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## **Medicaid – NEBRASKA Enrollment Instructions Professional / Institutional Claims and ERA**

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. Incorrect provider IDs will cause the enrollment to be delayed.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the completed request in case you should need to follow up or resubmit.

**FAX COMPLETED REQUEST FORMS TO-  
MEDICAID NEBRASKA  
402-742-2353**

### **837 – Claims Provider Enrollment (New) or (Change of Service)**

To authorize Practice Insight as the submitter of (837) electronic claims, complete and submit this form for the billing provider.

1. 5010 Nebraska Medicaid Billing Provider Trading Partner Authorization (3 pages)  
ENTER information for BILLING PROVIDER GROUP ONLY (OR for INDIVIDUAL PROVIDER if provider is billing solo).

### **835 – ERA Electronic Remittance Request (New) or (Change of Service)**

To authorize Practice Insight as the receiver of (835) electronic claims, complete these forms..

**NOTE:** EFT (Elec Funds Transfer) enrollment is REQUIRED in order to get setup for 835 ERAs.

1. Same Form as above – Put Check in box next to “**835 Remittance Advice.**”
2. State of Nebraska ACH/EFT Enrollment Form (1 page).  
(It is not necessary to complete/submit this form if you are already setup and receiving EFT payments from MCD NE.)

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## **ALLOW 2-4 WEEKS FOR PROCESSING**

*If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller for assistance, or you can phone Medicaid Nebraska EDI at 1-866-498-4357.*



**SUBMIT / RECEIVE 5010 TRANSACTIONS WITH NEBRASKA MEDICAID:**

		Start Date	End Date
<input type="checkbox"/>	837 Professional Claim*		
<input type="checkbox"/>	837 Institutional Claim*		
<input type="checkbox"/>	837 Dental Claim*		
<input type="checkbox"/>	270/271 Eligibility Inquiry / Response		
<input type="checkbox"/>	276/277 Claim Status Request / Response		
<input type="checkbox"/>	278 Prior Authorization Inquiry / Response		
<input type="checkbox"/>	835 Remittance Advice / Refund Requests Report**		

\* Trading partners will receive a weekly Electronic Claims Activity (ECA) Report and a 999/TA1 Functional Acknowledgements for submitted files.

Providers will not select an ECA or 277CA acknowledgement. Providers will receive the selection made by their Trading Partners.

\*\* Electronic Fund Transfer required. EFT enrollment form is available on web site. When receiving the 835, the Refund Requests Report will only be provided electronically.

Authorization

On behalf of the Nebraska Medicaid Provider(s) listed above, the undersigned hereby attests and acknowledges that:

- he or she is authorized to complete and sign this Authorization;
- the information provided is accurate and true;
- electronic submission of claims through a trading partner constitutes certification as required by 471 NAC 3-003.02;
- the Trading Partner is responsible to communicate to the Provider any problems or delays in transmission, as well as error/reject information or reports that the provider needs in order to correct, track or complete transactions;
- Nebraska Medicaid will not exchange transactions with a Trading Partner on behalf of a provider without this Trading Partner Authorization;
- the Trading Partner must have an active Trading Partner Agreement with Nebraska Medicaid, or this Authorization is null and void; and,
- this information will be kept current by completing new Authorizations as necessary.

Typed or Printed

Name: \_\_\_\_\_ (Required)  
 Signature: \_\_\_\_\_ (Required)  
 Title: \_\_\_\_\_ (Required)  
 Date: \_\_\_\_\_ (Required)  
 Provider/Office Name: \_\_\_\_\_ (Required)  
 Provider/Office Address: \_\_\_\_\_ (Required)  
 City, State, Zip: \_\_\_\_\_ (Required)  
 Phone Number: \_\_\_\_\_ (Required)  
 FAX: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**If you are switching from one clearinghouse to another, please indicate your previous clearinghouse to discontinue submission of the above transactions.**

**Discontinue Clearinghouse** \_\_\_\_\_

Please complete and submit this form to Nebraska Medicaid. If using a clearinghouse, you may be requested to return this form to the clearinghouse. If submitting this form directly to Nebraska Medicaid, mail or fax to:

FAX: 402-742-2353

Mail: Department of Health and Human Services  
 Attn: Medicaid EDI Help Desk  
 PO BOX 95026  
 Lincoln, NE 68509-5026

If you have questions, please contact the Nebraska Medicaid EDI Help Desk at:

Email: [DHHS.MedicaidEDI@nebraska.gov](mailto:DHHS.MedicaidEDI@nebraska.gov)

Phone 402-471-9461 (In Lincoln)

866-498-4357 (Outside of Lincoln)

**MEDICAID**

**State of Nebraska ACH/EFT Enrollment Form**

Mail or Fax to:  
Department of Health and Human Services  
Attn: Medicaid Provider Enrollment  
PO Box 95026  
Lincoln, NE 68509-5026  
Phone: (402) 471-9717  
Fax: (402) 742-2373

New       Change

If you have any questions when completing this form, please contact the State Treasurer's Office:  
State Treasurer  
Attn: Treasury Management  
Room 2003, State Capitol  
Lincoln, NE 68509  
Phone: (402) 471-2455  
Fax: (402) 471-0816

CTX or CCD+

The information below should be completed by the Medicaid Provider (Vendor). If the vendor has any questions, please contact DHHS at (402) 471-9717.

It is the Financial Institution's responsibility to assure the accuracy of the following banking information. If there are any questions, please contact the State Treasurer's Office at (402) 471-2455.

**Provider (Vendor) Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Medicaid Provider Numbers (11):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Financial Institution Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

ACH Coordinator: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax: \_\_\_\_\_

Nine Digit Routing Transit Number \_\_\_\_\_

Deposit Account Number: \_\_\_\_\_

Deposit Account Title \_\_\_\_\_

Type of Account:     Checking     Savings  
 Check here if the bank is outside of the United States

It is the responsibility of the state vendor to obtain the ACH payment related remittance information from their financial institution. The State of Nebraska sends this information through the ACH network in the Addenda Records. ACH Rules state the financial institution is required to provide this information to the state vendor by the opening of business on the second banking day following the Settlement Date of the payment. Please contact the ACH department at your financial institution regarding the services your bank provides to obtain the payment information.

(Please print or type - Signature required)

Vendor Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

(Please print or type - Signature required for verification of bank routing and account numbers))

Bank Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_