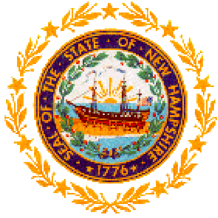

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

New Hampshire Medicaid Program

NH Medicaid Non-Billing ORP Provider Enrollment Instructions

Completing the Non-Billing ORP Provider Enrollment Application

www.nhmmis.nh.gov

- Select “Enrollment” under Quick Links
- Additional assistance is located in the blue “Help” hyperlink at the top of each page
- Please prepare all documentation needed for this application by first referring to the Required Enrollment Documents to Upload with New Applications document located in the “Documents and Forms” quick link on the NHMMIS home page

New Hampshire MMIS Health Enterprise Portal

Jun 22, 2022

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Welcome

Welcome to the Conduent Government Solutions Health Enterprise Portal. This system supports all of your State Medicaid and Decision Support needs.

NH MMIS has established a maintenance window from 12:01 A.M. to 12:00 P.M. every Sunday to apply scheduled system upgrades. During the maintenance window, the system may not be accessible.

Provider Registration

For providers to obtain a user name and password to use the Health Enterprise portal, they must be a current provider for Medicaid. For trading partners to obtain a username and password, they must be a current Trading Partner with a trading partner ID. To begin the registration process, they must have their enrollment form ready.

Register

Quick Links

- Enrollment
- Documents and Forms
- Find a Health Care Provider
- Department of Health and Human Services
- Report Fraud & Abuse
- ICD10 Resources
- Provider Revalidation
- Interoperability Exchange

Sign In

Log into the system based upon your role:

- Providers
- Internal Users

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- Select the "Non-Billing ORP Provider Enrollment" link
  NOTE: You can also check the status of an application on the below page by entering the Application Tracking Number (ATN) in the Application Status section and selecting "Submit"
  NOTE: To return to a partially completed application, enter the ATN and SSN in the Recall Provider Application section and select "Submit"

New Hampshire MMIS Health Enterprise Portal

Jul 13, 2022

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Provider Enrollment — Print | Help

* Required Field

Become a Billing Provider

If you would like to become a Billing Provider for New Hampshire Medicaid, please complete the appropriate online application. If you are a billing group or individual applying with a Federal Employer Identification Number (FEIN), please select the *Group Provider Enrollment* link below.

If you are an Individual billing provider that does not have an FEIN and would be applying with your Social Security Number (SSN), please select the *Individual Billing Provider Enrollment* link below.

If you have questions, please contact Provider Enrollment at (603) 223-4774 or (866) 291-1674, Monday through Friday, 8 am - 5 pm EST.

FAQ
Instructions
Group Provider Enrollment
Individual Billing Provider Enrollment

Become a Non-Billing Provider

If you would like to become a Non-Billing Provider for New Hampshire Medicaid, please complete the appropriate online application.

Non-Billing Individual Rendering Providers are providers who, through an affiliation with a billing provider, render services for New Hampshire Medicaid members. Please select the *Non-Billing Rendering Provider Enrollment* link below.

Non-Billing Individual Ordering/Referring/Prescribing (ORP) Providers are providers who enroll for the sole purpose of ordering, referring or prescribing supplies, services and/or pharmaceuticals for New Hampshire Medicaid members. Please select the *Non-Billing ORP Provider Enrollment* link below.

If you have questions, please contact Provider Enrollment at (603) 223-4774 or (866) 291-1674, Monday through Friday, 8 am - 5 pm EST.

FAQ
Instructions
Non-Billing Rendering Provider Enrollment
Non-Billing ORP Provider Enrollment

Become a Trading Partner

If you would like to become a Trading Partner (EDI) to electronically exchange data with New Hampshire Medicaid, please complete the online Trading Partner application. Select the *Trading Partner Enrollment* link below.

If you have questions, please contact Provider Enrollment at (603) 223-4774 or (866) 291-1674, Monday through Friday, 8 am - 5 pm EST.

FAQ
Instructions
Trading Partner Enrollment

Application Status

To check the status of your New Hampshire Title XIX Program Provider or Trading Partner Application, use your Application Tracking # and click the SUBMIT button.

*Application Tracking # [ ] Submit

Recall Provider Application

To recall an application that you have partially completed, enter your Application Tracking Number, and SSN / FEIN and click the SUBMIT button.

*Application Tracking # [ ]
*SSN/ FEIN [ ]
Submit

Recall Trading Partner Application

To recall an application that you have partially completed, enter your Application Tracking Number and SSN / FEIN and click the SUBMIT button.

*Application Tracking # [ ]
*SSN/FEIN [ ]
Submit

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- Please read the following information and select "Enroll as Non-Billing ORP Provider"

  NOTE: Fingerprint-based Criminal Background Check (FCBC) Notification is based on the risk level of the provider type, and the provider will be notified by DHHS if required

Jul 13, 2022

New Hampshire MMIS Health Enterprise Portal

Skip Navigation | Contact Us | Help | Search

Home | Program | Member | Provider | Documentation | Directories

Non-Billing ORP Provider Enrollment Instructions — Print | Help

* Required Field

Application Links
Instructions

Non Billing ORP Provider Enrollment

- This application is for the sole purpose of enrolling providers that order, refer or prescribe supplies, services and/or pharmaceuticals for New Hampshire Medicaid members.This type of enrollment does not allow NH Medicaid to reimburse the applicant/provider for services provided.
- Providers with more than one provider type must complete a separate Enrollment Application for each provider type.

Non Billing ORP Provider Enrollment Instructions

- After completing Section I - "Identifying Information", click the SAVE button at the bottom of the page. The system will return an Application Tracking Number that can be used to recall a partially completed application. Retain this tracking number for future access to the application.
- After completing each page of your application, first click the SAVE button at the bottom of the page, then click the CONTINUE button to continue through the application process and follow the steps to validate your application.
- Data fields marked with an asterisk (*) are mandatory for application processing.
- For all date fields, use the date format (mm/dd/yyyy) unless otherwise indicated.
- Print, sign, scan and upload the signature page in the **Signature Page** section.
- Additional options for other required documentation to be scanned and uploaded are available at the end of the application.

Partially completed applications that are saved but not yet submitted may be retrieved by using the Application Tracking Number (ATN) to recall the application.

Fingerprint-based Criminal Background Check (FCBC) Notification

The Affordable Care Act (Section 6401), under 42 CFR 455.434, identifies Medicaid providers whose owners are required to submit fingerprint-based criminal background checks. The Medicaid providers identified as high-risk per 42 CFR 455.450 are owners with a 5% or more direct or indirect ownership interest, providers that deliver home health services, Durable Medical Equipment, have been sanctioned within the past 10 years or have an existing State Medicaid Plan qualifying overpayment. For more information please go to Department of Health & Human Services website at https://www.dhhs.nh.gov/bii/pi.htm.

Enroll as Non-Billing ORP Provider | Cancel

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Identifying Information – Section 1

NOTE: The left side of the application will show the links to each section of the application, as well as instructions for each section.

1. Service Authorization Letters are sent to your provider inbox. If you would like this changed, contact NH Medicaid Provider Relations Call Center at 866-291-1674

2-4. Enter the Provider's Name

5. Select a Suffix from the drop-down list, if applicable
6. Select a Title from the drop-down list, if applicable
7. Enter the Provider's Date of Birth
8. Select Male or Female
9. Select Yes or No
10. Enter the Provider's SSN
11. Select Yes or No NOTE: If you select yes, the field will expand, and you will be required to enter your current or previous Provider Number

- Once all required fields are completed, select "Save" and your Application Tracking Number (ATN) will be displayed in a red message at the top of the screen NOTE: Note this number somewhere as you will need it to check the status of the application or recall the application

Identifying Information Print | Help

* Required Field

Application Links
Application Tracking Number -

- Instructions
- **Identifying Information**
- Licensure / Certification
- Provider Identifier Number
- Service Location
- Exclusion / Sanction
- Signature Page

Help

Name
The name you enter will be used in all searches and on all correspondence.

Date of Birth
Enter as MM/DD/YYYY, MM-DD-YYYY, MMDDYYYY or click the Calendar icon to choose a date.

SSN
Enter as 9 digits with or without dashes.

Click the **Save** button at the bottom of the page to validate the page content and save the information. Click the **Continue** button to move to the next step. If you choose to **Exit Application**, please save and note the Tracking Number or print this page so you can make updates to this application at another time.

For additional Enrollment Help, click the **Help** link on the blue bar at the top of this form.

SA Waiver Medium

*Requested Delivery Media for SA Letters (1)
Inbox Mail
Letters will be sent to your provider mailing address. If this will create a provider hardship please contact Provider Relations.

Identifying Information- Section 1

*Last Name (2) | *First Name (3) | MI (4) | Suffix (5) | Title (6)

*Date of Birth (7)

*Gender (8)
Male Female

*May gender information be shared with members? (9)
Yes No

SSN is equivalent to Provider Tax Identification Number(TIN).
*SSN (10)

Note: The applicant's SSN will be linked to a NH Medicaid Provider Number. This SSN must be for the Individual Provider whose information is provided on this application.

Current/Previous NH Medicaid Provider #

*Were you previously enrolled as a Medicaid provider in NH? (11)
Yes No

Continue>> Save Reset Exit Application

- Select "Continue" to move to the next section

Licensure / Certification – Section 2

1. Select your "Provider Type" from the drop-down menu
2. Select "Add Licensure/Certification" to add a License or Certification NOTE: Please refer to your state's Office of Professional Licensure and Certification (OPLC) for licensing information
    A. Select License or Certification
    B. Enter the License Number or Certification Number
    C. Select a License or Certification Agency from the drop-down list
    D. Enter the License or Certification Effective Date
    E. Enter the License or Certification Expiration Date
    F. Select the License or Certification State from the drop-down list
    G. Select "Save"
3. Select "Add Specialty" if applicable and enter the appropriate fields
4. The Taxonomy code is required for all individual providers. Select "Add Taxonomy" to expand the field and enter the requested information. TIP: You can find your taxonomy information on your NPI, which can be located on the NPI Registry website: https://npiregistry.cms.hhs.gov/
    A. Enter your 10-digit taxonomy code
    B. Enter the Begin Date of the taxonomy NOTE: This date should be the enumeration date that is listed on your NPI
    C. Taxonomies do not expire, so enter the end date of 12/31/9999
    D. Select "Save"

- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Provider Identifier Number – Section 3

NOTE: Refer to the image on the following page regarding the below numbered instructions

1. Select "Add NPI"
   A. Enter your 10-digit NPI number TIP: You can find your NPI information on the NPI Registry website: https://npiregistry.cms.hhs.gov/
   B. Select "Save"
2. Disclose Medicaid information for other states that you are enrolled with
   A. Select Yes or No. If selecting Yes, an expanded view with options for B and C will appear
   B. Select the additional state that you are enrolled as a Medicaid provider in.
   C. Select the right arrow to move the selected state from the Available box to the Selected box. You can also select a state from the Selected box and use the left arrow to move it back to the Available box NOTE: You can add multiple states to the Selected box as necessary
   D. Select Yes or No. If selecting Yes, an expanded view with options for E and F will appear
   E. Click the dropdown and select the state you've revalidated with within the last 5 years
   F. Select Yes or No
3. Select "Add Medicare" if you are Medicare enrolled and have an assigned Medicare ID NOTE: If you have multiple Medicare numbers, repeat this step
   A. Enter your Medicare number
   B. Check off all Parts that apply
   C. Select "Save"
4. Select "Add History" if you have any former Medicare IDs to enter NOTE: If you have multiple former Medicare IDs, repeat this step
   A. Enter your previous Medicare number
   B. Select a Carrier/Intermediary from the drop-down list
   C. Check off all Parts that apply
   D. Select "Save"

- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Provider Identifier Number – Section 3

Provider Identifier Number- Section 3

National Provider Identifier (NPI)

1 Add NPI

NPI

Add NPI B Save | Reset | Cancel

*NPI A

Other State Medicaid Program Information

*Are you currently enrolled as a Medicaid provider in another State? A
Yes No

*Please select all states other than NH in which you are currently enrolled as a Medicaid provider.

Available C Selected

B Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida

2

*Have you revalidated with another state Medicaid program within the last 5 Years? Yes No D

*Please identify the state. E

*Have you paid the application fee? Yes No F

Medicare Crossover Payment- Section 3

Enter the current Medicare Number assigned to you as an individual practitioner. Do not include numbers assigned to group Providers.

Medicare #

3 Add Medicare

Medicare #	Parts

Add Medicare # C Save | Reset | Cancel

*Medicare # A

*Please check all applicable Medicare Parts that pertain to Medicare crossover claims that you may submit.
Part B Part C B

Other Medicare Numbers

For historical purposes, please list any former Medicare Provider#(s) and Carrier/Intermediary Name(s).

4 Add History

Medicare #	Carrier/Intermediary Name	Parts

Add History D Save | Reset | Cancel

*Medicare # A

*Carrier/Intermediary Name B

*Please check all applicable Medicare Parts that pertain to Medicare crossover claims that you may submit.
Part B Part C C

Continue>> Save Reset Exit Application

Service Location Information – Section 4

NOTE: Maintenance of an accurate location address is a requirement of participating with NH Medicaid. Providers are responsible for keeping their addresses up to date. Additionally, physical mail to the mailing address on file is the primary method of communicating crucial updates from the Medicaid program to the provider.

NOTE: When entering the provider addresses, ensure you enter the Zip + 4 code to ensure proper claim mapping

1-5. Enter the primary Service Location physical address with the Zip +4 code NOTE: The address entered here should match what is entered on the Provider Participation Agreement (PPA) document

6. Select "Validate Address" to ensure the address is in proper postal format.
   - A. Select the appropriate address from the list NOTE: If none of the addresses are correct, select the Override option to accept the address that you entered
   - B. Select "Submit"
7. Select "Add Numbers" to add a phone and fax number for the service location
   - A. Enter the service location phone number NOTE: The phone number must be entered as a 10-digit number
   - B. Enter the service location fax number if applicable NOTE: The fax number must be entered as a 10-digit number
   - C. Select "Save"
8. Select "Add Contact Person" to add a service location contact person NOTE: Repeat this step if you need to add multiple contact persons
   - A-H. Enter the appropriate information for the service location contact person
   - I. Select "Save"

NOTE: The service location contact person should be someone who can respond to enrollment related issues for this location

NOTE: Please ensure any contact persons listed have their email address entered

NOTE: You should provide contact information for any staff who will need to be apprised of updates to the Medicaid program, including: billing, CFO/CEO, Medicaid administrators, etc. Please add all of these contacts and indicate their role

Service Location Information – Section 4

9. Select Yes or No. If No is selected, enter the Mailing Address
   - A-E. Enter the Mailing Address Information with the Zip +4 code
   - F. Select "Validate Address" to ensure the address is in proper postal format
   - G. Select the appropriate address from the list. NOTE: If none of the addresses are correct, select the Override option to accept the address that you entered
   - H. Select "Submit"
10. Select "Add Numbers" to add a phone and fax number for the Mailing Address Location
    - A. Enter the mailing address location phone number. NOTE: The phone number must be entered as a 10-digit number
    - B. Enter the mailing address location fax number if applicable. NOTE: The fax number must be entered as a 10-digit number
    - C. Select "Save"
11. Select "Add Contact Person" to add a mailing address location contact person. NOTE: Repeat this step if you need to add multiple contact persons
    - A-H. Enter the appropriate information for the mailing address location contact person
    - I. Select "Save"

NOTE: The mailing address contact person should be someone who handles mailings. They may be contacted for mail related issues

NOTE: Please ensure any contact persons listed have their email address entered

- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Exclusion/Sanction – Section 7

- Select Yes or No for each question. If you select Yes for any question, additional required fields will appear
  NOTE: Any question answered Yes will require a copy of the original adverse action or a dated signed statement from the provider which must be submitted with the application

Exclusion / Sanction — Print | Help

* Required Field

Application Links
Application Tracking Number -

- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Number
- Service Location
- **Exclusion / Sanction**
- Signature Page

Help

Exclusion/Sanction
Answer all of the questions. Additional information will be required if your response is Yes.

Name & Federal Program
To add Name and/or Federal Program information, click the appropriate 'Add' button. Enter the required information, and Save the form. Click anywhere on an existing row to update or delete the row.

Date of Occurrence
Enter as MM/DD/YYYY, MM-DD-YYYY or MMDDYYYY or click the Calendar icon to choose a date.

Click the **Save** button at the bottom of the page to validate the page content and save the information.
Click the **Continue** button to move to the next step. If you choose to **Exit Application**, please save and note the Tracking Number or print this page so you can make updates to this application at another time.

For additional Enrollment Help, click the **Help** link on the blue bar at the top of this form.

Exclusion/Sanction- Section 7

*1.Has any person who has ownership of, or a controlling interest in, the provider's practice or business entity, or who is an agent, managing employee, contract employee, subcontractor, or employee of the provider's practice or business entity, ever been convicted of a criminal offense related to New Hampshire's Medical Assistance Programs, the Medicaid program in another state or territory, the Medicare program, or any other federally funded health or social service program?
○ Yes ○ No

*2.Have you or any member of your immediate family ever been convicted, assessed, debarred, or excluded from the Medicaid, Medicare, or Title XVIII, Title XIX, Title XX Social Security program or any other federal program due to fraud, obstruction of an investigation, or a controlled substance violation?
○ Yes ○ No

*3.Do you, under any name or business identity, have any outstanding overpayments with any state or federal program?
○ Yes ○ No

*4.Have you ever plead guilty, no contest or been sentenced for any felony crime and/or had a criminal fine or restitution order assessed or do you have a felony charge pending under Federal or State law?
○ Yes ○ No

*5.Have you or any of your employees, contract employees, or any person or entity with ownership of your business, ever been sanctioned by the Office of Inspector General (OIG), Medicare, Medicaid, or the Social Security Act, including a state Medicaid program?
○ Yes ○ No

*6.Have you or any of your employees, contract employees, or any person, or entity with ownership of your business, ever been denied malpractice insurance or ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license, certification, or permit including any formal or informal Professional Board Disciplinary Action (s)?
○ Yes ○ No

*7.Have you or any of your employees, contract employees, or any person or entity with ownership of your business, ever had any Program Exclusions from any federally funded program?
○ Yes ○ No

*8.Have you or any of your employees, contract employees, or any persons or entity with ownership of your business, been involved in any civil litigation whereby a judgment or settlement was entered into, or a Civil Monetary Penalty(s) was paid?
○ Yes ○ No

*9.Do you or any of your employees, contract employees, or any person or entity with ownership of your business have any Judgment(s) or Pending Actions under the False Claims Act?
○ Yes ○ No

*10.Have you, under any name or business identity, ever had payment suspended by any state or federal program?
○ Yes ○ No

Continue>> | Save | Reset | Exit Application

- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Signature Page Section

1. Select “Print” to print a pre-filled signature page that requires the signature of the provider
   NOTE: You will need to have the signed signature page scanned back onto your computer and saved as a .jpeg, .png, or .pdf file format
2. Select “Upload Document” to open the Add Attachment section
   A. Select Browse to browse your files for the signature page you saved
   B. Add a Description for the attachment
   C. Select “Save”

NOTE: Only one file can be uploaded here. Additional documentation must be submitted with the application in the **Submit Complete Section**

Signature Print | Help

* Required Field

Application Links
Application Tracking Number -

- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Number
- Service Location
- Exclusion / Sanction
- **Signature Page**

Signature Page Instructions

- Please print, sign, and upload this signature page with your Enrollment Application or Revalidation.
- Additional Options for other required documentation to be scanned and uploaded are available at the end of the application.
- You may also fax it to the secure NH Medicaid Provider Relations fax: 1-866-446-3318.
- If you need assistance with uploading the signature page, please contact NH Medicaid Provider Relations Call Center: 1-866-291-1674.

1 Print

Upload Signature Page

Note: Only one file allowed to upload. If you attach the file incorrectly, please detach the existing attachment and attach the new file.

2 Upload Document

Upload only .jpeg,png,pdf format file.

Date Added	Added By	File Name	Description
No Data Available.			

Add Attachment C Save | Reset | Cancel

*File
Browse... A

Note:Maximum allowed size limit is 10MB

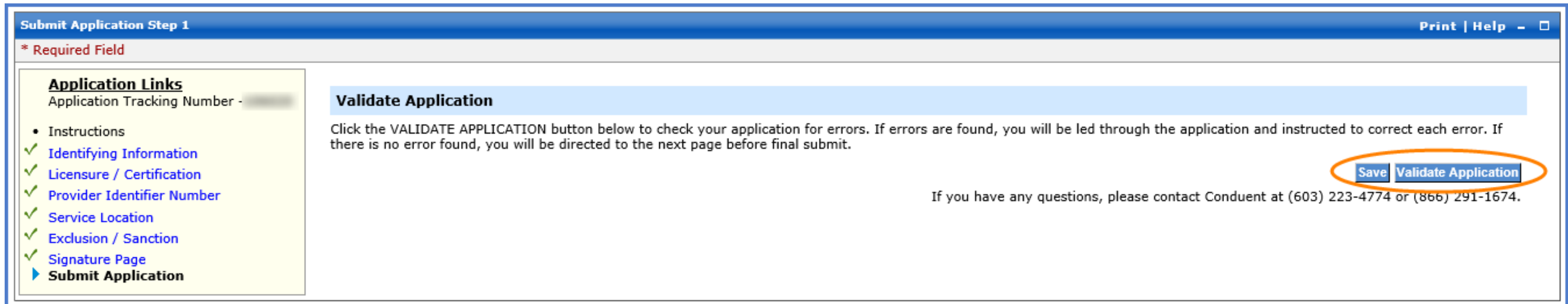
*Description
B

Continue>> Save Reset Exit Application

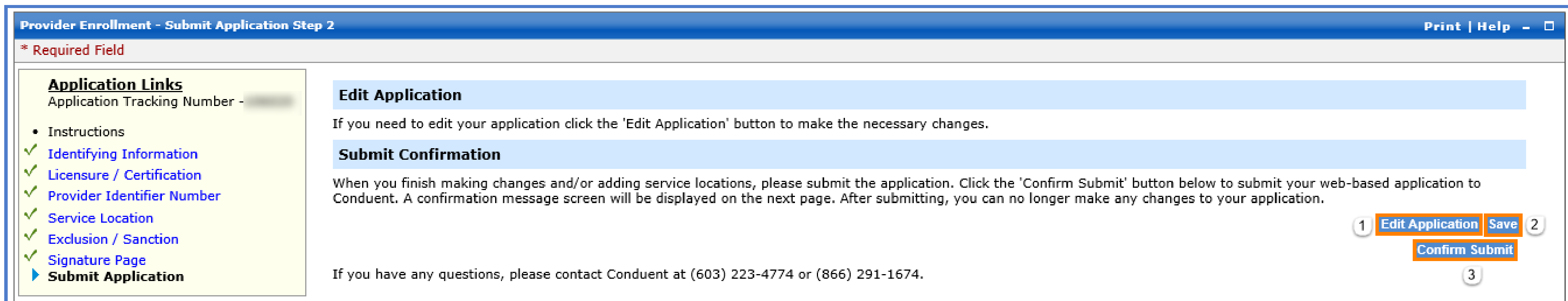
➢ Select “Save” at the bottom of the section, then select “Continue” to move to the next section

Submit Application Section

- Select "Save" at the bottom of the section, then select "Validate Application" NOTE: Validating the application will check the application for errors. If any errors are found, it will bring you to the sections that contain the error where you will need to correct it before being able to submit



1. If you need to edit the application, select "Edit Application"
2. Select "Save" to save the application
3. Select "Confirm Submit" to submit the application NOTE: You will not be able to make edits to the application after making this selection. If there are any changes needed, you will need to contact the NH Medicaid Provider Relations Call Center at 866-291-1674



Submit Complete Section

1. Once you submit the application, you will be brought to the Submit Complete page. The required documents for the application will be listed here. When you select the document, you will be able to print and complete it.
2. If you have completed required documents or have any additional documentation, they can be uploaded here. Select "Add Attachment" to upload a document
3. Select "Save All Attachments" to save the attachments once they've been uploaded
4. Select "Print Application" to print a PDF of the entire application that was completed. Then select "Exit Application" to bring you back to the MMIS home page

Submit Complete Print | Help

* Required Field

Thank you for submitting your application on-line. In order to fully process your application the required documents listed below must be **submitted to NH Medicaid.** Once all documents have been received and your application **has been** reviewed you will be notified via mail with the application decision.

You may check the status of your application at any time, through the Application Status function located on the main Enrollment home page or by contacting Provider Enrollment Services at the number listed below, and providing your Application Tracking Number.

Application Tracking Number

Application Tracking Number:

Please make a record of this Application Tracking Number. Use this number when inquiring about the status of the application.

Print, Sign, and Submit your Documents

The PRINT APPLICATION button may be used to print a copy of the application. This copy is for your records only and should not be submitted to **NH Medicaid.**

All providers must print and sign the **Provider Enrollment/Revalidation Signature Page and NH Medicaid Provider Participation Agreement.** Additional documents may be required depending on your provider type and business situation. Documents must be completed, signed and submitted to **NH Medicaid via upload or mailed to** the address below. Copied or stamped signatures are not acceptable. Print the **Required Enrollment Documents** Checklist to identify the supplemental information by provider type and business model that **are required** to finalize your application. **Submit all provider enrollment documentation via upload or by mail to:**

NH Medicaid Program

PO BOX 2059

Concord, NH 03301 - 2059

NOTE:Include the Application Tracking Number indicated above on any documents mailed to **NH Medicaid** in reference to your application.

Upload or Mail the following required documents:

1. Enrollment/Revalidation Signature Page
2. NH Medicaid Provider Participation Agreement (PPA)
3. Document Requirements Checklist

(1)

Attachments

System successfully saved the Information

(2) Add Attachment (3) Save All Attachments

NOTE: Please select 'Save All Attachments' button to successfully upload documents.

Date Added	Added By	File Name	Description
07/13/2022 04:49 PM	GUESTUSER	Blank PPA.pdf	PPA

1 - 1 of 1

Once all required documents have been printed, click the EXIT APPLICATION button to return to the NH Medicaid Provider Enrollment home page.

Fingerprint-based Criminal Background Check (FCBC) Notification

The Affordable Care Act (Section 6401), under 42 CFR 455.434, identifies Medicaid providers whose owners are required to submit fingerprint-based criminal background checks. The Medicaid providers identified as high-risk per 42 CFR 455.450 are owners with a 5% or more direct or indirect ownership interest, providers that deliver home health services, Durable Medical Equipment, have been sanctioned within the past 10 years or have an existing State Medicaid Plan qualifying overpayment. For more information please go to Department of Health & Human Services website at https://www.dhhs.nh.gov/bii/pi.htm.

(4) Print Application Exit Application

If you have any questions, please contact Conduent at (603) 223-4774 or (866) 291-1674.