 11. Click Save
- 12. Click Next

Identification Save Next

Provider Information

ProviderName	Tax ID	Provider Type	Effective Date
First Last	505888888	HCBS	

Primary Contact Information

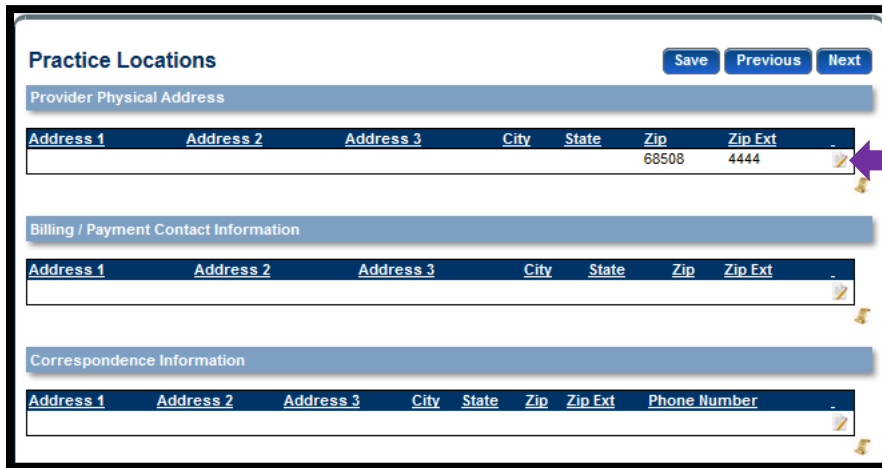
Primary Contact Name	Title	Phone Number	EmailAddress
First Last	Owner	(402) 555-5555	provider@email.com

Practice Locations

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

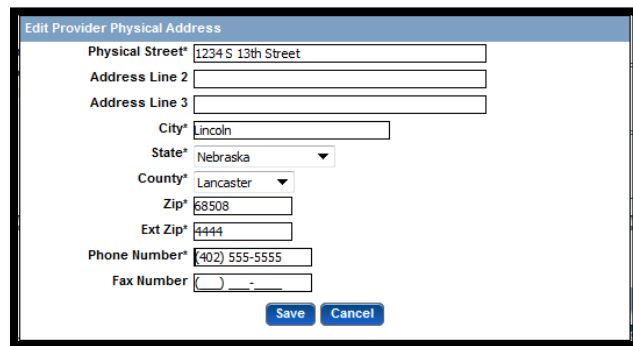
NOTE: If you provide services in a client's home do not enter the client's address in the Provider Physical Address section. Enter the address of your primary residence.

13. Provider Physical Address section: Click '✎' symbol to add the provider's physical address



The screenshot shows the 'Practice Locations' form with three sections: 'Provider Physical Address', 'Billing / Payment Contact Information', and 'Correspondence Information'. Each section has a table with columns for Address 1, Address 2, Address 3, City, State, Zip, and Zip Ext. The 'Provider Physical Address' section has one row with '68508' in the Zip column and '4444' in the Zip Ext column. A purple arrow points to the '✎' icon in the first row of the 'Provider Physical Address' table.

14. Complete all required fields



The screenshot shows the 'Edit Provider Physical Address' form with the following fields filled out:

- Physical Street*: 1234 S 13th Street
- Address Line 2: (empty)
- Address Line 3: (empty)
- City*: Lincoln
- State*: Nebraska
- County*: Lancaster
- Zip*: 68508
- Ext Zip*: 4444
- Phone Number*: (402) 555-5555
- Fax Number: () - -

Buttons for 'Save' and 'Cancel' are visible at the bottom.

15. Click Save

16. Billing/Payment Contact Information section: Click '✎' to add the provider's billing/payment contact information

Practice Locations Save Previous Next

Provider Physical Address

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
					68508	4444	✎

Billing / Payment Contact Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
							✎

Correspondence Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	Phone Number	
								✎

17. Enter billing/payment information

If the information is the **same as the practice location** (physical address), put a check mark in the box and the information will automatically populate except for the Pay To/Check Payable Name, which will need to be completed.

Edit Billing / Payment Contact Information

* Payable To Name is required

Same as Practice Location

Pay To / Check Payable To Name*

Address*

Address Line 2

Address Line 3

City*

State*

Zip*

Zip Ext*

Save Cancel

18. Click Save

Correspondence Information

19. Click '✎' to add provider correspondence information

Practice Locations Save Previous Next

Provider Physical Address

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
					68508	4444	✎

Billing / Payment Contact Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
							✎

Correspondence Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	Phone Number	
								✎

20. Enter correspondence address

If the information is the **same as the practice location** (physical address), put a check mark in the box and the information will automatically populate.

Edit Correspondence Information

Same as Practice Location

Address* 1234 S 13th Street

Address Line 2

Address Line 3

City* Lincoln

State* Nebraska

Zip* 68508

Zip Ext* 4444

Phone Number* (402) 555-5555

Save Cancel

21. Click Save

Completed Practice Locations Page

Practice Locations

[Save](#) [Previous](#) [Next](#)

Provider Physical Address

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
1234 S 13th Street			Lincoln	NE	68508	4444	

Billing / Payment Contact Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	
1234 S 13th Street			Lincoln	NE	68508	4444	

Correspondence Information

Address 1	Address 2	Address 3	City	State	Zip	Zip Ext	Phone Number	
1234 S 13th Street			Lincoln	NE	68508	4444	(402) 555-5555	

Services

The Program Service Code(s) the provider is authorized to provide will be present on this page. No action is required

22. Click Next

Services

Save Previous Next

Eligible Services - Licenses

The services listed below were submitted with your services referral. If changes are needed, please contact your RD worker.

Services	Service Type Code	Service Type Name	Start Date	End Date
AD Waiver	9233	TRAINING INDEPENDENT SKILLS IN HOME		
PAS	4475	PERSONAL ASSISTANCE SVC		

Household Members

23. Click on  symbol to add household member information (if applicable)

[Home](#)
[My Profile](#)
[Reports](#)
[Contact Us](#)
[Log Out](#)

Provider File

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

Household Members

[Save](#) [Previous](#) [Next](#)

Click on the section header to expand or collapse the panel.

- Instructions

I understand that the Nebraska Department of Health and Human Services requires the following background information on me. History may be requested from law enforcement or criminal justice agencies, including but not limited to:


- State of Nebraska Adult/ Child Abuse and Neglect Central Registry/er
- Law Enforcement Records
- The State of Nebraska Sex Offender's Registry
- The Nebraska Department of Motor Vehicles Nebraska Driver License Information System
- License Information System
- GSA website <http://epls.gov> for debarment actions by federal agencies and exclusion actions from Medicare, Medicaid or other federal programs through the Office of Inspector General at www.oig.hhs.gov/fraud/exclusions.asp.

Based on the services you are providing, you will be providing services in your home. The Department requires background information on all members of that household including full names, previous names, birthdates and Social Security numbers on all persons living in that residence and any criminal background information. This information is required in determining your approval as a service provider.

Please complete this information in the section below.

Household Members

Name	Date of Birth	Household Status	Sex
<i>No household members found.</i>			





- 24. Enter Household member information
- 25. Click Save

Household Member

Name* (First, Middle, Last)

Household Status* (Husband, Son, etc.)

Birth Date*

SSN*

Sex

Previous Last Names

(List All Previous Married, Maiden or Other Legal Names)

Member Address History

County	City	State	From Date	To Date
<i>No previous addresses found.</i>				

List each residence in the last 10 years

Member Criminal History

History
<i>No criminal history found.</i>

List details including dates and disposition, i.e., Parole, Probation, Fine, Time Served, etc.

- 26. Click Next

Owner Information

27. Click on  symbol to add Owner(s) Information

Ownership/Controlling Interest and Conviction Disclosure Previous Next

Click on the section header to expand or collapse the panel.

+ Instructions

+ Definitions

- 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.

+ Additional Addresses

- 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

- 28. Enter required information
- 29. Click Save

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

To Add Additional Addresses click on the + symbol to expand the section



30. Click on the + symbol to expand the “Questions” section



31. Answer all Questions. (A box will appear to add comments if you answer Yes.)

- 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

32. Click Save

33. Click Next

Substitute W4

34. Enter all required information

Note: A link to the IRS website is provided at the bottom of the first section if you need to obtain a current copy of the W4 form

35. Click Save

36. Click Next

Substitute W4 Form

[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 First Last

Tax ID 505888888

DBA

**Please visit <http://www.irs.gov> to obtain a copy of the W4 with instructions.

Marital Status

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

ACH Authorization

37. Select Direct Deposit or ReliaCard

ACH Authorization

[Previous](#) [Next](#)

Please mark your choice:

Direct Deposit

ReliaCard

For Direct Deposit

38. Click on  symbol to add Banking Information

Note: Only if your bank is outside of the United States place a check in box below the instructions

ACH Authorization

[Save](#) [Previous](#) [Next](#)

Please mark your choice:

Direct Deposit
 ReliaCard

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



- 39. Enter Banking information
- 40. Click Save

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*

For ReliaCard

41. Click on  symbol to add ReliaCard Information

ACH Authorization

[Save](#) [Previous](#) [Next](#)

Please mark your choice:

Direct Deposit

ReliaCard

Instructions

READ INSTRUCTIONS BEFORE COMPLETING

The Nebraska Department of Health and Human Services is hereby authorized to initiate credit entries for deposit of state payments and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated below and the financial institution named below. I acknowledge that the designation of direct deposit transactions to my account must comply with the provisions of U.S. law.


There are new processing requirements for electronic vendor payments that are being sent to a financial institution outside of the United States. If our payments to you are being forwarded from a U.S. financial institution to a financial institution in another country, please notify Claims Processing, (402) 471-9170. (Section 1902(a) of the Social Security Act and 2011 NACHA Operating Rules & Guidelines, Article Two, SUBSECTION 2.5.8 Specific Provisions for IAT Entries (International ACH Transaction), page OR 13.)

Click [here](#) for Late/Missing EFT Resolution Procedures.

Go to http://dhhs.ne.gov/Pages/fis_claimsprocessing.aspx for information about these payment methods.

ReliaCard Authorization

No Personal ReliaCard Information found.





42. Enter ReliaCard Authorization Information

Make sure you include your full address including Street

43. Click Save

ReliaCard Authorization

Provider

First Name

Middle Initial

Last Name

Street

City

State

Zip Code/Postal Code

44. Check the box next to “I confirm the information provided is true and accurate

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.

confirm the information provided is true and accurate

45. Click Save

46. Click Next

Agreements

47. Click on each web link. A separate tab will show on your web browser that contains each agreement.

48. Place a checkmark in the “I agree” or “I attest” box. (Note: The check box is only accessible after clicking the web link.)

Agreements 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.

Questions section

49. Click "No" or "Yes" for each question and add any comments if applicable

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.

- 50. Signature section: Enter the characters in the image (not case sensitive)
- 51. Enter the password you used to log into DecisionPoint
- 52. Click "Save"

Signature



Please enter the characters in the image above:

Enter password:

The password requested is your user login password.

Application complete box will appear

53. Click Ok

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

Actions: **Submit for Review**

Generate PDF



54. Click “Generate PDF” under the “Actions” section towards the top of the screen if you would like to save or print a copy of your completed application

55. Click on “Submit for Review” when completed

Actions: **Submit for Review**



56. Next you will see the Submission Confirmation Screen indicating you have successfully submitted your registration to enroll in Nebraska Medicaid.

Home My Profile Contact Us Log Out	<p style="text-align: center;">Submission Confirmation</p> <p style="text-align: center;">You have successfully submitted your registration to Nebraska Medicaid. Please allow at least 10 days for processing before attempting to submit any changes.</p> <p style="text-align: center;">Return to Home Page</p>
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57. Click on “Return to Home Page”

After successfully submitting an application you will be able to track its progress from your Provider Management Home Page

You can contact MAXIMUS Provider Customer Service at 1-844-374-5022 if you have any questions regarding your application or the Nebraska Medicaid provider enrollment and screening process.

[Home](#)

[My Profile](#)

[Contact Us](#)

[Log Out](#)

[Update My Profile](#)

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

Provider Summary

Tax ID: 505888888

My Providers

Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	Location	Effective Date	Submit Date	Revalidation Due Date
First Last	Submitted	HCBS			HCBS	88508 - 4444		10/19/15	

[Add New Provider Location](#)

My Group Member Profiles

Provider	Status	Provider Type	NPI	Specialty	Effective Date	Submit Date
<i>No group member profiles found.</i>						

Create a Group Member Profile if you are or will be part of a Group Practice.

[Add Group Member Profile](#)

Provider Details

First Last 88508 - 4444

Registration Information

Effective Date

Revalidation Due Date

Term Date

Nebraska MLTC Status **New**

Application Status Submitted

Medicaid ID

Manage Provider

[View Provider File](#)

Communications

Subject	NPI	Date
Nebraska MLTC Provider Account Created		10/19/2015
Password Reset		10/19/2015