STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

New Hampshire Medicaid Program

Authorized Representative Appointment or Removal

Please print, sign, and upload this authorization page to your Enrollment Application or Revalidation Application. You may also fax this form in to Conduent to make changes to your existing Provider ID.
NH Medicaid Provider Relations secure fax: 1-866-446-3318.

Each provider may have up to two assigned representatives. A separate form is required for each Authorized Representative appointment or removal. The employee listed on the form will have approval and authorization to make the following changes/updates to the NH Medicaid Provider ID file.

The Authorized Representative will have the authority to request the following maintenance:

Submit *Provider Information Change Form*
Submit *Change of Demographic Form*
Change of Service Location Address
Change of Billing Address (for payments)
Change of Mailing Address (for correspondence)
Change/update Individual Provider Name
Affiliate Providers
Un-affiliate Providers
Change of Contacts information
Change/Update EDI Software Information
Submit *NH MMIS Portal Access* form for Employee

It is the responsibility of Providers that participate in the NH Medicaid Program to notify the NH DHHS Medicaid fiscal agent of any changes to information on your account within 30 days of the effective date of the change.

* Required Fields

* **Check appropriate box**: ☐ Add Authorized Representative ☐ Remove Authorized Representative
(no Authorized Rep signature needed)

Either/Or

* NH Medicaid ID:	* Enrollment ATN:
* Group Name:	Doing Business As (DBA) Name *(if applicable)*:

* Print Authorized Representative Name:	* Title/Positon:
* Signature of Authorized Representative:	* Date:

I certify that I am the individual practitioner or one of the identified authorized signees for the group who is assigning the "Authorized Representative" for the NH Medicaid Provider:

- For Group: Signature of Owner, CEO, General Partner, Board Officer, or Managing/Directing Employee
- For Individual: Signature of Individual Provider

* Approver Name - Printed:	* Title/Positon:
* Approver Signature:	* Date: