



Nebraska Medicaid ERA's

If you wish to receive Electronic Remittance Advice (ERA's) from Medicaid, complete the attached agreement and return it to Infinedi.

Provider Number Requirements

If billing by group, the group provider number is required.

- Billing provider numbers must consist of:

Eleven numerics

For example: 12345678911

Agreement Instructions

- Complete the page 1. Please specify if it is a group number and an individual number. Make sure you fill in a start date for 835 Remittance Advice.
- Complete the middle section on page 2 and have the provider sign where indicated. If you are currently receiving your Remittances electronically, fill in a Discontinue Clearinghouse date to let Medicaid know when to change your linkage to Infinedi, LLC.
- Complete page 3 of the agreement. Your bank will need to sign the agreement, as well as the provider.

Please complete agreements and fax or mail back to:

Infinedi
Attn: Enrollment Dept.
1437 S Boulder Ave
Suite 1030
Tulsa, OK 74119-3616
Fax #: 918-249-4460

If you have any questions, contact our client implementation department at 800-688-8087

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: Infinedi, LLC 6260
(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 checked="" 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: 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: medicaid.edi@dhhs.ne.gov

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

STATE OF NEBRASKA ACH ENROLLMENT FORM

Mail or Fax to:

Dept of Health and Human Services
Attn: Medicaid Provider Enrollment
PO Box 95026
Lincoln, NE 68509-5026
Phone: 402-471-9558
Fax: 402-742-2373

New Change

If you have an questions when completing the Financial Institution Information, please contact the State Treasurer's Office:

State Treasurer
Attn: Treasury Management
Rm. 2005, 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 402-471-9558.

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

Provider (Vendor) Information

Name: _____

Address: _____

Medicaid Provider Numbers (11-digits):

Contact Person: _____

Phone #: _____

Fax #: _____

Financial Institution Information

Name: _____

Address: _____

ACH Coordinator: _____

Phone #: _____

Fax #: _____

Nine Digit Routing Transit #: _____

Depositor Account #: _____

Depositor Account Title: _____

Type of Account: Checking Savings

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 with the payment to your financial institution. 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)

Bank Signature: _____

Name: _____

Title: _____

Date: _____