Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Nebraska Service Provider Agreement
Facility Provider Addendum

Provider information

Legal name (as it appears on Tax ID form)

Provider ID

Provider Certification

☐ NF ☐ ICF/MR

Phone Number

Type of Ownership

Government:
☐ State ☐ County ☐ City

Profit:
☐ Corporation ☐ Partnership ☐ Proprietorship ☐ LLC ☐ LLP

Nonprofit?
☐ Yes

Registered in to do Business in Nebraska
☐ Yes ☐ No

State or County of Incorporation

Signatures and Dates

I certify the information on this form is true, accurate, and complete.

Provider/Authorized Representative Signature
(Stamped signature NOT accepted)

Date

Title

FOR MEDICAID OFFICE USE ONLY - Comments