NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

MEDICAID PROVIDER ACH/EFT ENROLLMENT FORM

- 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.
- When enrolling for multiple provider numbers/entities, please complete separate ACH/EFT Enrollment Forms for each.

Please Complete the Following (required fields are indicated with *)

Enter the 11-digit Nebraska Medicaid-assigned Provider Number:
If not previously enrolled in Nebraska Medicaid, leave blank. __ __ __ __ __ __ __ __ __ __ __

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.

PROVIDER INFORMATION

Provider Name*

PROVIDER ADDRESS

Street*

City*

State/Province*

Zip Code/Postal Code*
__ __ __ __ __ +__ __ __ __

PROVIDER IDENTIFIERS INFORMATION

PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)*

National Provider Identifier (NPI)
__ __ __ __ __ __ __ __ __ __

OTHER IDENTIFIERS

Assigning Authority:
NE Medicaid

Trading Partner ID

Provider Taxonomy Code
__ __ __ __ __ __ __ __ __ __

PROVIDER CONTACT INFORMATION

Provider Contact Name*

Telephone Number	Telephone Number Extension

Email Address

Fax Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name*

FINANCIAL INSTITUTION ADDRESS

Street*

City*

State/Province*

Zip Code/Postal Code*

Financial Institution Telephone Number	Telephone Number Extension

Financial Institution Routing Number*

Type of Account at Financial Institution* (Select one)

☐ Checking ☐ Savings

Provider's Account Number with Financial Institution*

ACCOUNT NUMBER LINKAGE TO PROVIDER IDENTIFIER

Provider Tax Identification Number (TIN)

National Provider Identifier (NPI)

SUBMISSION INFORMATION

REASON FOR SUBMISSION*: (Select one)

☐ New Enrollment ☐ Change Enrollment

INCLUDE WITH ENROLLMENT SUBMISSION*: (Select one)

☐ Voided Check ☐ Bank Letter

AUTHORIZED SIGNATURE

Written Signature of Person Submitting Enrollment[1]

Printed Name of Person Submitting Enrollment[1]*

Printed Title of Person Submitting Enrollment*

Submission Date*

[1] By signing or completing "Printed Name of Person Submitting Enrollment", 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.

Submit completed form and attachment via secure Email, fax or mail to:

Maximus
Nebraska Medicaid Provider Enrollment
PO BOX 81890
Lincoln, NE 68501-1890

Email: NebraskaMedicaidPSE@MAXIMUS.com
Fax: 844-374-5026

- Direct questions to Nebraska Provider Screening and Enrollment:
  Phone: 844-374-5022
  Fax: 844-374-5026
  Email: NebraskaMedicaidPSE@MAXIMUS.com
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