



220 Burnham Street • South Windsor, CT 06074  
 Vox 888-255-7293 • Fax 860-289-0055

**NEBRASKA MEDICAID  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKNE1</b>						
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<b>Emdeon Business Services Enrollment Form</b> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> <b>Nebraska Medicaid Trading Partner Authorization</b> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul>						
<b>SEND REGISTRATION FORMS TO</b>	<p align="center">Emdeon Business Services        220 Burnham Street        South Windsor, CT 06074        Attn: Provider Enrollment        Or        Fax to: 860-289-0055</p>						
<b>ENROLLMENT CONFIRMATION</b>	<p>Enrollment will be coordinated between Nebraska Medicaid and Emdeon Business Services. Once confirmed Emdeon Business Services will notify the provider's software vendor or office when they may begin sending claims electronically.</p>						
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	<p>If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.</p>						
<b>CONTACT PHONE NUMBERS</b>	<table border="0"> <tr> <td><b>Nebraska Medicaid EDI Support</b></td> <td><b>402-471-9461 (in Lincoln)</b></td> </tr> <tr> <td></td> <td><b>866-498-4357 (Outside of Lincoln)</b></td> </tr> <tr> <td><b>Emdeon Business Services Provider Enrollment</b></td> <td><b>888-255-7293</b></td> </tr> </table>	<b>Nebraska Medicaid EDI Support</b>	<b>402-471-9461 (in Lincoln)</b>		<b>866-498-4357 (Outside of Lincoln)</b>	<b>Emdeon Business Services Provider Enrollment</b>	<b>888-255-7293</b>
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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Nebraska Medicaid – payer ID CKNE1**

Provider/Organization Name: \_\_\_\_\_

Tax Identification or Social Security Number: \_\_\_\_\_  
*(Number that will be used to submit electronic claims)*

Software Vendor: \_\_\_\_\_

Group Number: \_\_\_\_\_  
*(if applicable)*

Group NPI Number: \_\_\_\_\_  
*(if applicable)*

Name	Number	Rendering	NPI
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

City, State, Zip Code: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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

## NEBRASKA MEDICAID TRADING PARTNER AUTHORIZATION

This Authorization is required of all Nebraska Medicaid Providers who wish to submit or receive electronic transactions directly or through a third party, such as a clearinghouse, to Nebraska Medicaid (hereinafter known as "NE Medicaid"). The submitter of such transactions is hereinafter known as "Trading Partner."

NE Medicaid will only exchange transactions with an approved Trading Partner when an Authorization is on file from a NE Medicaid provider. The Authorization must list the specific provider number(s), transaction(s) and the effective date(s) of the Authorization. For each transaction, the Start Date is the date upon which NE Medicaid can start accepting that transaction, and the End Date is the last date upon which a transaction can be accepted. The End Date is not required until applicable. When a Trading Partner is no longer authorized for any or all of the provider numbers and/or transactions listed, a new Authorization must be completed providing the End Date(s). Only one Trading Partner can be authorized per transaction at a time and the authorized dates may not overlap. NOTE: When authorizing for multiple provider numbers, if the transaction(s) or effective date(s) information varies for provider numbers, please complete separate Authorizations.

**With this understanding, I,** \_\_\_\_\_,  
(Name) (Title)

**representing:** \_\_\_\_\_  
(Provider Name)

**authorize:** Emdeon Dental TP # 174  
(Trading Partner)

**to submit and/or receive the electronic transactions indicated below on behalf of the listed NE Medicaid Provider Numbers for the dates indicated:**

Authorized for the following NE Medicaid Provider(s) and Provider Number(s):

PROVIDER NUMBER (11 digits)	PROVIDER NAME

(Note: Please attach a separate sheet for additional provider numbers, if necessary.)

SUBMIT / RECEIVE 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 an Electronic Claims Activity Report for deleted/rejected claims and 997 Functional Acknowledgements for submitted files.

\*\* 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.

# NEBRASKA MEDICAID TRADING PARTNER AUTHORIZATION

## 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: HHS Finance and Support  
Attn: Medicaid EDI Customer Support  
PO BOX 95026  
Lincoln, NE 68509-5026~~

If you have questions, please contact the Nebraska Medicaid EDI Customer Support Team at:

Email: [medicaid.edi@hss.ne.gov](mailto:medicaid.edi@hss.ne.gov)

Phone: 402-471-9461 (*In Lincoln*)  
866-498-4357 (*Outside of Lincoln*)