



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

The screenshot shows the New Hampshire MMIS Health Enterprise Portal interface. At the top right, the date is Jun 22, 2022, and there are links for Skip Navigation, Contact Us, Help, and Search. The main navigation bar includes Home, Program, Member, Provider, Documentation, and Directories. Below the navigation bar is a banner image with five panels depicting healthcare scenes: a newborn baby, an elderly patient being examined, hands being held, a doctor's stethoscope, and a doctor examining a patient. Below the banner are four panels: Welcome, Provider Registration, Quick Links, and Sign In. The Quick Links panel is highlighted, and the 'Enrollment' link is circled in red. Other links in the Quick Links panel include Documents and Forms, Find a Health Care Provider, Department of Health and Human Services, Report Fraud & Abuse, ICD10 Resources, Provider Revalidation, and Interoperability Exchange. The Sign In panel lists Providers and Internal Users. At the bottom, there is a copyright notice for Conduent, Inc. and links for Privacy Policy, Site Map, Terms of Use, Browser Requirements, and Accessibility Compliance.

➤ 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”

The screenshot displays the 'New Hampshire MMIS Health Enterprise Portal' with a navigation bar containing 'Home', 'Program', 'Member', 'Provider', 'Documentation', and 'Directories'. The main content area is titled 'Provider Enrollment' and includes a 'Print | Help' icon. A red asterisk indicates a required field. The page is divided into three columns:

- Left Column:** Contains three sections: 'Become a Billing Provider', 'Become a Non-Billing Provider', and 'Become a Trading Partner'. Each section includes instructions and contact information. In the 'Become a Billing Provider' section, the 'Group Provider Enrollment' link is circled in orange.
- Middle Column:** Contains 'Recall Provider Application' and 'Recall Trading Partner Application' sections. Each section has input fields for 'Application Tracking #' and 'SSN/ FEIN', and a 'Submit' button. The 'Submit' button in the 'Recall Provider Application' section is circled in orange.
- Right Column:** Contains the 'Application Status' section, which has an input field for 'Application Tracking #' and a 'Submit' button. The 'Submit' button is circled in orange.

At the bottom of the page, there is a copyright notice for Conduent, Inc. and a footer with links for 'Privacy Policy', 'Site Map', 'Terms of Use', 'Browser Requirements', and 'Accessibility Compliance'.

➤ 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

New Hampshire MMIS Health Enterprise Portal Jun 22, 2022
Skip Navigation | Contact Us | Help | Search

Home | Program | Member | Provider | Documentation | Directories

Group Provider Enrollment Instructions Print | Help - □

* Required Field

Application Links
▶ Instructions

Group Provider Enrollment

- This application is for all billing entities using a Federal Employer ID Number(FEIN), for-profit and not for-profit.
- Providers with more than one provider type must complete a separate Enrollment Application for each provider type.

Group Application 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 required for application processing.
- For all date fields, use the date format (mm/dd/yyyy) unless otherwise indicated.
- Providers with multiple service locations with different owners/managing employees should complete another separate application. Providers with multiple service locations with the same owners/managing employees should complete the additional service location section of the group application.
- 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>.

Continue>> **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 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

The screenshot shows the 'Demographic' section of the application. On the left, there is a sidebar with 'Application Links' (including Identifying Information, Licensure / Certification, etc.) and 'Help' (with instructions for Group Name, FEIN, and the Save/Continue/Exit buttons). The main form area is titled 'Identifying Information- Section 1' and includes the following fields and questions:

- SA Waiver Medium:** *Requested Delivery Media for SA Letters (1) with radio buttons for 'Inbox' (selected) and 'Mail'.
- Identifying Information- Section 1:**
 - *Group Name (2) and *Federal Employer Identification # (FEIN) (3) - both are text input fields.
 - Doing Business As (DBA) Name (4) - text input field.
 - ? Have you used a different DBA Name? (5) - Yes/No radio buttons.
 - Important:** Submit/Attach a copy of a valid form of FEIN verification. Acceptable forms: IRS Forms-SS4, IRS LTR-147C, or a notarized statement.
 - Note:** The applicant's FEIN will be linked to a NH Medicaid Provider Number. All claims paid to the NH Medicaid Provider Number will be reported as income under the FEIN to the IRS. This FEIN must be for the Group Provider whose information is provided on this application. If the FEIN changes, the applicant must re-apply for a NH Medicaid Provider Number.
 - ? Is this application due to a change of ownership? (6) - Yes/No radio buttons.
 - Current/Previous NH Medicaid Provider #:** ? *Were you previously enrolled as a Medicaid provider in NH? (7) - Yes/No radio buttons.
 - Non-Profit Organization Tax Exempt Status:** ? Is the business listed under tax-exempt status? (8) - Yes/No radio buttons.

At the bottom right of the form, there are four buttons: 'Continue>>', 'Save', 'Reset', and 'Exit Application'. The 'Save' button is circled in orange.

- 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”

The screenshot displays the 'Licensure / Certification - Section 2' form. On the left, there is a sidebar with 'Application Links' (Instructions, Identifying Information, Licensure / Certification, Service Location / Billing Information, Group Affiliation, Electronic Claims Submission, Ownership, Exclusions / Sanctions, Signature Page) and 'Help' sections for Provider Type, Licensure/Certification, Specialty & Taxonomy, and Date. The main form area includes:

- Provider Type:** A dropdown menu with '1' selected.
- Licensure and Certification - Section 2:** A table with columns for License #, Certification #, State, Effective Date, and Expiration Date. An 'Add Licensure / Certification' button is circled in red.
- Add Licensure and Certification:** A form with fields for License # (B), Licensing Agency (C), State (D, set to New Hampshire), Effective Date (E), and Expiration Date (F). Radio buttons for License (A) and Certification are present. A 'Save' button is circled in red.
- Specialty List:** A table with columns for Specialty, Cert #, Cert Agency, and State. An 'Add Specialty' button is circled in red.
- Taxonomy:** A table with columns for Taxonomy, Begin Date, and End Date. An 'Add Taxonomy' button is circled in red.
- Add Taxonomy:** A form with fields for Taxonomy (A), Begin Date (B), and End Date (C). A 'Save' button is circled in red.
- At the bottom, a 'Continue' button is circled in red.

➤ 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

Provider Identifier Number
Print | Help

Application Links
Application Tracking Number -

- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ▶ **Provider Identifier Number**
- Service Location / Billing Information
- Group Affiliation
- Electronic Claims Submission
- Ownership
- Exclusions / Sanctions
- Signature Page

Help

NPI, DEA, NCPDP, Medicare and/or Other Medicare
To add NPI, DEA, NCPDP, Medicare and/or Other Medicare 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.

NPI
Enter as 10 digits.

DEA
A DEA number is required for anyone who prescribes or dispenses controlled substances.

NCPDP
Enter as 7 digits.

Medicare
Select at least one 'Part' for each Medicare entry.

Other Medicare
Enter the required information for former Medicare Carriers/Intermediaries.

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.

Provider Identifier Number- Section 3

National Provider Identifier (NPI)

NPI	1
No Data	Add NPI

Add NPI (B) [Save](#) | [Reset](#) | [Cancel](#)

*NPI

Drug Enforcement Administration (DEA)

DEA #	2
No Data	Add DEA Number

Add DEA Number (B) [Save](#) | [Reset](#) | [Cancel](#)

*DEA #

National Council for Prescription Drug Programs (NCPDP)

NCPDP	3
No Data	Add NCPDP

Add NCPDP (B) [Save](#) | [Reset](#) | [Cancel](#)

*NCPDP

Other State Medicaid Program Information

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

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

Available	Selected
<input type="checkbox"/> Alabama <input type="checkbox"/> Alaska <input type="checkbox"/> Arizona <input type="checkbox"/> Arkansas <input type="checkbox"/> California <input type="checkbox"/> Colorado <input type="checkbox"/> Connecticut <input type="checkbox"/> Delaware <input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Massachusetts

(B)

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

*Please identify the state. Massachusetts (E)

*Have you paid the application fee? Yes No (F)

Medicare Crossover Payment- Section 3

Enter the current Medicare Number assigned to your Group practice. Do not include numbers assigned to Individual Providers.

Medicare Numbers

Medicare #	Parts	5
No Data	No Data	Add Medicare

Add Medicare # (C) [Save](#) | [Reset](#) | [Cancel](#)

*Medicare #

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

All Part A Part B Part C Part D

Other Medicare Numbers

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

Medicare #	Carrier/Intermediary Name	Parts	6
No Data	No Data	No Data	Add History

Add History (D) [Save](#) | [Reset](#) | [Cancel](#)

*Medicare #

*Carrier/Intermediary Name

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

All Part A Part B Part C Part D

[Continue>>](#) | [Reset](#) | [Save](#) | [Exit Application](#)

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

The screenshot shows a web form titled "Service Location Information - Section 4". It contains several sections:

- Application Links:** A sidebar menu with options like "Instructions", "Identifying Information", "Licensure / Certification", "Provider Identifier Number", "Service Location / Billing Information", "Group Affiliation", "Electronic Claims Submission", "Ownership", "Exclusions / Sanctions", and "Signature Page".
- Service Location Information:** Fields for "Primary Physical Address (P.O. Box not accepted)", "Building, Suite #, etc.", "City", "State", "Zip", and "County".
- Validate Address:** A section with a "Suggested Address" list and "Submit" and "Cancel" buttons.
- Add Numbers:** Fields for "Phone #" and "Fax #", with "Save", "Reset", and "Cancel" buttons.
- Location Contact Person(s):** A table with columns for "Last Name", "First Name", "MI", "Phone", "Ext.", "Fax #", and "Email".
- Add Contact Person:** Fields for "Last Name", "First Name", "Middle Initial", "Phone #", "Ext.", "Fax #", "Email", and "Position".

Red circles and letters A-I highlight specific elements: (1) Address fields, (2) City, (3) State, (4) Zip, (5) County, (6) Validate Address button, (7) Add Numbers button, (8) Add Contact Person button, (9) Save button in Add Numbers, (10) Save button in Add Contact Person, (A) Submit button, (B) Cancel button, (C) Save button in Add Contact Person, (D) Phone # field, (E) Ext. field, (F) Fax # field, (G) Email field, (H) Position dropdown, (I) Save button in Add Contact Person.

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- Section 4

9. *Gender Served:
 Male Female Both

10. *Age Range Served:
 All
 0-5 Years 6-12 Years
 13-17 Years 18-21 Years
 22-59 Years 60+ Years

11. *Languages Supported:
 Available:
 Albanian
 American Sign Language
 Arabic
 Bangla
 Selected:
 English
 Other Language:

12. ? *Is this location wheelchair accessible?
 Yes No

13. ? *Is this location TDD/TTY Equipped for receiving calls for hearing impaired?
 Yes No
 *TDD/TTY Phone #

14. ? *Does this location provide emergency services after standard business hours?
 Yes No
 *After Hours Contact Phone #

15. ? *Are you a pharmacy or do you provide pharmacy services?
 Yes No

? *Does this location have drive-thru accessibility?
 Yes No

? *Do you provide delivery service?
 Yes 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](#)”

Bed Data 16

If this application is for a Hospital, Nursing Facility, or other Institutional Facility, please complete the following information regarding licensed beds located at this facility.

Total # of Facility Beds	Total # of Acute Beds
<input style="width: 90%;" type="text" value="A"/>	<input style="width: 90%;" type="text" value="E"/>
Total # of Psychiatric Beds (Hospital Only)	Total # of Rehabilitation Beds (Hospital Only)
<input style="width: 90%;" type="text" value="B"/>	<input style="width: 90%;" type="text" value="F"/>
Total # of NH Title XIX-Certified Beds Only	Total # of Dually Certified Beds
<input style="width: 90%;" type="text" value="C"/>	<input style="width: 90%;" type="text" value="G"/>
Total # of Swing Beds	
<input style="width: 90%;" type="text" value="D"/>	

Clinical Laboratory Improvement Amendments (CLIA) 17

If this application is for a hospital, independent laboratory, or physicians office that performs non-waivered laboratory services, a current CLIA Certificate is required. Please list all CLIA certificates, and related effective dates, that pertain to the requested dates of enrollment. Applicants will need to include photocopies of all certificates listed below with this application.

A Add CLIA

CLIA #	Effective Date	Expiration Date

E Save Reset Cancel

*CLIA #	*Effective Date	*Expiration Date
<input style="width: 90%;" type="text" value="B"/>	<input style="width: 90%;" type="text" value="C"/>	<input style="width: 90%;" type="text" value="D"/>

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

The screenshot shows a web form with three main sections:

- Mailing Address:**
 - Question: "Is this mailing address the same as service location?" with radio buttons for Yes and No (No is selected).
 - Fields: *P.O. Box / Street Address (A), Building, Suite #, etc (B), *City (C), *State (D), *Zip (E), County.
 - Buttons: [Validate Address](#) (F), [Submit](#) (H), [Cancel](#).
 - Suggested Address:** A list of addresses with radio buttons. One address is selected (G): "2 Pillsbury St, Ste 302, Concord, NH, 03301, Merrimack County".
- Add Numbers:**
 - Fields: *Phone # (A), Fax # (B).
 - Buttons: [Save](#), [Reset](#), [Cancel](#).
- Add Contact Person(s):**
 - Table with columns: Last Name, First Name, MI, Phone, Ext., Fax #, Email.
 - Buttons: [Add Contact Person](#), [Save](#) (I), [Reset](#), [Cancel](#).
- Add Contact:**
 - Fields: *Last Name (A), *First Name (B), Middle Initial (C), *Phone # (D), Ext. (E), Fax # (F), *E-mail (G), *Position (H).
 - Buttons: [Save](#) (I), [Reset](#), [Cancel](#).

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

The screenshot shows a web form titled "Billing Address". It contains several sections with red circles and letters A-I highlighting specific elements:

- Billing Address Section:**
 - Question 22: "Is this billing address the same as the service location?" with radio buttons for Yes and No.
 - Question A: "Is this billing address the same as the mailing address?" with radio buttons for Yes and No.
 - Fields B-F: *P.O. Box/Street Address, Building, Suite, etc., *City, *State, *Zip.
 - Field G: "Validate Address" button.
 - Section H: "Suggested Address" with a list of addresses and an "Override" option.
 - Field I: "Submit" button.
- Add Numbers Section:**
 - Question 23: "Add Numbers" button.
 - Fields A-B: *Phone #, Fax #.
 - Field C: "Save" button.
- Location Contact Person(s) Section:**
 - Question 24: "Add Contact Person" button.
 - Table with columns: Last Name, First Name, MI, Phone, Ext., Fax #, Position, Email.
- Add Contact Person Section:**
 - Field I: "Save" button.
 - Fields A-H: *Last Name, *First Name, Middle Initial, *Phone #, Ext., Fax #, *Position.
- Final Questions Section:**
 - Question 25: "Does a third party billing agent submit your claims?" with radio buttons for Yes and No.
 - Question A: "Does this billing agent have access to make inquiries on your behalf?" with radio buttons for Yes and 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

Remittance Advice

*Requested Delivery Media for Remittance Advices(RAs)

Electronic (835) Web Portal - Provider Message Center (Downloadable to paper) Electronic (820) Electronic Remittance Advice Report (820) 26

Providers are able to download and print paper RAs from the secure Provider Message Center on the NH MMIS Health Enterprise Portal. Enrolling Providers must complete the information in the Register for Web Access section at the end of the application process to obtain a password and user id for secure access to the Portal.
 Note: You must register for web access to access RAs through the Health Enterprise system.

You can enroll later by using the ERA Enrollment link off the provider portal home page after you have your login credentials.

[Continue](#) [Reset](#) [Save](#) [Exit Application](#)

- 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

ERA Enrollment Print | Help

*** Required Field**

For Instructions related to ERA Enrollment click [here](#)

1. Provider Information

*Provider Name Doing Business As (DBA) Name

Provider Address

*Street *City *State/Province *Zip Code/Postal Code

2. Provider Identifiers Information

*Provider Federal Tax Identification Number(TIN) or Employer Identification Number(EIN) National Provider Identifier(NPI)

Provider License Number License Issuer Provider Type Provider Taxonomy Code

3. Provider Contact Information

*Provider Contact Name Title *Telephone Number Telephone Number Extension

Email Address

Fax Number

4. Electronic Remittance Advice Information

*Preference for Aggregation of Remittance Data(e.g., Account Number Linkage to Provider Identifier) **B**

5. Submission Information

*Reason For Submission **C**

*Authorized Signature **D**

E [Save](#) [Reset](#) [Cancel](#)

➤ 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”

Group Affiliation Print | Help - □

* Required Field

Application Links

Application Tracking Number -

- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Number
- ✓ Service Location / Billing Information
- ▶ **Group Affiliation**
- Electronic Claims Submission
- Ownership
- Exclusions / Sanctions
- Signature Page

Help

Affiliation
To add Affiliation 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.

Effective Date
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.

Affiliation- Section 5

Instructions:
List all active NH Medicaid Individual Providers, and related information, who perform services on behalf of the Group at the location identified in Section 4. This information will be cross referenced to Affiliations identified by Individual Providers to ensure consistency.

Information Regarding Affiliations and Claims Processing:
In order for Group Providers to receive payment for services performed by individual practitioners on behalf of the Group, performing providers must be enrolled in the NH Medicaid program as Individual Providers and affiliated with the Group Providers in the NH Medicaid Management Information System (MMIS).
Group applicants are responsible for identifying in this Section 5 all Individual Providers who perform services on behalf of the group practice at the location identified in Section 4.
The performing practitioners must enroll separately as NH Medicaid Individual Providers, likewise identifying the Group Providers with which they are affiliated. Individual Providers and Group Providers will be affiliated in the system for claims processing purposes.
When the Group Provider submits a valid claim for services performed by an affiliated Individual Provider, payment will be made to the Group.
If the Group Provider has not identified an affiliated Individual Provider, claims submitted by the Group Provider for services performed by the individual practitioner will be denied.

NH Medicaid Provider #	Name of Individual Practitioner	Effective Date of Affiliation
No Data		

1 [Add Affiliation](#)

Add Affiliation D [Save](#) [Reset](#) | [Cancel](#)

*NH Medicaid Provider # <input style="width: 90%;" type="text" value="A"/>	*Name of Individual Practitioner <input style="width: 90%;" type="text" value="B"/>	*Effective Date of Affiliation <input style="width: 90%;" type="text" value="C"/>
---	--	--

[Continue>>](#) [Reset](#) [Save](#) [Exit Application](#)

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

Electronic Claims Submission – Section 6

- Always select the New Hampshire MMIS Health Enterprise System Web Portal. This will allow you to submit claims on the portal
- 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
 - Enter the Software Vendor Name
 - Enter the Software Name
 - Enter the Version Number of the Software
 - Select the Software Protocol from the drop-down menu
- 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
 - 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
- Select All if you utilize all the options to submit and receive transactions
- If you selected Vendor Software or Billing Agent / Clearinghouse, you would need to select the transactions you submit and receive.

Electronic Transaction Submission

Required Field

Application Links
Application Tracking Number -

- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Number
- Service Location / Billing Information
- Group Affiliation
- Electronic Claims Submission**
- Ownership
- Exclusions / Sanctions
- Signature Page

Help

Electronic Transaction Submission
Select one or more of the submission methods. Additional information will be required if selection includes **Vendor Software or Billing Agent/Clearinghouse**.

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.

Electronic Claims Submission- Section 6

Providers who choose to submit electronic claims-related transactions must be aware that payment of claims will be from Federal and State funds, and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. Furthermore, providers must understand and agree to do the following:

- Safeguard the NH Medicaid Program against abuse in the use of electronic transaction submission.
- Correctly enter the claims data, monitor the data, and certify that the data entered is correct.
- Assure that the transmission of transaction data is restricted to authorized personnel to prevent erroneous payments by the Department's fiscal agent, which might result from carelessness or fraud.
- Have on file the applicable documentation to substantiate any transactions submitted to the NH Medicaid Program.
- Allow the Department or any of its designees and representatives of the Attorney General to review and copy all records, including source documents and data related to information entered through electronic transaction submission.
- Abide by all Federal and State statutes, rules, regulations, and manuals governing the NH Medicaid Program.
- Sign and adhere to all conditions of the NH Medicaid Provider Participation Agreement, and be officially enrolled in the NH Medicaid Program to participate in electronic transaction submission.

Indicate which of the following will be used to submit transactions electronically:

New Hampshire MMIS Health Enterprise System Web Portal **1**

Vendor Software **2**

*Software Vendor Name:

*Software Name: *Version #:

*Protocol:

Billing Agent/Clearinghouse **3**

*Agent/Clearinghouse Name:

*Contact First Name: *Contact Last Name: *Contact Phone #:

*Street Address:

Street Address2:

*City: *State: *Zip Code & Extension:

All **4**

***Please check transactions that you submit and/or receive:**

Submit	Receive
<input type="checkbox"/> 837I Institutional Claim	<input type="checkbox"/> 835 Remittance Advice *
<input type="checkbox"/> 837P Professional Claim	<input type="checkbox"/> 271 Eligibility Response
<input type="checkbox"/> 837D Dental Claim	<input type="checkbox"/> 277 Claim Inquiry Response
<input type="checkbox"/> 270 Eligibility Request	<input type="checkbox"/> 278 Service Authorization Response
<input type="checkbox"/> 276 Claims Inquiry Request	<input type="checkbox"/> 820 Premium Payment (Applies to Qualified Health Plans)
<input type="checkbox"/> 278 Service Authorization Request	<input type="checkbox"/> 834 Member Enrollment
<input type="checkbox"/> 834 Confirmation(EI)	

* If selecting 835 Remittance Advice, please indicate "835 Electronic Remittance Advice" in Section 4 Service Location / Billing information under Remittance Advice (RA) Requested Delivery Media for Remittance Advice (RAs).

Continue>> Reset Save Exit Application

➤ 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”

The screenshot shows the 'Ownership - Section 7' form. On the left is a sidebar with 'Application Links' and 'Help'. The main form area includes a confirmation checkbox, a question about the number of owners (0), an 'Add Ownership' button, and a detailed 'Add Ownership Information' section. The information section contains fields for name, dates, address, and SSN, along with radio buttons for ownership type and a question about family relationships. A 'Save' button is also present.

Application Links

- Instructions
- Identifying Information
- Licensure / Certification
- Provider Identifier Number
- Service Location / Billing Information
- Group Affiliation
- Electronic Claims Submission
- Ownership**
 - Exclusions / Sanctions
 - Signature Page

Help

Ownership and Control Interest
 Person with an ownership or control interest is defined at CFR 455.101 to include individuals or corporations that have a direct, indirect, or a combination of direct and indirect ownership interest totaling 5 percent or more in a disclosing entity. This interest includes any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

Under CFR 455.101, a person with an ownership or control interest includes (1) an officer or director (i.e. Board of Directors) of a disclosing entity that is organized as a corporation; and (2) a partner in a disclosing entity that is organized as a partnership.

All officers and directors must be disclosed, regardless of their number (e.g., 100 board members) and even if they serve in a voluntary (e.g., unpaid) capacity. Also, if a non-profit corporation has "trustees" instead of officers or directors, these trustees must be disclosed. Officers and directors (e.g., board members) of the entity's indirect owners need

Ownership- Section 7

By continuing with this application, I, the submitter, confirm that the Ownership and Controlling Interest information entered is complete and accurate at the time of submission. Completion of this section is a condition of participation in the New Hampshire Medicaid program and is mandated by 42CFR 455.100-106. Click to view the full regulation.

? *1.How many owners of this applicant have a 5% or more direct or indirect ownership interest in the group?
 0

Ownership

Name	DBA Name	Effective Date of Ownership	NH Title XIX Provider ID
No Data			

Please enter ownership information for each owner included in the number above

Add Ownership Information

*Is the Owner an Individual or Group? Individual Group

*Last Name: B *First Name: C MI: D Title: E Doing Business As (DBA) Name: F

*Effective Date of Ownership: G End Date of Ownership: H *Date of Birth: I *Address: J

*City: K *State: L *Zip Code: M *SSN: N NH Title XIX Provider ID: O

*Type of Ownership? Direct Ownership Indirect Ownership

*Does this person have a familial relationship with another owner or person with controlling interest?
 Yes No *Relationship: Q

Buttons: Add Ownership, Save, Reset, Cancel

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

By continuing with this application, I, the submitter, confirm that the Ownership and Controlling Interest information entered is complete and accurate at the time of submission. Completion of this section is a condition of participation in the New Hampshire Medicaid program and is mandated by [42CFR 455.100-106](#). Click to view the full regulation.

? *1.How many owners of this applicant have a 5% or more direct or indirect ownership interest in the group?
0

Name	DBA Name	Effective Date of Ownership	NH Title XIX Provider ID
No Data			

Please enter ownership information for each owner included in the number above

Add Ownership Information

*Is the Owner an Individual or Group?
 Individual Group

*Business Name *Doing Business As (DBA) Name *FEIN *Effective Date of Ownership End Date of Ownership

*Address *City *State *Zip Code NH Title XIX Provider ID

*Type of Ownership?
 Direct Ownership Indirect Ownership

*Does this person have a familial relationship with another owner or person with controlling interest?
 Yes No *Relationship

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”

2. Please list all board members and executive officers that have a controlling interest in the corporation or partnership.

Name	DBA Name	Effective Date of Controlling Interest	NH Title XIX Provider ID
No Data			

Add Controlling Interest Information

*Last Name
 *First Name
 Middle Initial
 Title
 Doing Business As (DBA) Name

*Effective Date of Controlling Interest
 End Date of Controlling Interest
 *Date of Birth
 *Address

*City
 *State
 *Zip Code
 *SSN
 NH Title XIX Provider ID

*Type of Ownership? Direct Ownership Indirect Ownership O

*Does this person have a familial relationship with another owner or person with controlling interest?
 Yes No
 *Relationship

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”

? *3. Do any of the owners listed in question #1 have 5% or more ownership/controlling interest in a subcontractor to this provider? (A Subcontractor is an individual, agency, or organization to which a disclosing entity (i.e., the health plan) has contracted or delegated some of its management functions or responsibilities of providing Medicaid-covered services to its patients.)

Yes
 No
 4

A
Add Owner/Subcontractor

Owner Last Name	Owner First Name	MI	Relationship	Subcontractor Legal Name
No Data				

Add Owner and Subcontractor M Save | Reset | Cancel

*Owner Last Name <input style="width: 90%;" type="text" value="B"/>	*Owner First Name <input style="width: 90%;" type="text" value="C"/>	Middle Initial <input style="width: 80%;" type="text" value="D"/>
*Subcontractor Legal Name <input style="width: 90%;" type="text" value="E"/>	*Effective Date <input style="width: 80%;" type="text" value="F"/>	End Date <input style="width: 80%;" type="text" value="G"/>
*Address <input style="width: 90%;" type="text" value="H"/>	*City <input style="width: 80%;" type="text" value="I"/>	*State <input style="border: none; border-bottom: 1px solid #ccc;" type="text" value="J"/> v
*Zip <input style="width: 80%;" type="text" value="K"/>	*Does this person have a familial relationship with another owner or person with controlling interest? <input type="radio"/> Yes <input type="radio"/> No L	

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”

? 4a. Identify the ownership of subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the past 12 months

4b. List the significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request

5 Add Subcontractor Owner

Owner Last Name	Owner First Name	MI	Subcontractor Legal Name
No Data			

Add Subcontractor Owner J Save | [Reset](#) | [Cancel](#)

*Owner Last Name A

*Owner First Name B

Middle Initial C

*Subcontractor Legal Name D

*Address E

*City F

*State G ▼

*Zip H

*List the significant business transactions from 4b I

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”

The screenshot shows the 'Managing/Directing' section of the enrollment system. At the top, there is a question: "5. What is the total number of managing/directing employees for the group?" with a text input field containing '0'. To the right of this question is a circled '6' and an 'Add Employee' button, also circled in orange. Below this is a table with columns for Last Name, First Name, MI, Title, and Date of Birth, which currently shows 'No Data'. A message says "Please enter employee information for each employee included in the number entered". Below that is the 'Add Employee' form, which has a 'Save' button circled in orange. The form includes fields for:

- *Last Name (A), *First Name (B), Middle Initial (C), Title (D), *Date of Birth (E)
- *SSN (F), *Address (G), *City (H), *State (I), *Zip (J)
- Question 6: "Has the managing/directing employee ever had a Title XIX provider number in this or any other state?" with radio buttons for Yes and No (K).
- *Business Name (L), Effective Date (M), End Date (N), SSN/FEIN (O)
- Current Title XIX Provider # (P), State (Q), Prior Title XIX Provider # (R), State (S)

 At the bottom of the form, there are buttons for 'Continue>>', 'Reset', 'Save', and 'Exit Application', with the 'Save' button circled in orange.

➤ 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**

Exclusions / Sanctions Print | Help - □

*** Required Field**

Application Links
Application Tracking Number - [REDACTED]

- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Number
- ✓ Service Location / Billing Information
- ✓ Group Affiliation
- ✓ Electronic Claims Submission
- ✓ Ownership
- ▶ **Exclusions / Sanctions**
- Signature Page

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

Help

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

Name, Chain & Federal Program
To add Name, Chain 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.

- 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**

The screenshot shows a web application window titled "Signature". On the left is a sidebar with "Application Links" including "Instructions", "Identifying Information", "Licensure / Certification", "Provider Identifier Number", "Service Location / Billing Information", "Group Affiliation", "Electronic Claims Submission", "Ownership", "Exclusions / Sanctions", and "Signature Page". The main content area has a blue header with "Print | Help". Below the header is a "Signature Page Instructions" section with a "Print" button circled in orange. The "Upload Signature Page" section contains a "Note" and an "Upload Document" button circled in orange. Below this is a table with columns "Date Added", "Added By", "File Name", and "Description", showing "No Data Available.". The "Add Attachment" section has a "Browse..." button circled in orange, a "Description" text box circled in orange, and a "Save" button circled in orange. At the bottom right, a "Continue>>" button is circled in orange.

➤ 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

Provider Enrollment - Submit Application Step 2
Print | Help

*** Required Field**

Application Links
Application Tracking Number - [REDACTED]

- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Number
- ✓ Service Location / Billing Information
- ✓ Group Affiliation
- ✓ Electronic Claims Submission
- ✓ Ownership
- ✓ Exclusions / Sanctions
- ✓ Signature Page
- ▶ **Submit Application**

Add Another Service Location

- Medical Supplier (Durable Medical Equipment, Prosthetics, Orthotics Supplier - DMEPOS) providers with multiple service locations must add another service location and will be issued a unique NH Medicaid provider ID for each location.
- All other group provider types with multiple service locations may choose to add another service location, which will result in a unique NH Medicaid provider ID being assigned for each location.
- To add another service location, click on the 'Add Another Service Location' button below.

Edit Service Location

If after validation you need to edit information related to your additional locations, click the 'Edit Service Location' button to see all locations entered, and select the location you want to edit.

Edit Application

If you need to edit your application click the 'Edit Application' button to make the necessary changes.

Submit Confirmation

When you finish making changes and/or adding service locations, please submit the application. Click the 'Confirm Submit' button below to submit your web-based application to Conduent. A confirmation message screen will be displayed on the next page. After submitting, you can no longer make any changes to your application.

Add Another Service Location
Edit Service Location
Edit Application
Save

1
2
3
4
5

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

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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: [REDACTED]

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
4. Billing Agent Agreement
5. Electronic Remittance Advice Signature Page

Attachments

System successfully saved the Information

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

Date Added	Added By	File Name	Description
07/11/2022 06:02 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/bi/pi.htm>.

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