STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

New Hampshire Medicaid Program

Enrollment/Revalidation Signature Page

Please print, sign, and upload this signature page with your Enrollment Application or Revalidation. You may also fax it to the secure NH Medicaid Provider Relations fax: 1-866-446-3318.

* Required Field

*Group Name or Individual Name:

Doing Business As (DBA) Name *(if applicable):*

*Federal Employer Identification Number (FEIN) (9 digits) **OR** *Social Security Number (SSN) of Individual Provider

Group FEIN:	Individual SSN:

*For Enrollment: Application Tracking Number (ATN) **OR** *For Revalidation: Medicaid ID Number

Enrollment ATN:	Medicaid ID #:

1. I have read the contents of this application and the information contained herein is true, accurate, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the New Hampshire (NH) Department of Health and Human Services (DHHS) Medicaid fiscal agent of this fact immediately.

2. I authorize the NH DHHS Medicaid fiscal agent to verify the information contained herein. I agree to notify the NH DHHS Medicaid fiscal agent of any changes to information in this form within 30 days of the effective date of the change. I understand a change in my ownership status as an Individual or Group Provider may require a new application.

3. I am not currently subject to sanction under the NH Medicaid Program or debarred, suspended or excluded under any other federal agency or program, or otherwise prohibited from providing services for the NH Medicaid Program or other federal healthcare programs beneficiaries.

4. I understand that any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to NH Medicaid Program fiscal agent to complete or clarify this application may be punishable by criminal, civil or other administrative actions.

5. I understand that payment of all claims will be from federal and state funds, and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by the NH Medicaid fiscal agent and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

I certify that I am the individual practitioner or one of the identified authorized signees for the group who is applying for the NH Medicaid Provider number:

*For Group Enrollment/Revalidation: Signature of Owner, General Partner, Board Officer, or Managing/Directing Employee
*For Individual Enrollment/Revalidation: Signature of Individual Provider

*Signature:	*Title/Positon:
*Print Name:	*Date: