STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

New Hampshire Medicaid Program

NH Medicaid Facility or Entity Provider Enrollment Instructions

Completing the Group Provider Enrollment Application as a Facility or Entity

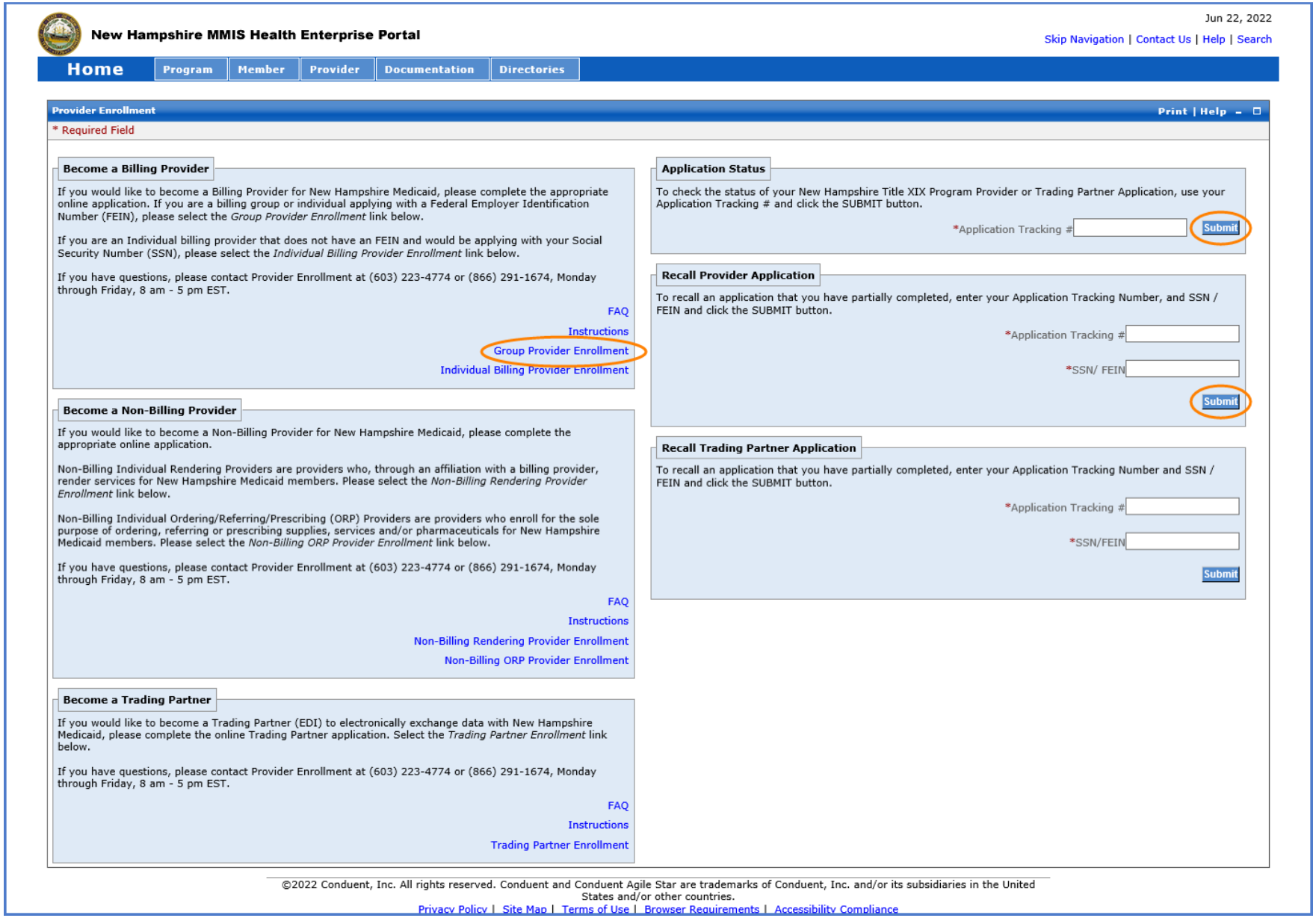
www.nhmmis.nh.gov

- 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

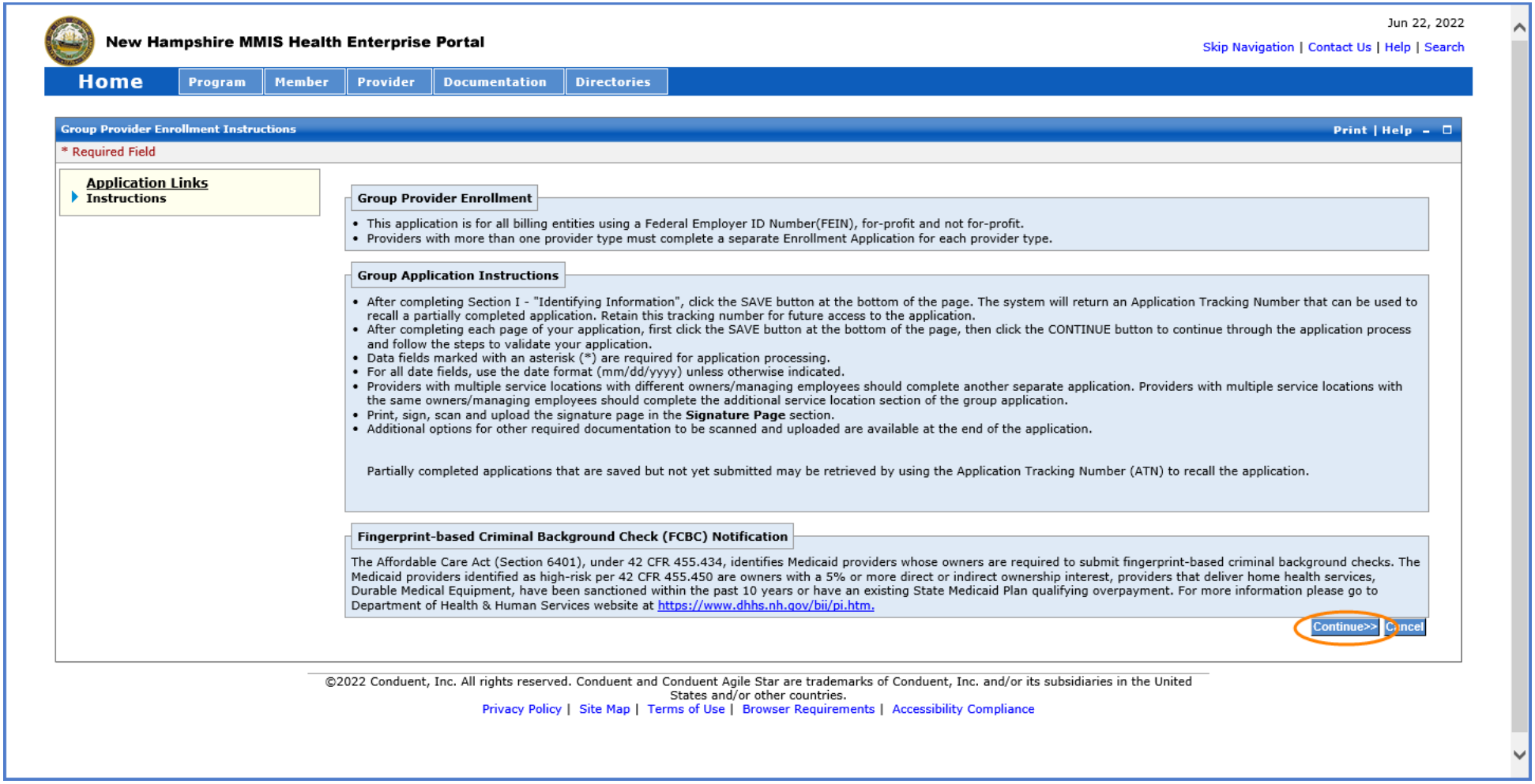
- Select the "Group Provider Enrollment" link

  NOTE: You can also check the status of an in-process 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 FEIN in the Recall Provider Application section and select "Submit"



- Please read the following information and select "Continue"
  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



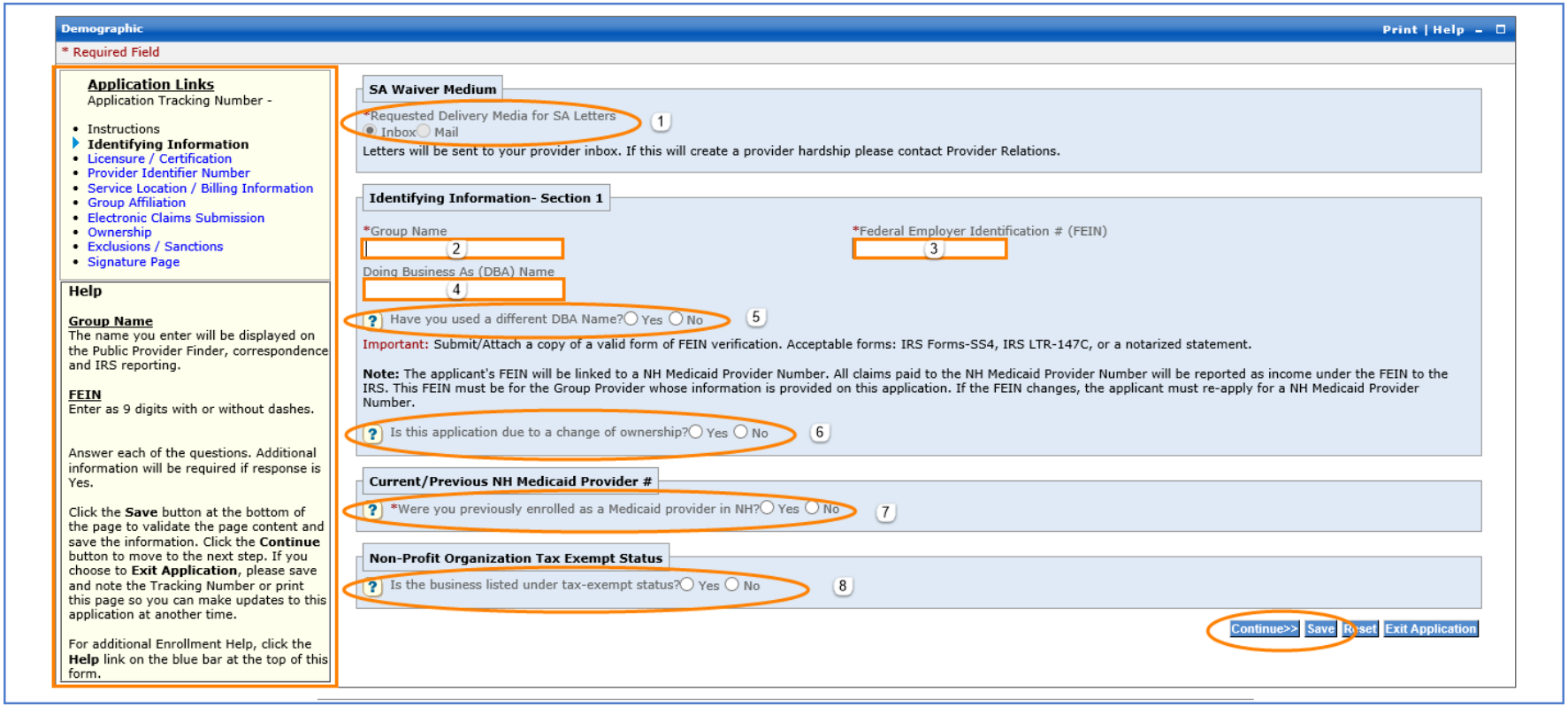
Identifying Information – Section 1

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 the NH Medicaid Provider Relations Call Center at 866-291-1674
2. Enter the facility/entity's Legal Name NOTE: Please use your legal name for all communications with Medicaid
3. Enter the Federal Employer Identification Number (FEIN), also known as the Tax ID NOTE: You will need to provide proof of the FEIN as part of the required supporting documentation
4. Enter the Doing Business As (DBA) name, if appropriate
5. Select Yes or No NOTE: If you select yes, the field will expand, and you will be required to enter your Former DBA Name
6. Select Yes or No NOTE: If you select yes, the field will expand, and you will be required to enter the previous owner's Provider Number
7. 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
8. Select Yes or No

- 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

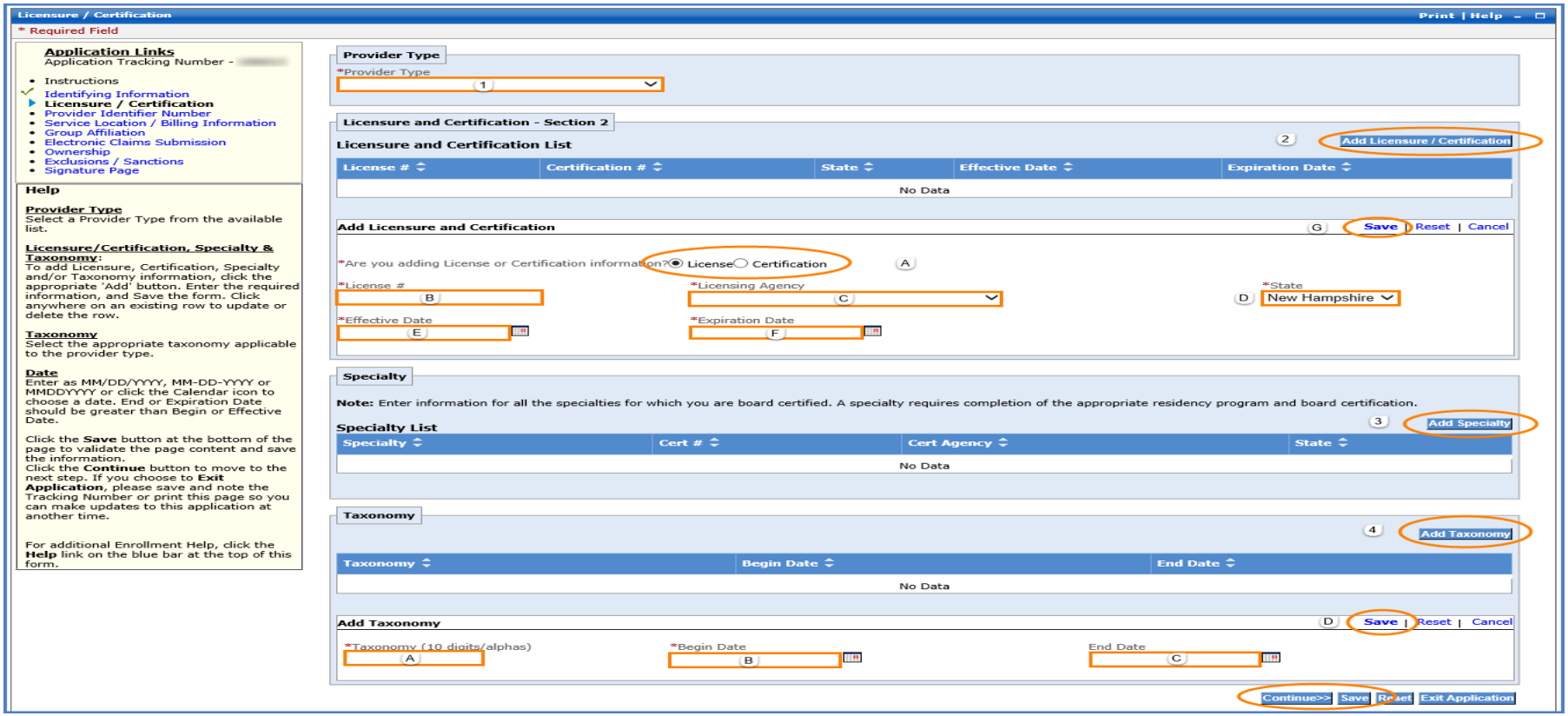
NOTE: Note this number somewhere as you will need it to check the status of the application or recall the application



- 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 if applicable NOTE: Facilities and Entities may require a License or Certification, depending on the Provider Type. 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. Select the License or Certification State from the drop-down list
   E. Enter the License or Certification Effective Date
   F. Enter the License or Certification Expiration Date
   G. Select "Save"
3. Select "Add Specialty" if applicable and enter the appropriate fields
4. The Taxonomy code is required for facilities and entities that have an NPI. 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

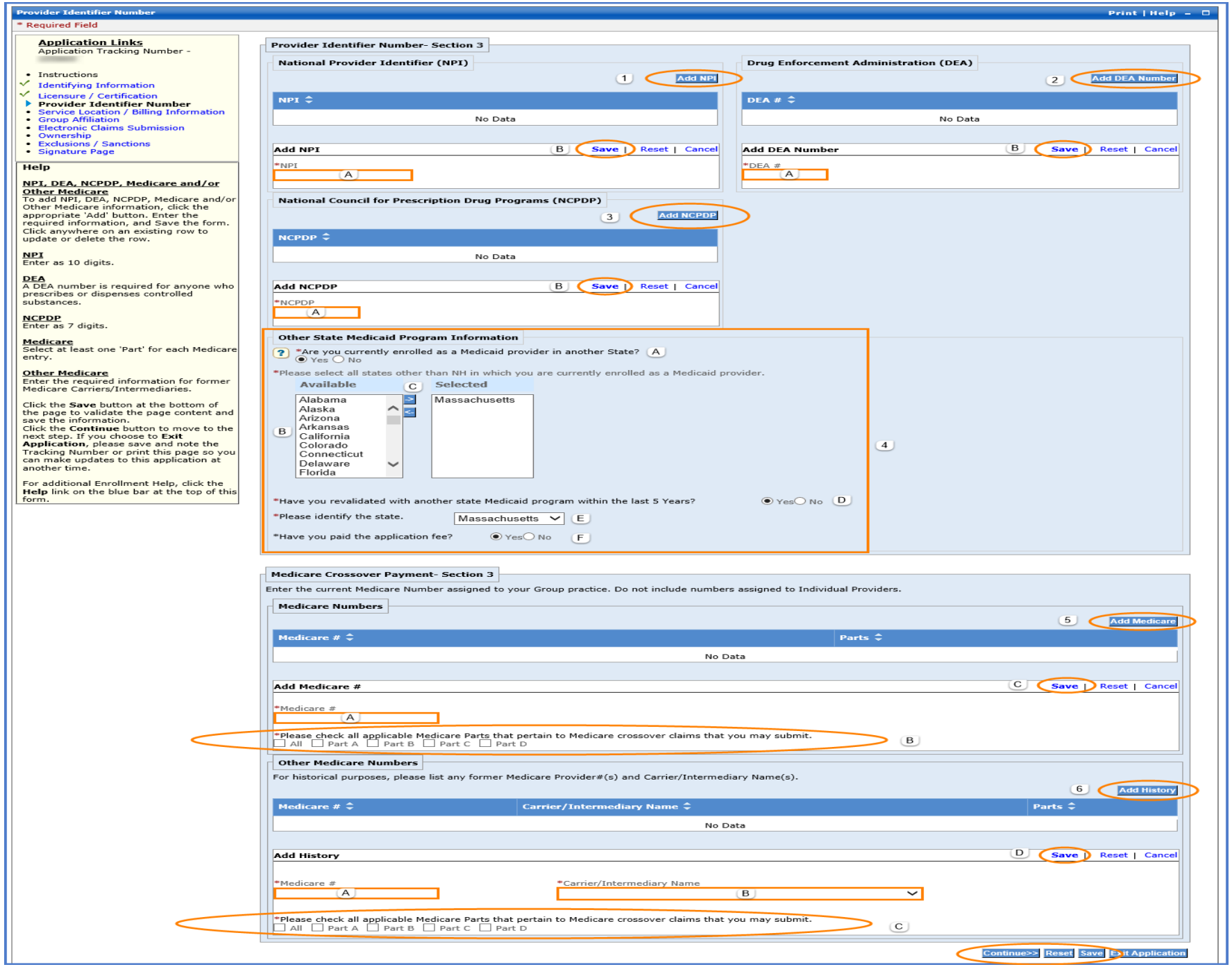
Provider Identifier Number – Section 3

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

1. Select "Add NPI" if applicable
    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. Select "Add DEA Number" if applicable NOTE: This section is only required for provider types that prescribe or dispense controlled substances
    A. Enter your DEA number
    B. Select "Save"
3. Select "Add NCPDP" if applicable NOTE: This section is only required for provider types that prescribe drugs.
    A. Enter your 7-digit NCPDP number
    B. Select "Save"
4. 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
5. 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"
6. 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



Service Location / Billing 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

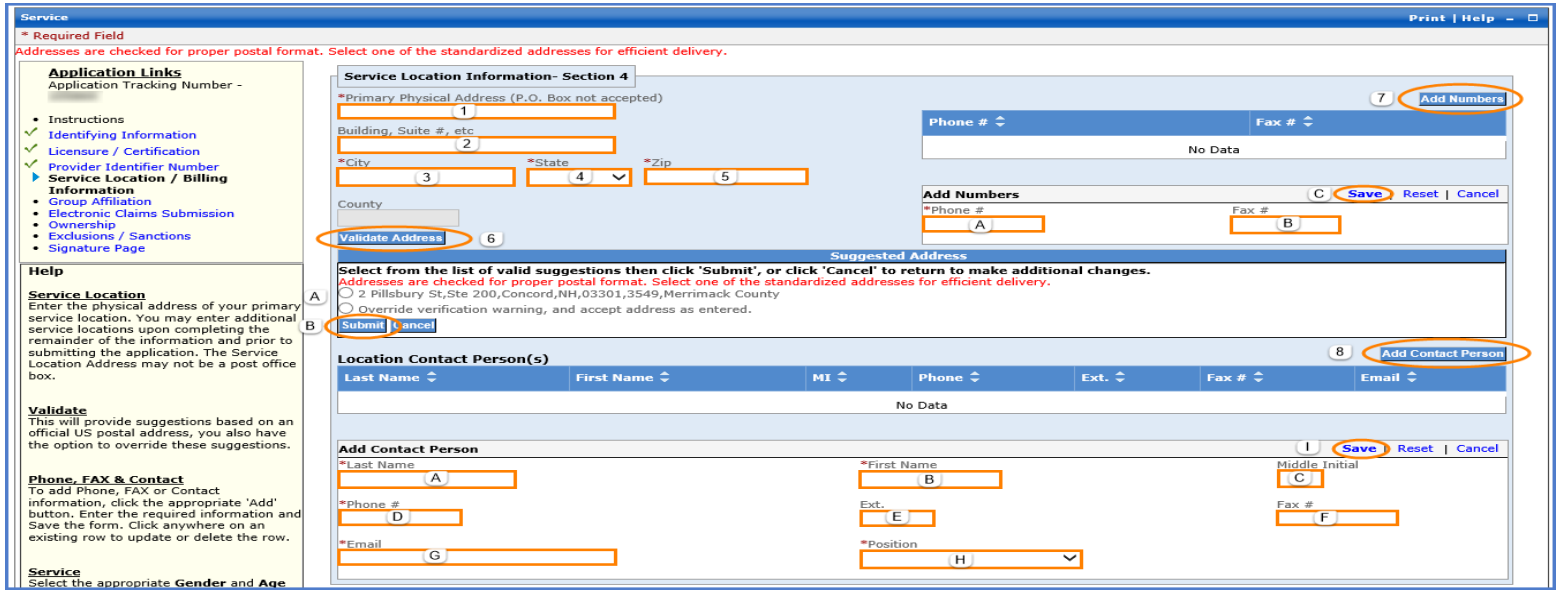
1-5. Enter the primary Service Location physical address with the Zip +4 code NOTE: The address entered here should match what is entered on the Provider Participation Agreement (PPA) document

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

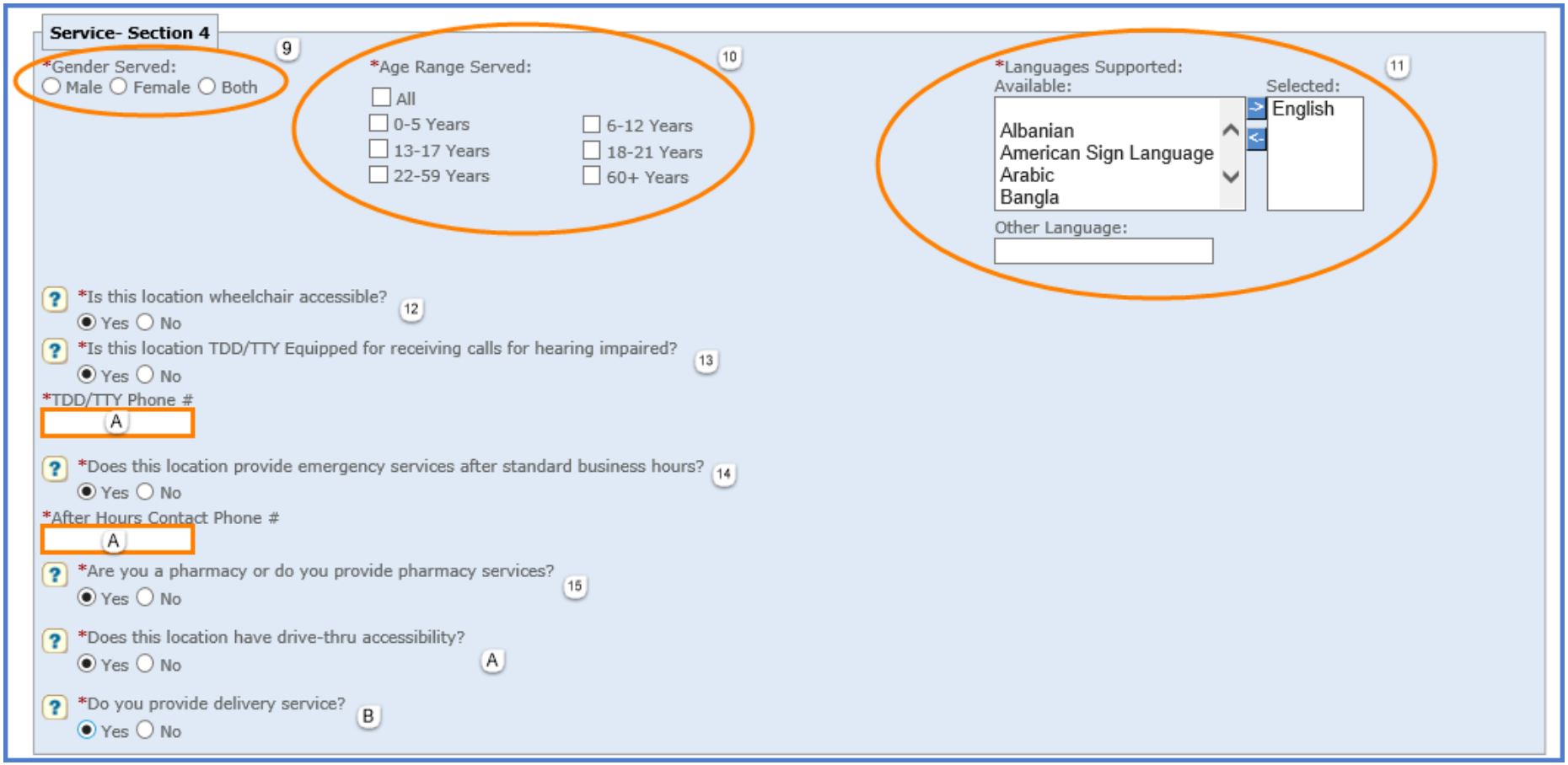
NOTE: Please ensure any contact persons listed have their email address entered

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 / Billing Information – Section 4

9. Select the Male, Female, or Both option
10. Check off the age ranges that are served at this service location
11. Select the languages that are supported at this service location. NOTE: Use the left and right arrows to move selections to and from the Available and Selected boxes. You may also enter an Other Language if the language is not listed
12. Select Yes or No
13. Select Yes or No
    A. If Yes is selected, enter the TDD/TTY Phone Number
14. Select Yes or No
    A. If Yes is selected, enter the After Hours Contact Phone Number
15. Select Yes or No NOTE: If Yes is selected, 2 additional questions will appear
    A. Select Yes or No
    B. Select Yes or No

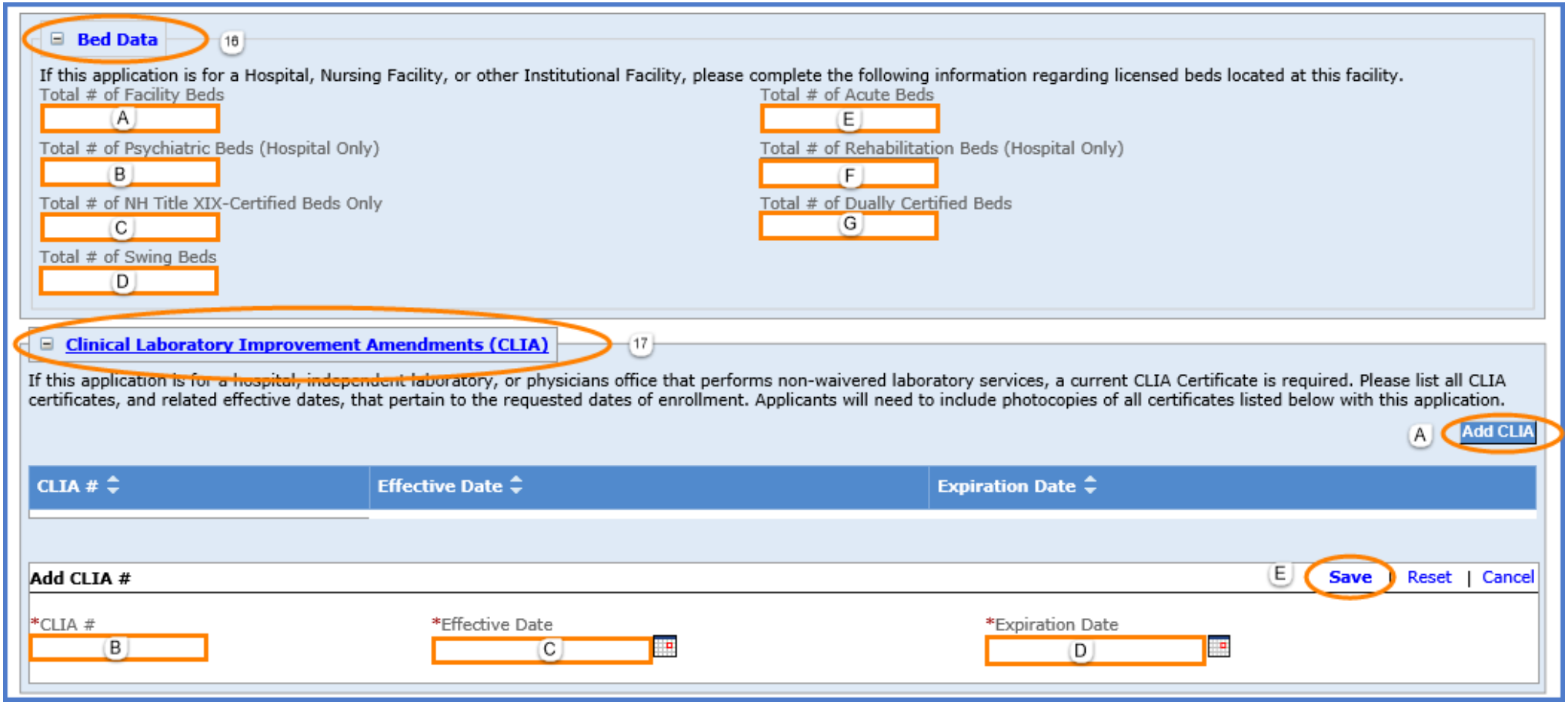


Service Location / Billing Information – Section 4

16. Select "Bed Data" to enter bed data if applicable

    A-G. Enter the applicable bed data information in each field NOTE: The Total # of Facility Beds field should equal the sum of all other bed data fields

17. If you have a CLIA certificate, select "Clinical Laboratory Improvement Amendments (CLIA)"
    A. Select "Add CLIA"
    B. Enter you CLIA number
    C. Enter the Effective Date
    D. Enter the Expiration Date
    E. Select "Save"

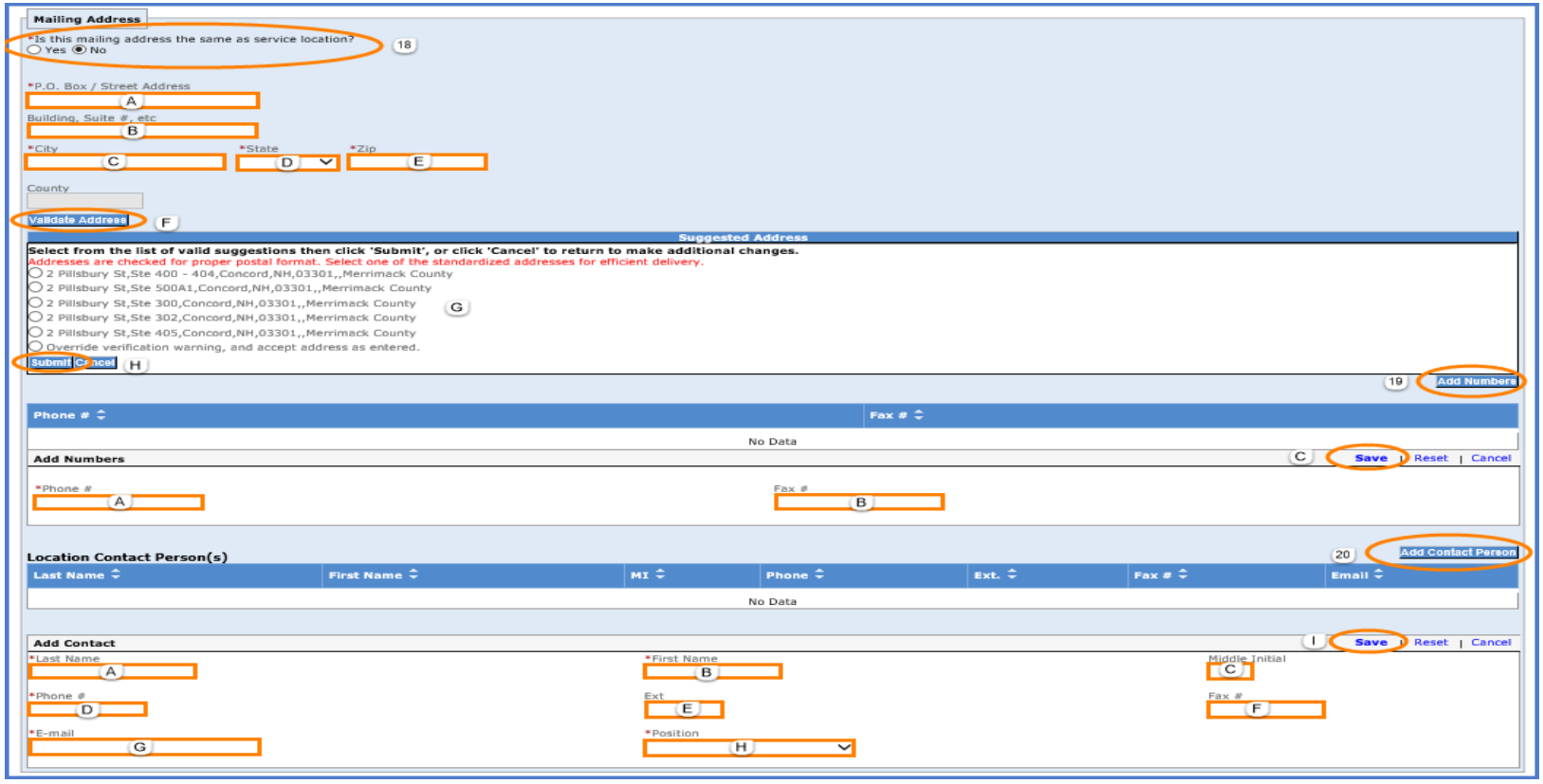


Service Location / Billing Information – Section 4

18. 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"
19. 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"
20. 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"

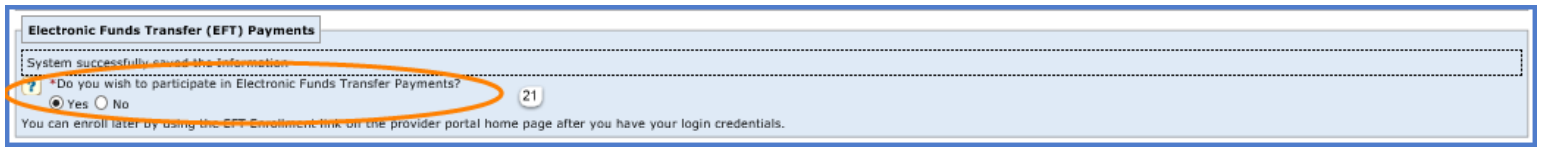
NOTE: The mailing address contact person should be someone who handles mailings. They may be contacted for mail related issues

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



Service Location / Billing Information – Section 4

21. Select Yes or No. Selecting Yes will enroll you in EFT payments, allowing you to receive payments via direct deposit. This will open a new screen to disclose the bank account information NOTE: NH Medicaid recommends participating in EFT payments to ensure quicker payment



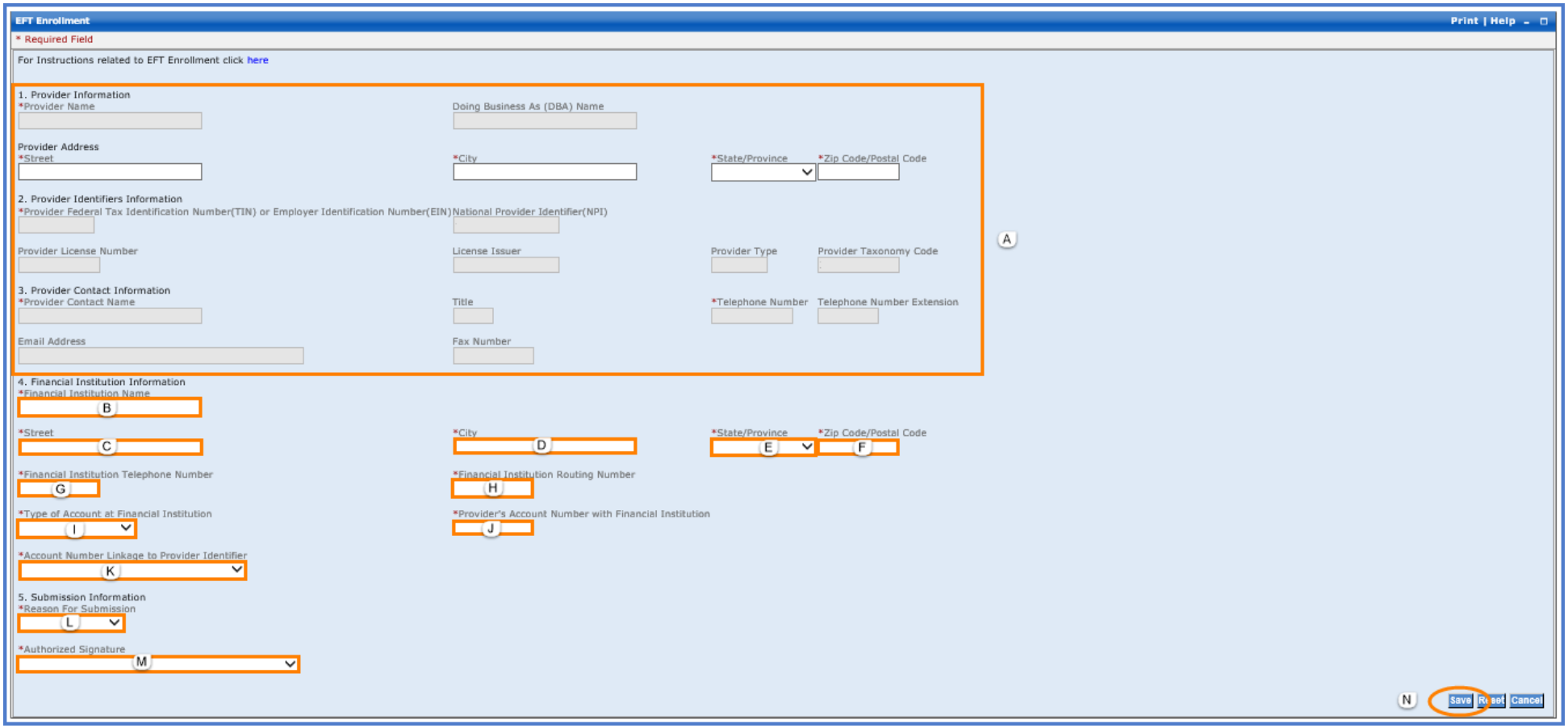
A. This information will be pre-filled with the information you have entered in previous sections of the application. NOTE: If information is missing or incorrect in this section, you will need to select "Cancel" and return to the previous applicable sections to correct that information

B-G. Enter the Financial Institution Name, address, and phone number

H-J. Enter your bank account information

K-M. There will only be one option for each drop-down menu. Select the one option for each section

N. Select "Save." This will return you to the Service Location / Billing Information page



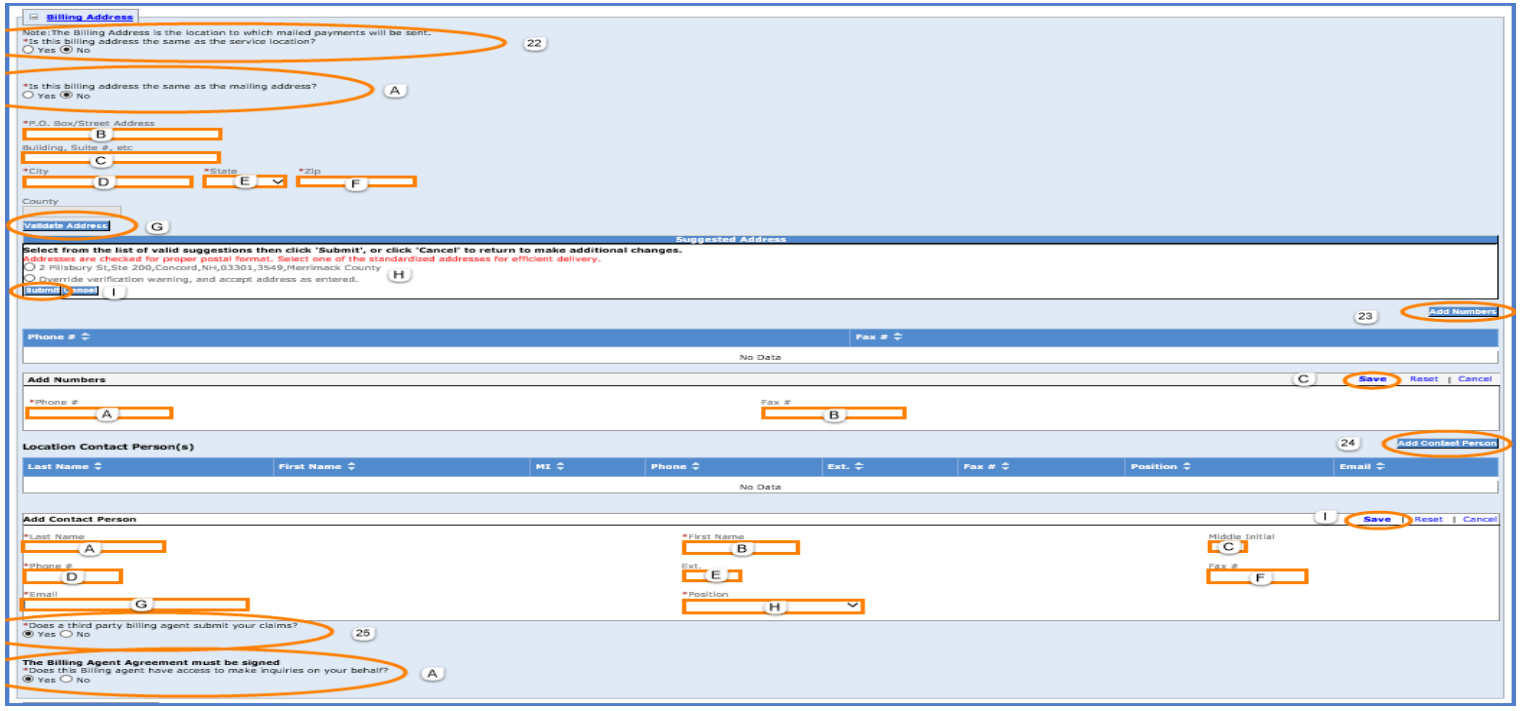
Service Location / Billing Information – Section 4

22. Select Yes or No. If No is selected, it will ask if the billing address is the same as the mailing address
    - A. Select Yes or No. If No is selected, enter the Billing Address
    - B-F. Enter the Billing Address information with the Zip +4 code
    - G. Select "Validate Address" to ensure the address is in proper postal format
    - H. 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
    - I. Select "Submit"
23. Select "Add Numbers" to add a phone and fax number for the Billing Address Location
    - A. Enter the billing address location phone number. NOTE: The phone number must be entered as a 10-digit number
    - B. Enter the billing address location fax number if applicable. NOTE: The fax number must be entered as a 10-digit number
    - C. Select "Save"
24. Select "Add Contact Person" to add a billing address location contact person. NOTE: Repeat this step if you need to add multiple contact persons
    - A-H. Enter the appropriate information for the billing address location contact person
    - I. Select "Save"

NOTE: The billing address contact person should be someone who can respond to billing, claims, or payment related issues

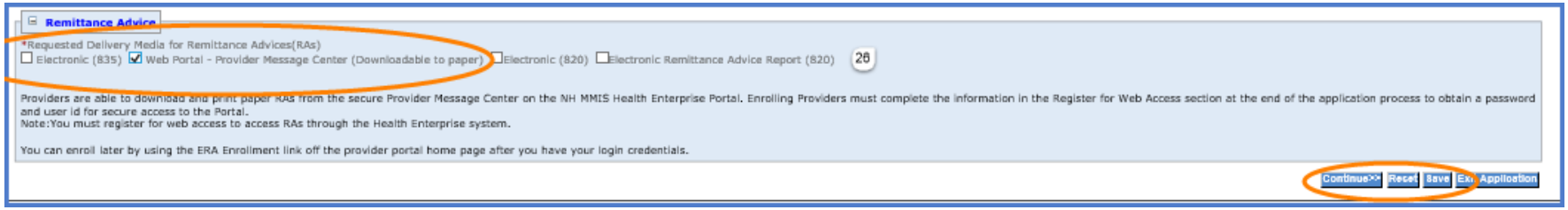
NOTE: Please ensure any contact persons listed have their email address entered

25. Select Yes or No. If Yes is selected, it will ask if the billing agent has access to make inquiries on your behalf
    - A. Select Yes or No



Service Location / Billing Information – Section 4

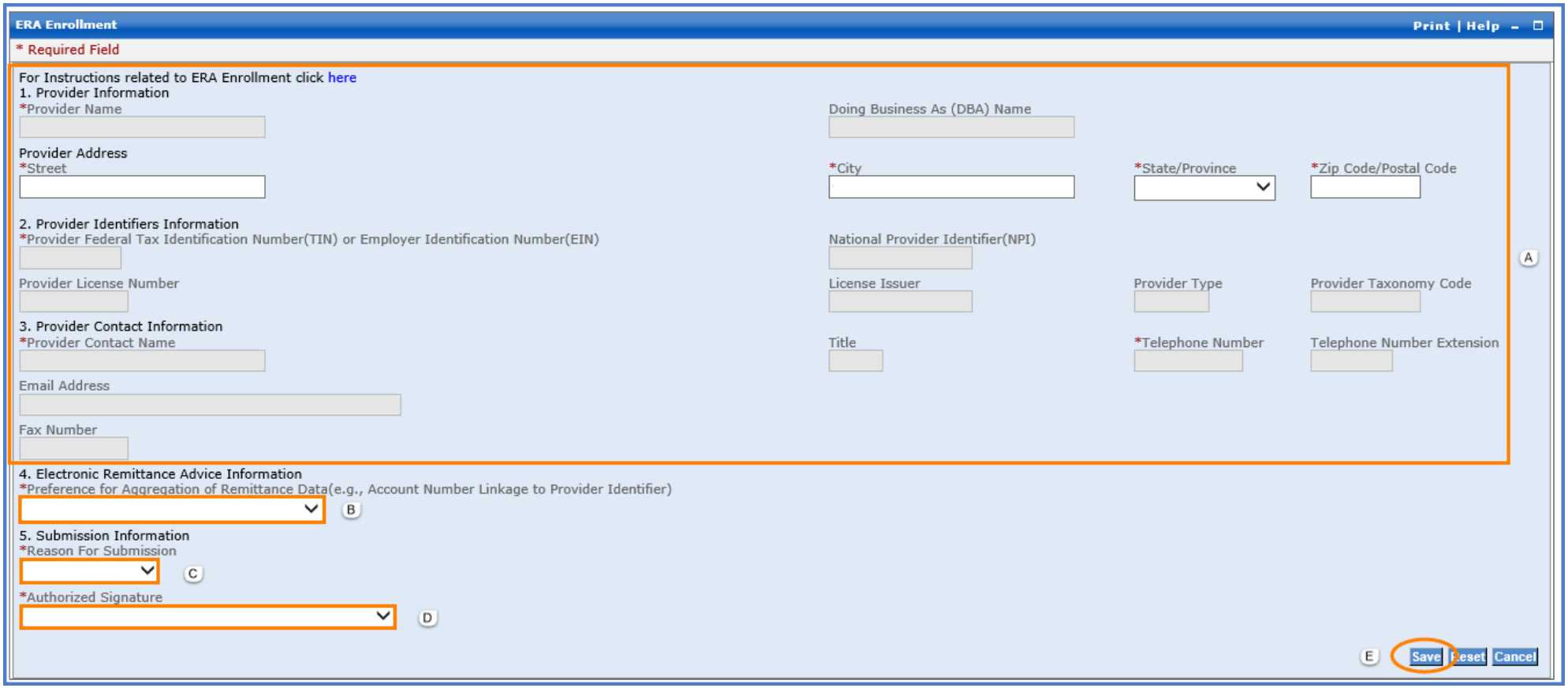
26. Select the medium you wish to receive remittance advices. Do not select either 820 option. If the 835 option is selected, the Electronic Remittance Advice (ERA) Enrollment screen will appear NOTE: You should always select Web Portal, so your remittance advices are available to download in the portal



A. This information will be pre-filled with the information you have entered in previous sections of the application NOTE: If information is missing or incorrect in this section, you will need to go to the previous applicable sections to correct that information

B-D. There will only be one option for each drop-down menu. Select the one option for each section

E. Select "Save." This will return you to the Service Location / Billing Information page

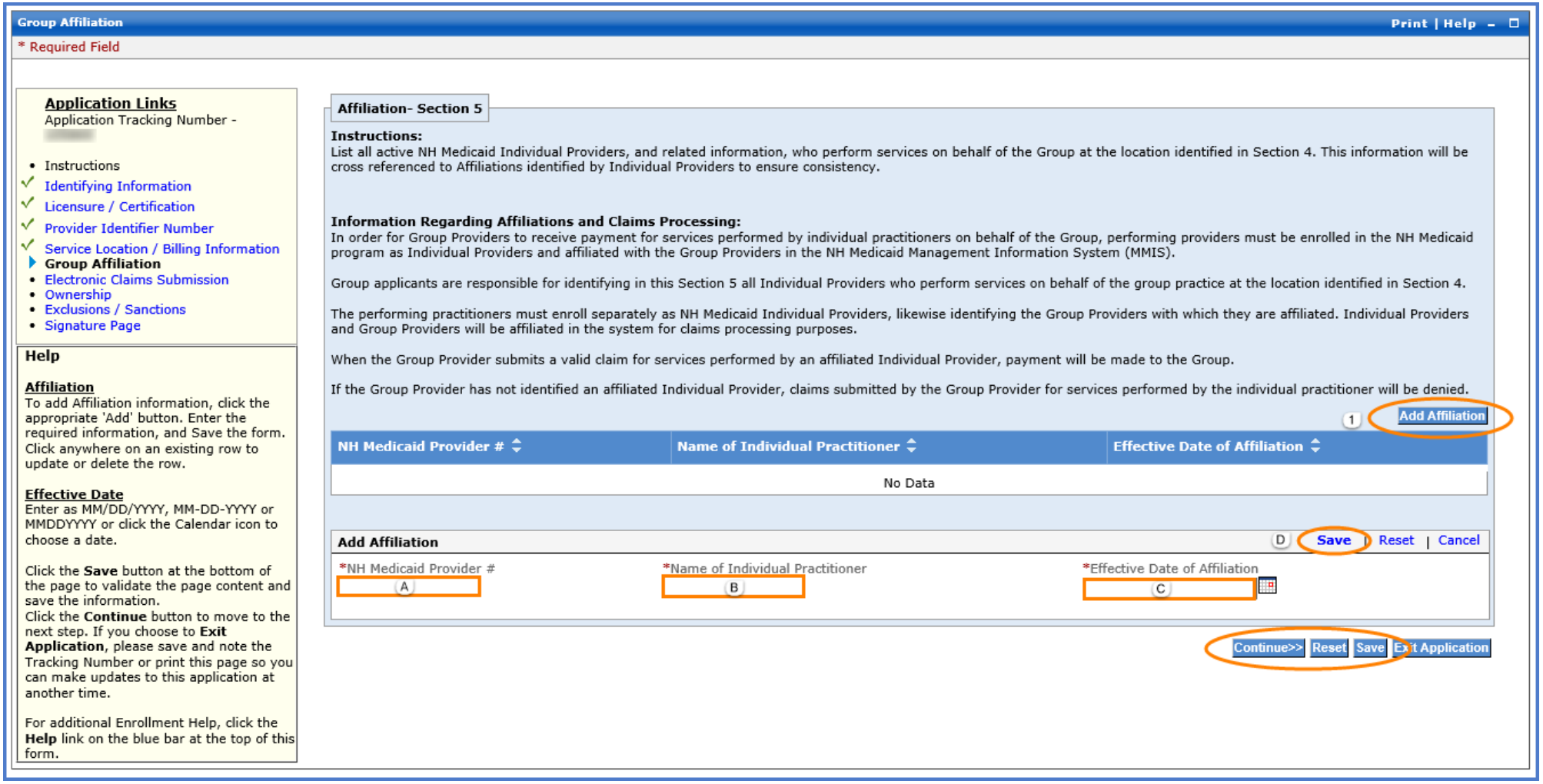


➢ Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Group Affiliation – Section 5

NOTE: All individual affiliated providers, in addition to the group, facility, and entity providers, are required to maintain their own provider account information and revalidate every 5 years.

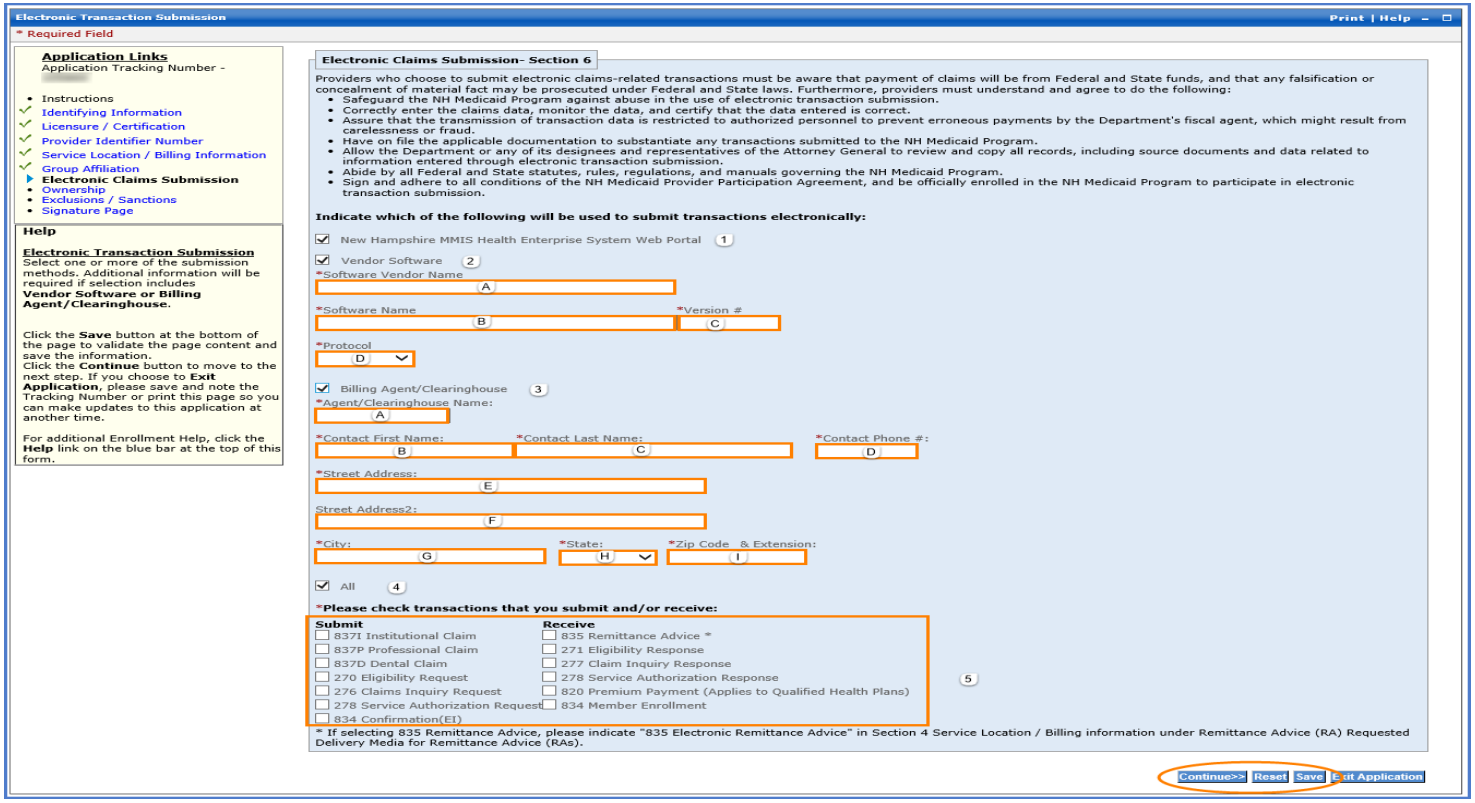
1. Select "Add Affiliation" to add the individual providers who are rendering services at this location if applicable NOTE: Repeat this step as needed to add multiple providers
    A. Enter the affiliated provider's 7-digit Medicaid ID NOTE: If you do not have the provider's Medicaid ID, enter the provider's NPI
    B. Enter the affiliated provider's name
    C. Enter the effective date of the providers' affiliation
    D. Select "Save"



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

Electronic Claims Submission – Section 6

1. Always select the New Hampshire MMIS Health Enterprise System Web Portal. This will allow you to submit claims on the portal
2. Select Vendor Software if you are using a software that generates an X12 batch file that you will upload to the portal NOTE: This selection will create a Trading Partner Self application that will create a new trading partner ID once approved
    A. Enter the Software Vendor Name
    B. Enter the Software Name
    C. Enter the Version Number of the Software
    D. Select the Software Protocol from the drop-down menu
3. Select Billing Agent / Clearinghouse if a third-party submits your claims. This selection means that the third-party will be submitting X12 batch files on your behalf
    A. Enter the Name of the Clearinghouse or Billing Agent
    B-D. Enter the Billing Agent / Clearinghouse contact name and phone number
    E-I. Enter the address of the Billing Agent / Clearinghouse
4. Select All if you utilize all the options to submit and receive transactions
5. If you selected Vendor Software or Billing Agent / Clearinghouse, you would need to select the transactions you submit and receive.

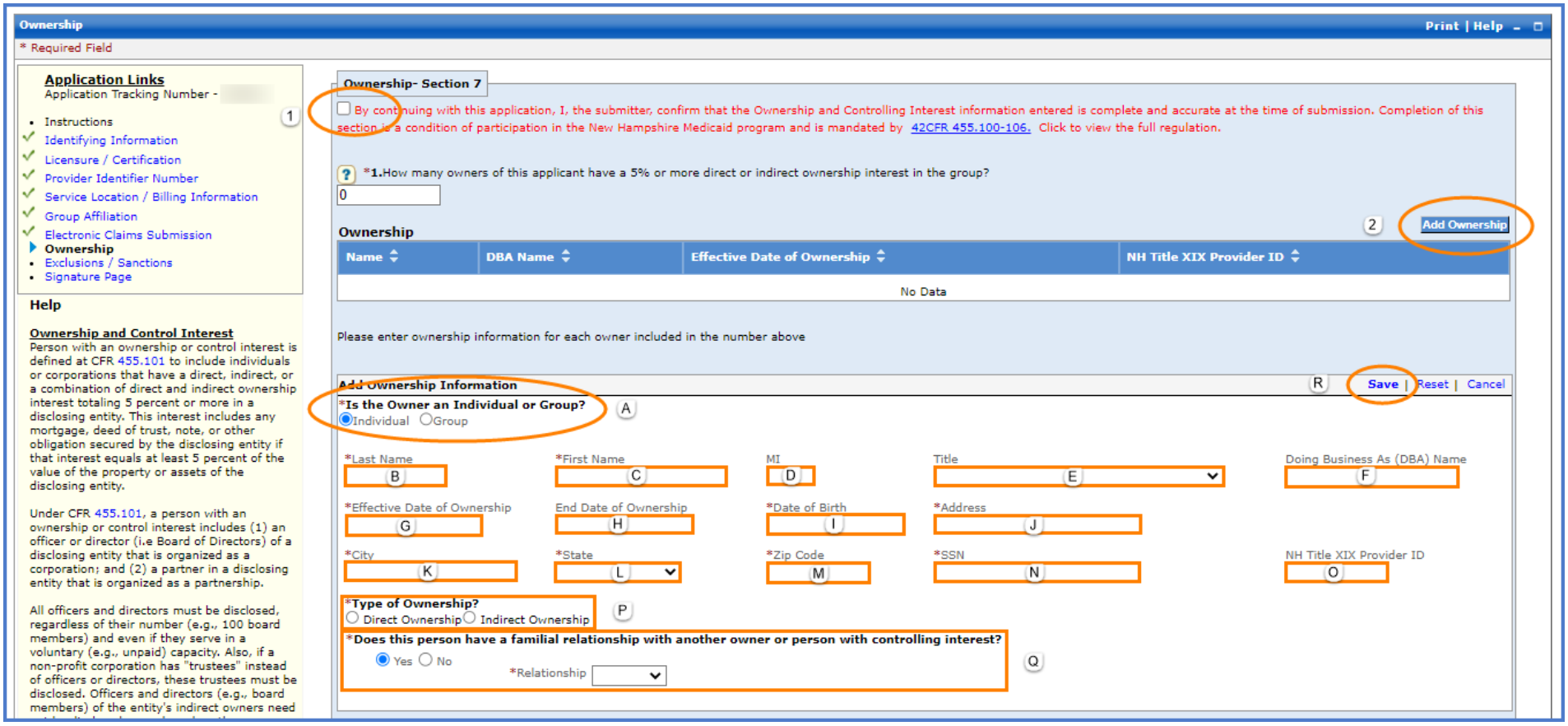


- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Ownership – Section 7 (Adding Individual Owners)

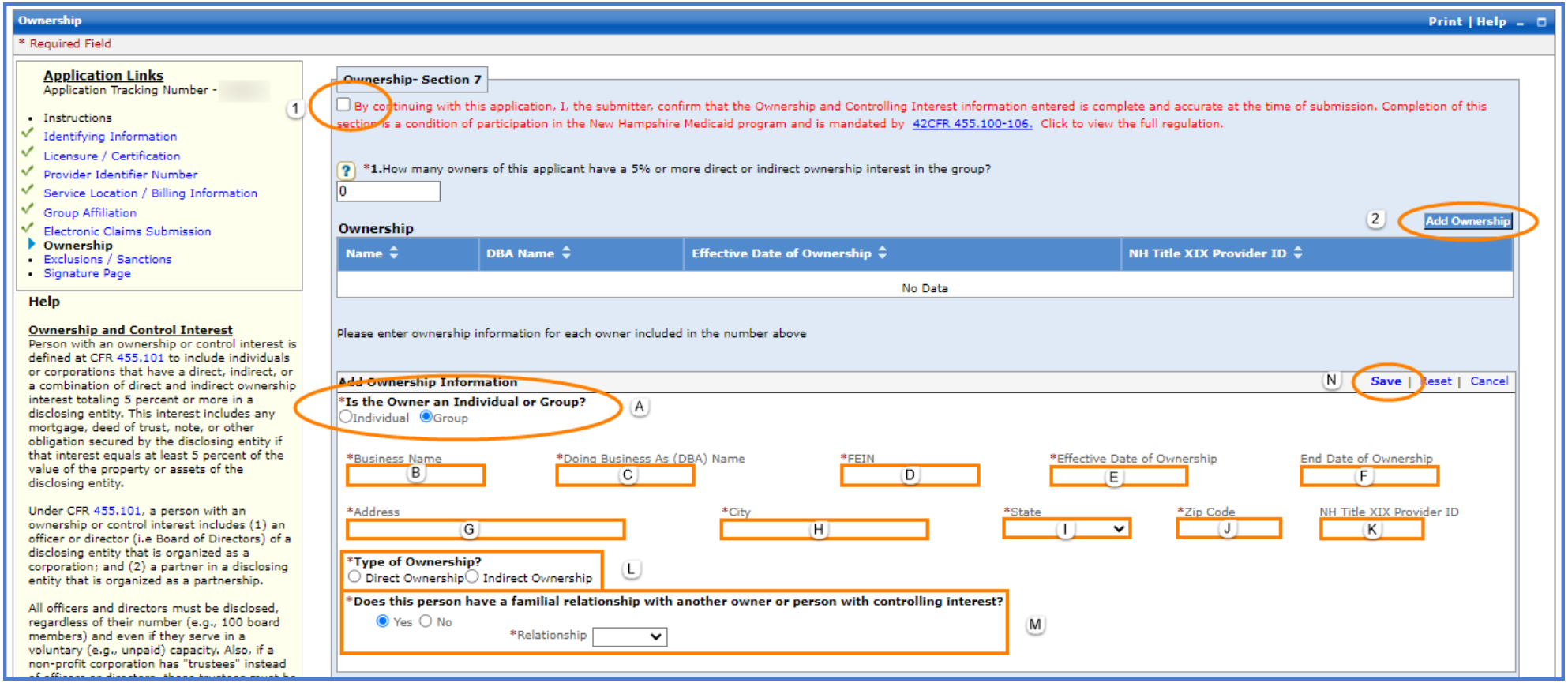
1. Check off the box confirming that what you are entering is complete and accurate
2. Select "Add Ownership" to enter both individual and group owners. Repeat this step if there are multiple owners NOTE: All owners with a 5% or more interest in the group are required to be disclosed. If your group does not have ownership, skip this question

A. For individual owners, select Individual
B-D. Enter the individual's name
E. Enter the individual's Title if applicable
F. Enter the DBA Name if applicable
G. Enter the individual's Effective Date of Ownership
H. Enter the individual's End Date of Ownership NOTE: Enter this as 12/31/9999 if there is not a set end date
I. Enter the individual's Date of Birth
J-M. Enter the individual's home Address
N. Enter the individual's SSN
O. Enter the individual's NH Medicaid ID if applicable
P. Select Direct Ownership or Indirect Ownership NOTE: Direct Ownership is defined as an individual or entity that has possession of equity in the capital, the stock, or the profits of the provider group. Indirect Ownership are owners that indirectly have ownership interest in the provider due to the having ownership interest in the direct owner of the provider.
Q. Select Yes or No NOTE: If selecting Yes, a drop-down box will appear where you will be required to select the type of relationship
R. Select "Save"



Ownership – Section 7 (Adding Group Owners)

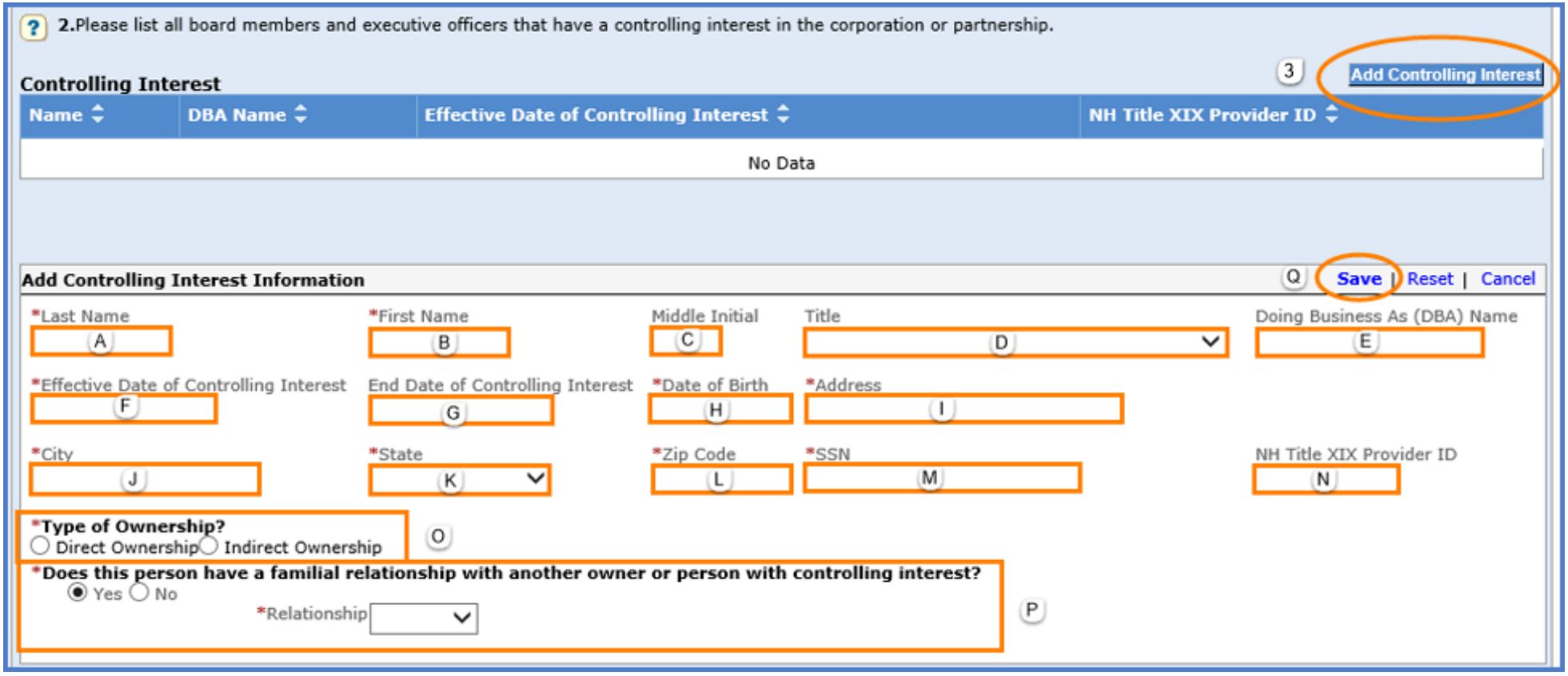
1. Check off the box confirming that what you are entering is complete and accurate
2. Select "Add Ownership" to enter both individual and group owners. Repeat this step if there are multiple owners NOTE: All owners with a 5% or more interest in the group are required to be disclosed. If your group does not have ownership, skip this question
   - A. For group owners, select Group
   - B. Enter the group's Business Name
   - C. Enter the group's DBA Name
   - D. Enter the group's Tax ID (FEIN)
   - E. Enter the group's Effective Date of Ownership
   - F. Enter the group's End Date of Ownership NOTE: Enter this as 12/31/9999 if there is not a set end date
   - G-J. Enter the group's Address
   - K. Enter the group's NH Medicaid ID if applicable
   - L. Select Direct Ownership or Indirect Ownership NOTE: Direct Ownership is defined as an individual or entity that has possession of equity in the capital, the stock, or the profits of the provider group. Indirect Ownership are owners that indirectly have ownership interest in the provider due to the having ownership interest in the direct owner of the provider.
   - M. Select No, as this question is only relevant to individual owners
   - N. Select "Save"



Ownership – Section 7

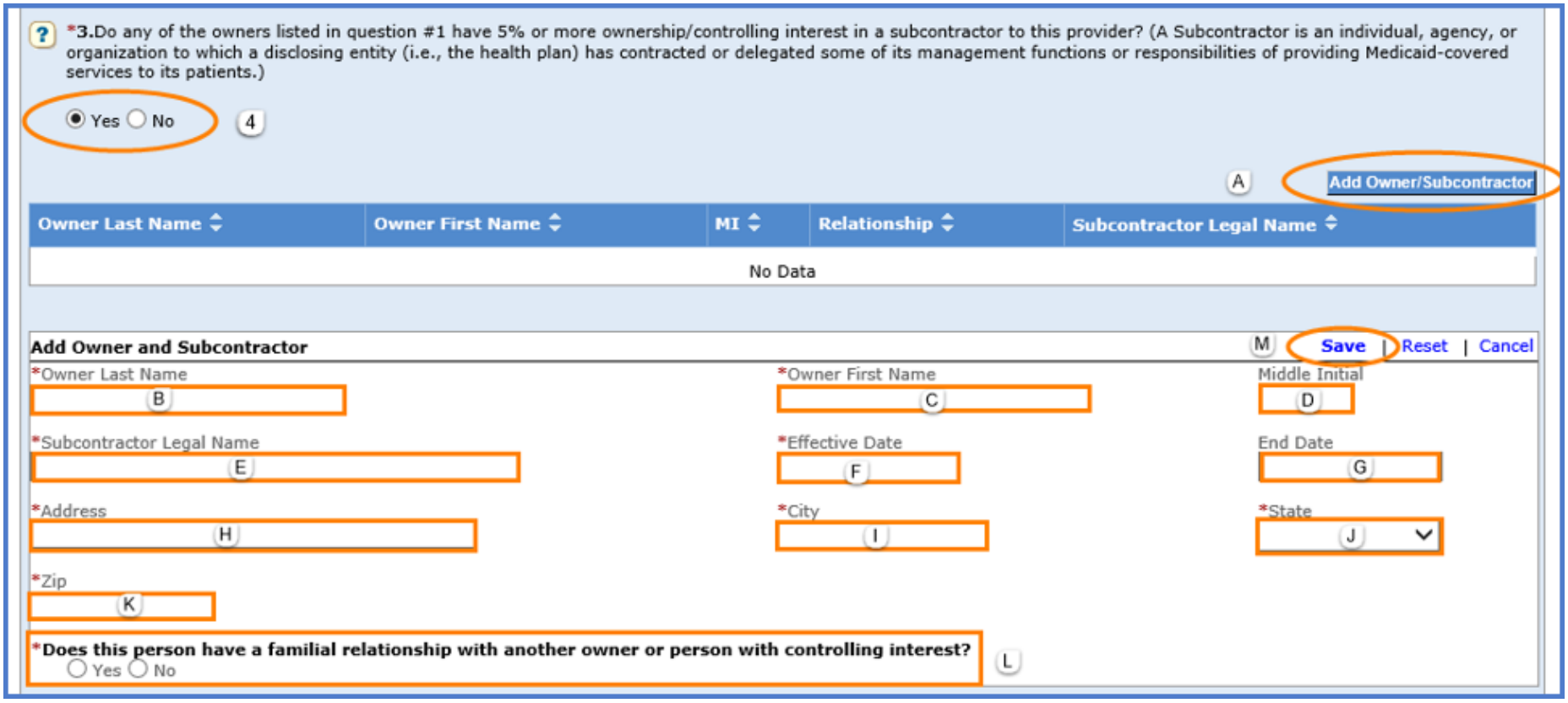
3. Select "Add Controlling Interest" to enter board members and executive officers that have a controlling interest in the provider. Repeat this step if there are multiple Controlling Interest to add

A-C. Enter the individual's Name
D. Enter the individual's Title if applicable
E. Enter the DBA Name if applicable
F. Enter the Effective Date of Controlling Interest
G. Enter the End Date of Controlling Interest NOTE: Enter this as 12/31/9999 if there is not a set end date
H. Enter the individual's Date of Birth
I-L. Enter the individual's home Address
M. Enter the individual's SSN
N. Enter the individual's NH Medicaid ID if applicable
O. Select Direct Ownership for any Controlling Interest individual
P. Select Yes or No NOTE: If selecting Yes, a drop-down box will appear where you will be required to select the type of relationship
Q. Select "Save"



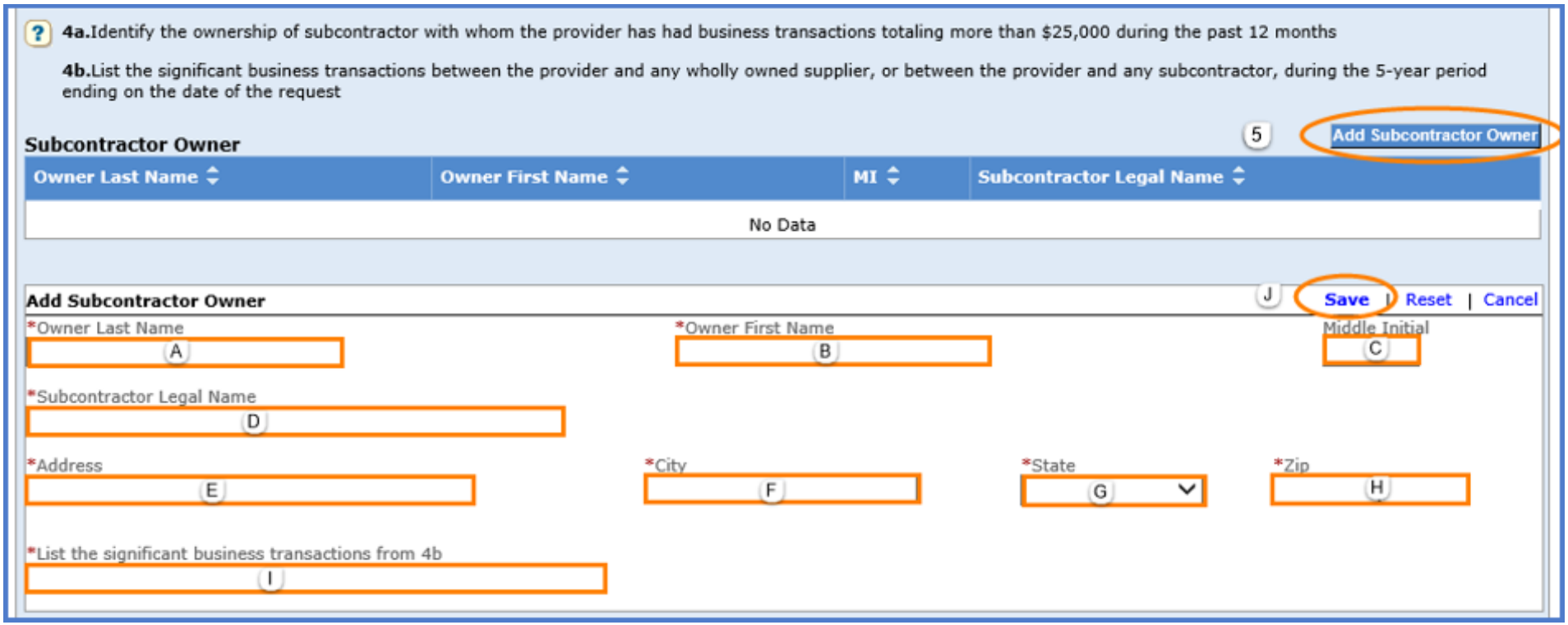
Ownership – Section 7

4. Select Yes or No. If Yes is selected, additional required fields will be displayed to disclose the owner and subcontractor information. Repeat this step if there are multiple Owners/Subcontractors to add
    - A. Select "Add Owner/Subcontractor"
    - B-D. Enter the Owner's Name
    - E. Enter the Subcontractor's Legal Name
    - F. Enter the Effective date of ownership
    - G. Enter the End date of ownership if applicable
    - H-K. Enter the Subcontractor Address
    - L. Select Yes or No. If selecting Yes, a drop-down box will appear where you will be required to select the type of relationship
    - M. Select "Save"



Ownership – Section 7

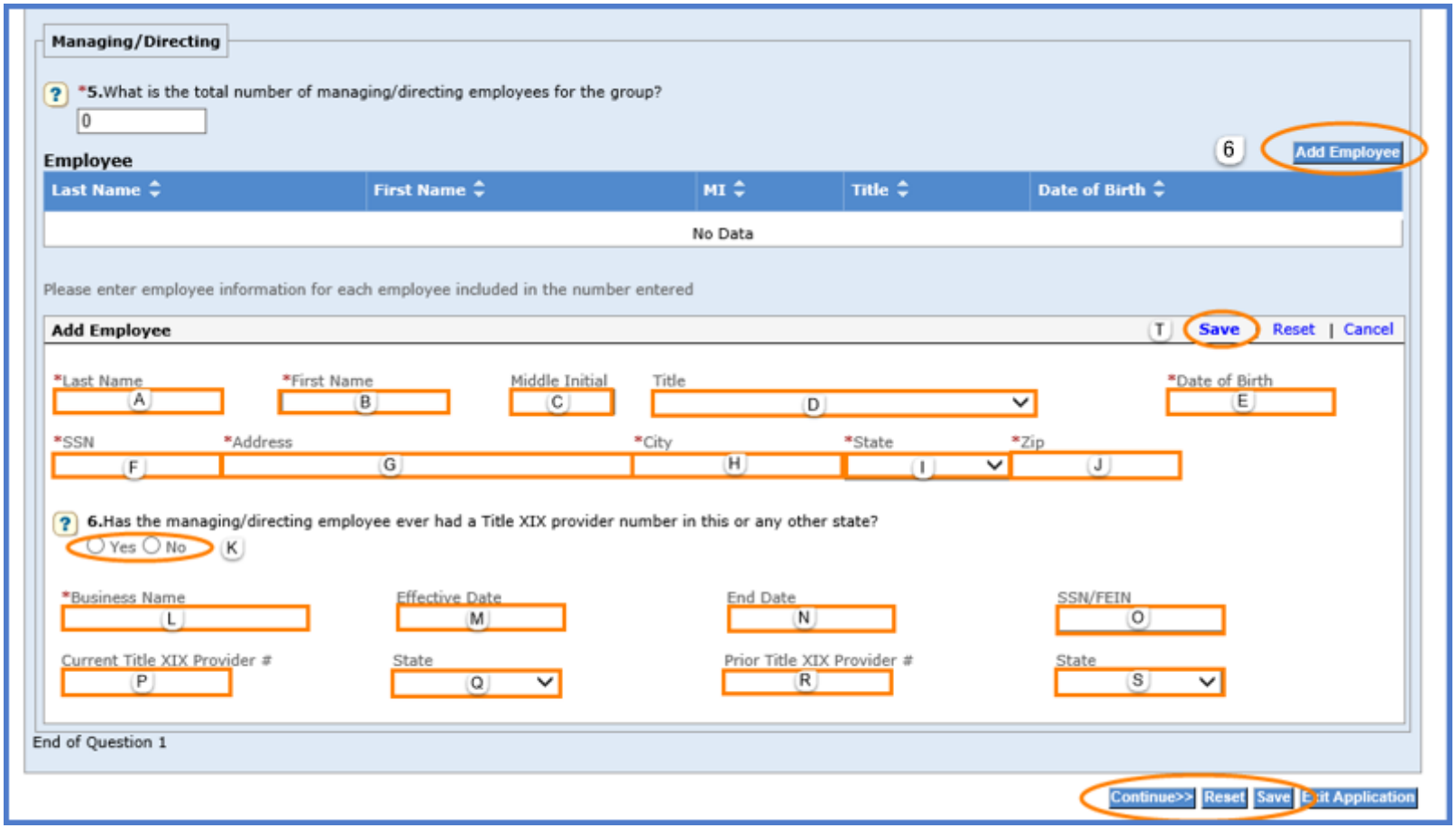
5. Select "Add Subcontractor Owner" to disclose the significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor
   - A-C. Enter the Owner's Name
   - D. Enter the Subcontractor Legal Name
   - E-H. Enter the Subcontractor Address
   - I. Enter the Significant Business Transactions
   - J. Select "Save"



Ownership – Section 7

6. Select "Add Employee" to add a Managing/Directing employee. All Managing/Directing employees must be disclosed in this section. If there is only one, add them here. If there are multiple Managing/Directing employees, repeat this step NOTE: A managing director is considered a general manager, business manager, administrator, director, or other individual who has operational or managerial control over the day-to-day operation of the organization

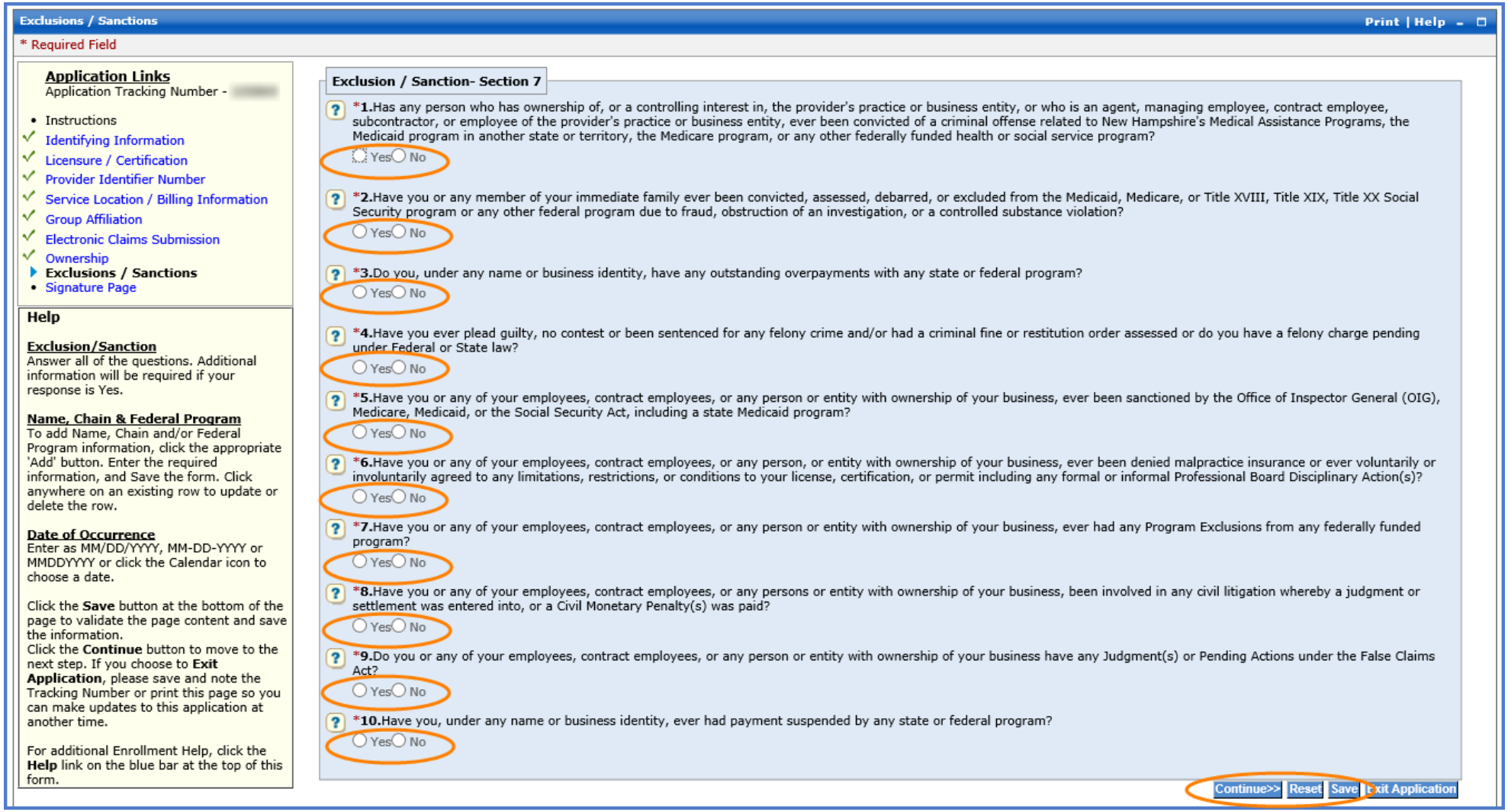
A-C. Enter the individual's Name
D. Enter the individual's Title if applicable
E. Enter the individual's Date of Birth
F. Enter the individual's SSN
G-J. Enter the individual's home Address
K. Select Yes or No NOTE: If Yes is selected, additional required fields will appear
L. Enter the Business Name
M. Enter the Effective Date
N. Enter the End Date
O. Enter the SSN/FEIN
P. Enter the Current Medicaid ID
Q. Enter the State of the Medicaid ID
R. Enter the Prior Medicaid ID
S. Enter the State of the Medicaid ID
T. Select "Save"



➢ 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 in the **Submit Complete Section**

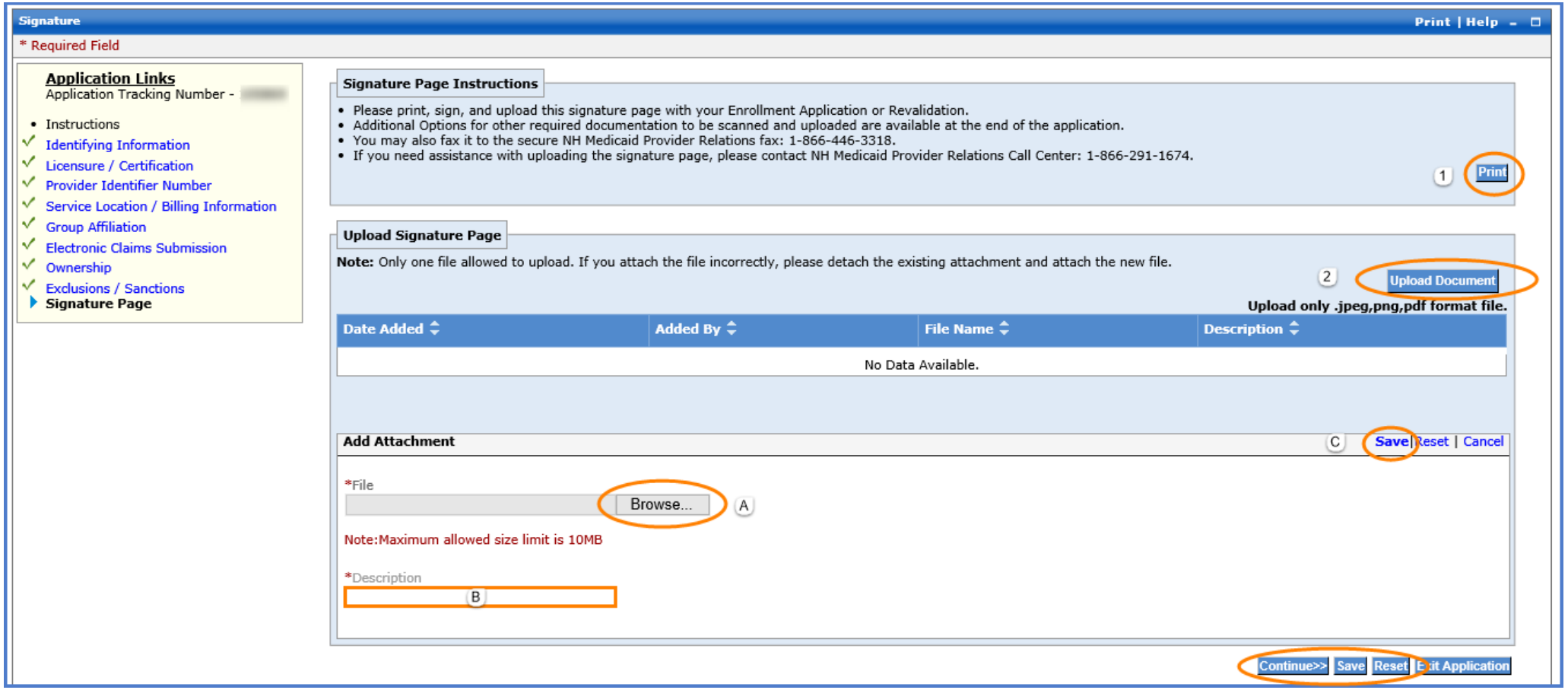


- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Signature Page Section

1. Select "Print" to print a pre-filled signature page that requires the signature of an Owner, General Partner, Board Officer, or Managing/Directing Employee
   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**



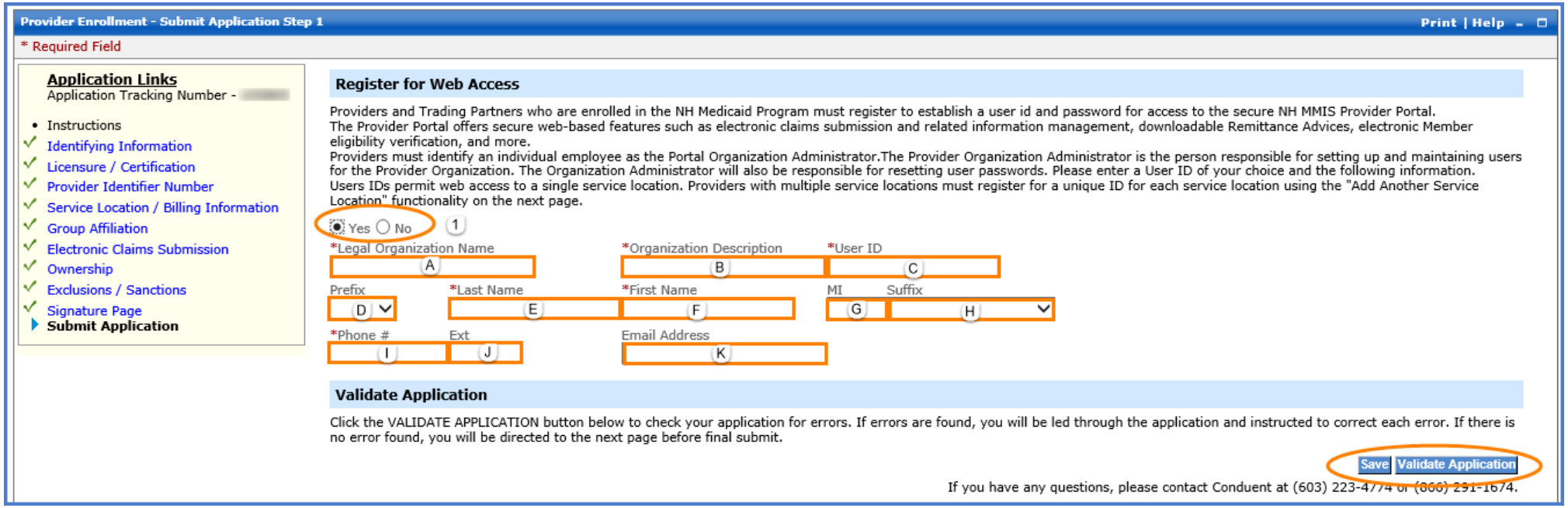
➢ Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Submit Application Section

1. Select Yes to create a User ID for the Portal Organization Administrator, who is responsible for utilizing the portal to set up and maintain users for the Provider Organization
    - A. Enter the Legal Organization Name for the Provider
    - B. Enter the Organization Description
    - C. Enter a User ID. This will be the User ID that you use to log into the MMIS portal NOTE: The User ID must be between 6 and 16 alpha-numeric characters and can contain hyphens, underscores, and/or periods
    - D. Select a Prefix from the drop-down list if applicable

    E-G. Enter the Organization Administrator's Name

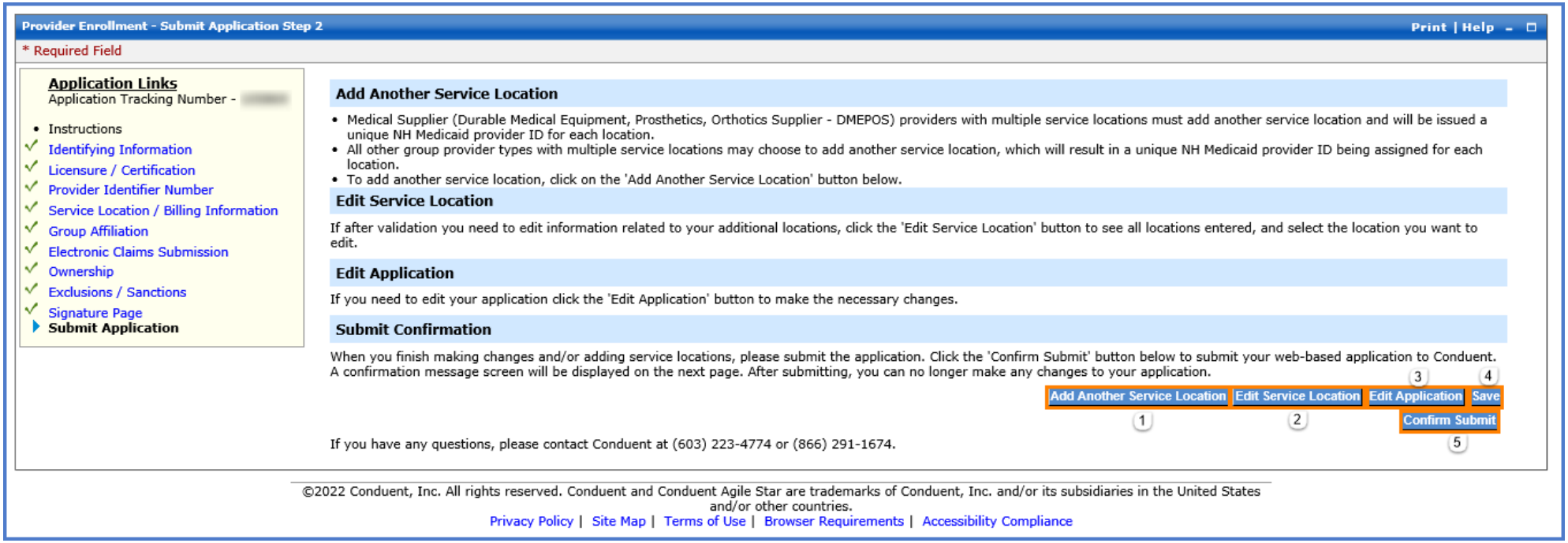
    - H. Select a Suffix from the drop-down list if applicable
    - I. Enter the Organization Administrator's Phone Number
    - J. Enter the Phone Number Extension if applicable
    - K. Enter the Organization Administrator's Email Address



- 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

Submit Application Section

1. If you need have additional service locations to enroll, select "Add Another Service Location" NOTE: Selecting this option will bring you to a shortened application for the additional service location.
   NOTE: If this is selected by accident, you will not be able to delete the additional service location. You will need to start a new application
2. If you need to edit any of the additional service locations, select "Edit Service Location"
3. If you need to edit the current service location, select "Edit Application"
4. Select "Save" to save the application
5. 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 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