



***Please type or print legibly. Do not use this form with a paper claim.***

**Use:** Use the Electronic Claim Attachment Control Number Form when an attachment is required for an electronic claim. When received, the Electronic Claim Attachment Control Number Form and attachments will be matched to the electronic claim using the attachment control number. Attachments must be received within **10 days** of the submission of the claim to be considered.

Fax completed form and attachment(s) to (402) 471-8703

Or mail to:

Medicaid Claims Processing  
Health and Human Services Finance and Support  
P.O. Box 95026  
Lincoln, NE 68509-5026

1. **Attachment Control Number:** Enter the "Claim Attachment Control Number" submitted on the electronic claim that requires an attachment. This is the unique number that was submitted on the electronic claim as the Attachment Control Number from PWK06, Claim Supplemental Information, Loop 2300, electronic claim format –ASC x 12N 837. This number must be the 11-digit Nebraska Medicaid legacy provider number of the billing provider and a unique number not exceeding 9-digits. Up to 20 characters will be accepted in this number. If you don't know the attachment control number, contact the person at your office or facility responsible for electronic claim billing. **Note:** For physician claims: The attachments must be specific to the date of service(s) of the electronic claim requiring documentation. For other provider claims: The same documentation may apply to more than one date of service or procedure code, so the same claim attachment control number may be used on more than one electronic claim.
2. **Provider Name:** Enter the name of the Nebraska Medicaid Billing Provider.
3. **Billing Contact Name:** Enter the name of the person who is responsible for submitting claims for Medicaid payment.
4. **Billing Contact Phone Number:** Enter the phone number of the billing contact.
5. **Medicaid Client Name:** Enter the full name of the person who received the services.
6. **Medicaid Client 11-digit Identification Number:** Enter the complete 11-digit client identification number. When billing for services provided to an ineligible mother of an eligible unborn/newborn child, enter the Medicaid number of the unborn/newborn child.
7. **Date(s) of service:** Enter the 8-digit numeric service dates for which the attachment is required (e.g. 10122006).
8. **Type of Attachment:** Describe the type of attachment accompanying the form. Some examples are invoices showing the provider's cost, descriptions of not otherwise classified procedure codes, and reports describing the procedure or service.
9. **Number of Pages:** Enter the total number of pages submitted including the form.