NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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

Disenrollment Request:

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: _____

Billing Provider Name: _____

Medicaid ID: _____

NPI (if applicable): _____

Requested Disenrollment Date: _____

Select one:

☐ Disenroll Provider Agreement

☐ Close only specific service(s) (HCBS provider only). 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's Signature Email

_____ _____

Title Phone Number