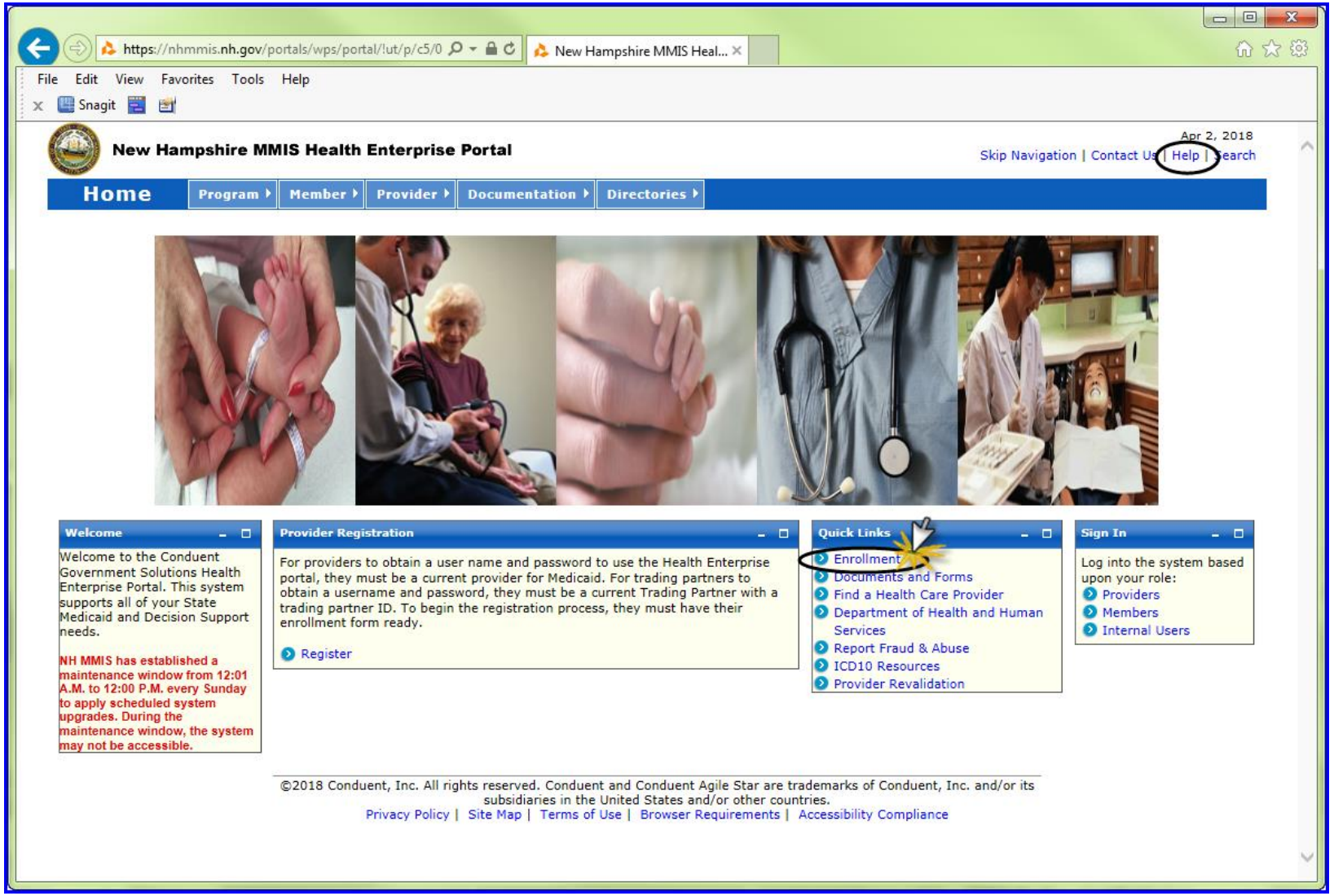
NH Medicaid Group Provider Enrollment Instructions

Completing the Group Enrollment Application

www.nhmmis.nh.gov

- Click on "Enrollment" under Quick Links
- Familiarize yourself with **Tips, Notes, & Important Information** at the end of the instruction pages to assist in the Enrollment (Pages 33-36)
- Additional assistance is located in the blue "Help" hyperlink at the top of each page



Click on "**Group Provider Enrollment**" link

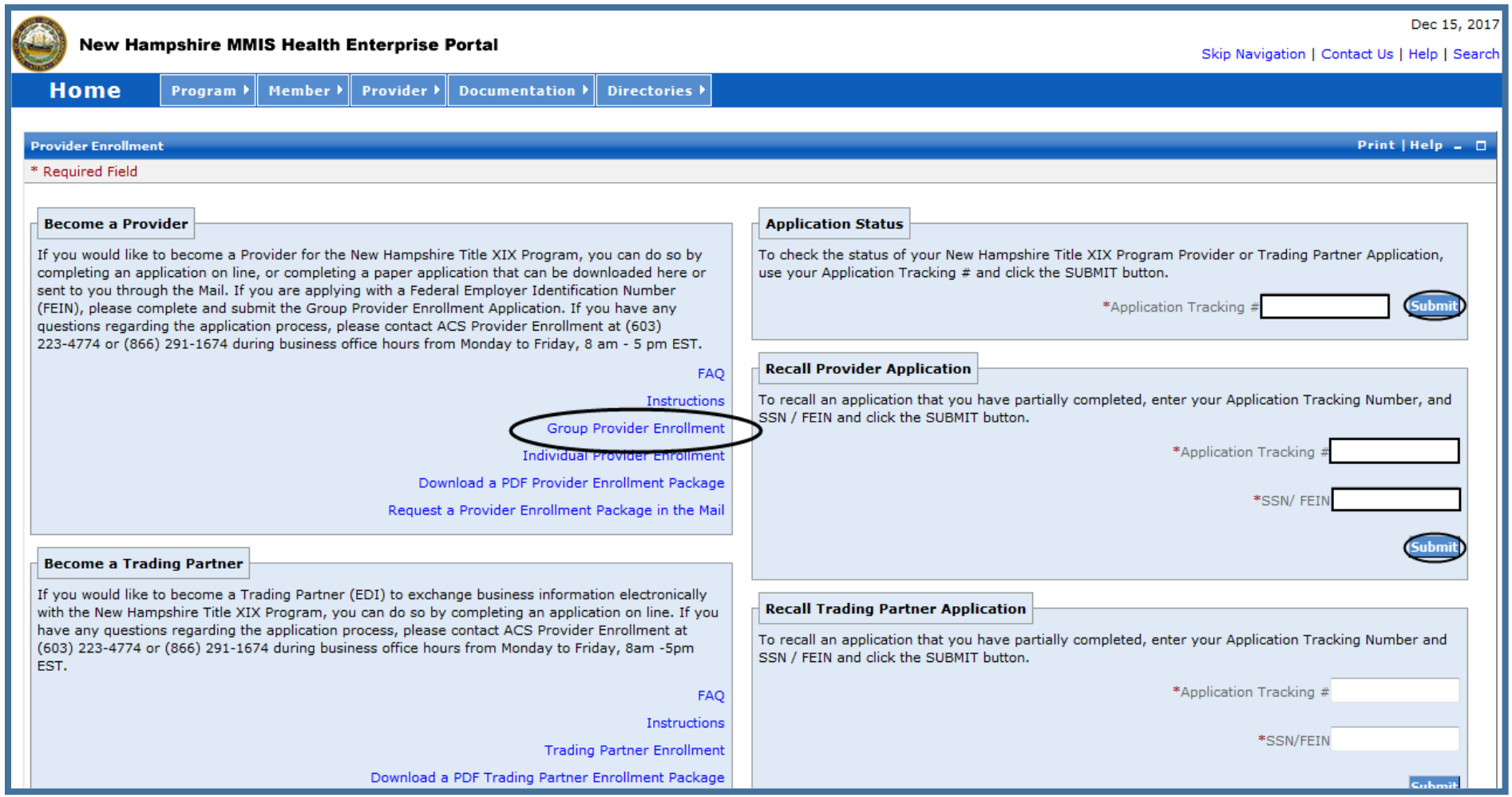
- Prepare all documentation needed for this application by referring to the Required Enrollment Documents to Upload with Application

  TIP: The "Required Enrollment Documents to Upload with Application" can be found under the "Documents and Forms" quick Link on the NHMMIS home page

  NOTE: Providers are to use the "Signature Page" upload to submit all required and supporting documents

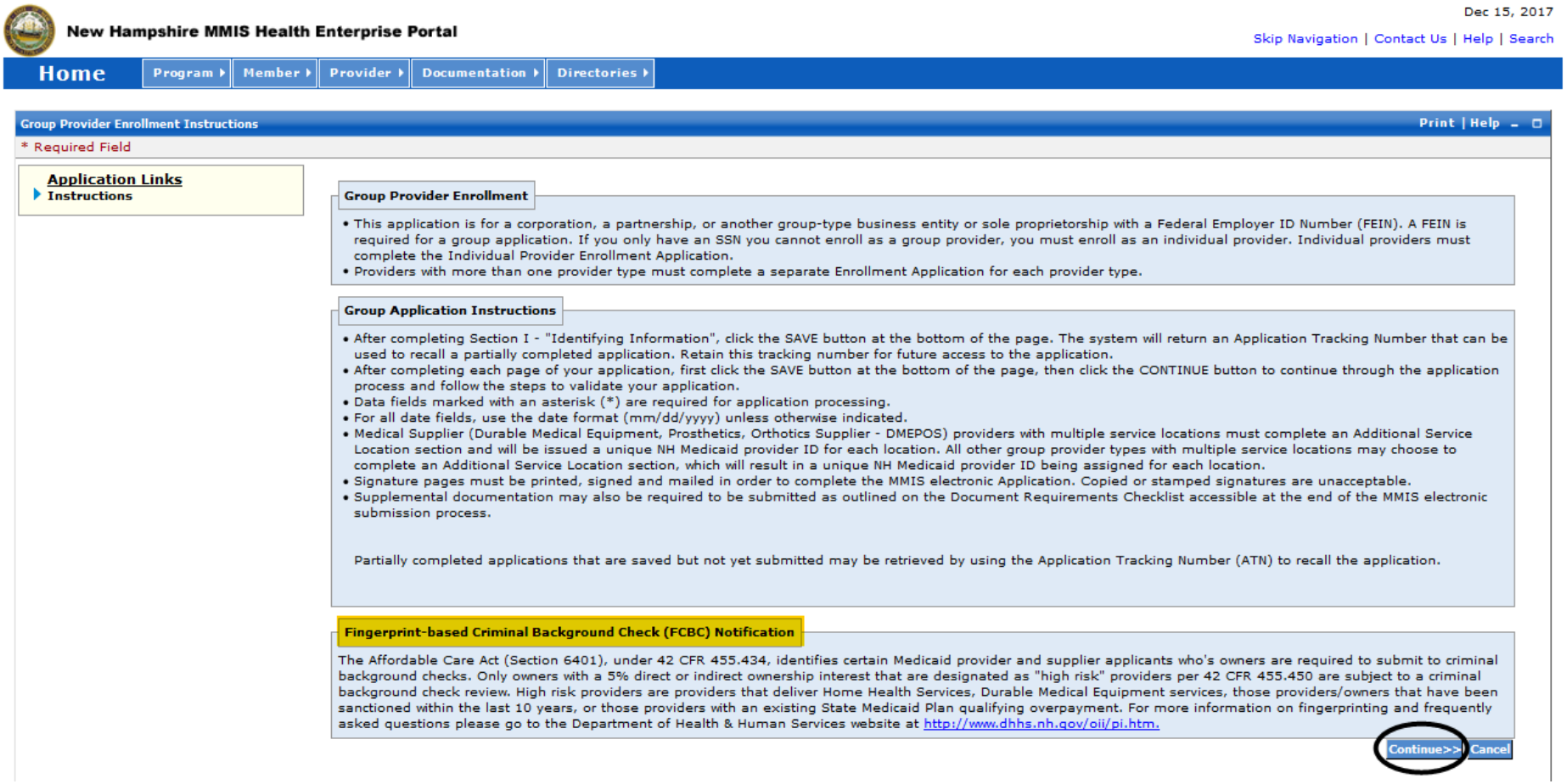
  NOTE: Below page is also where you can check on the status of the application. Enter the Application Tracking Number (ATN) and select **submit**

  NOTE: To return to a partially completed application, you can go back to it (Recall) by entering the ATN and FEIN and select **submit**



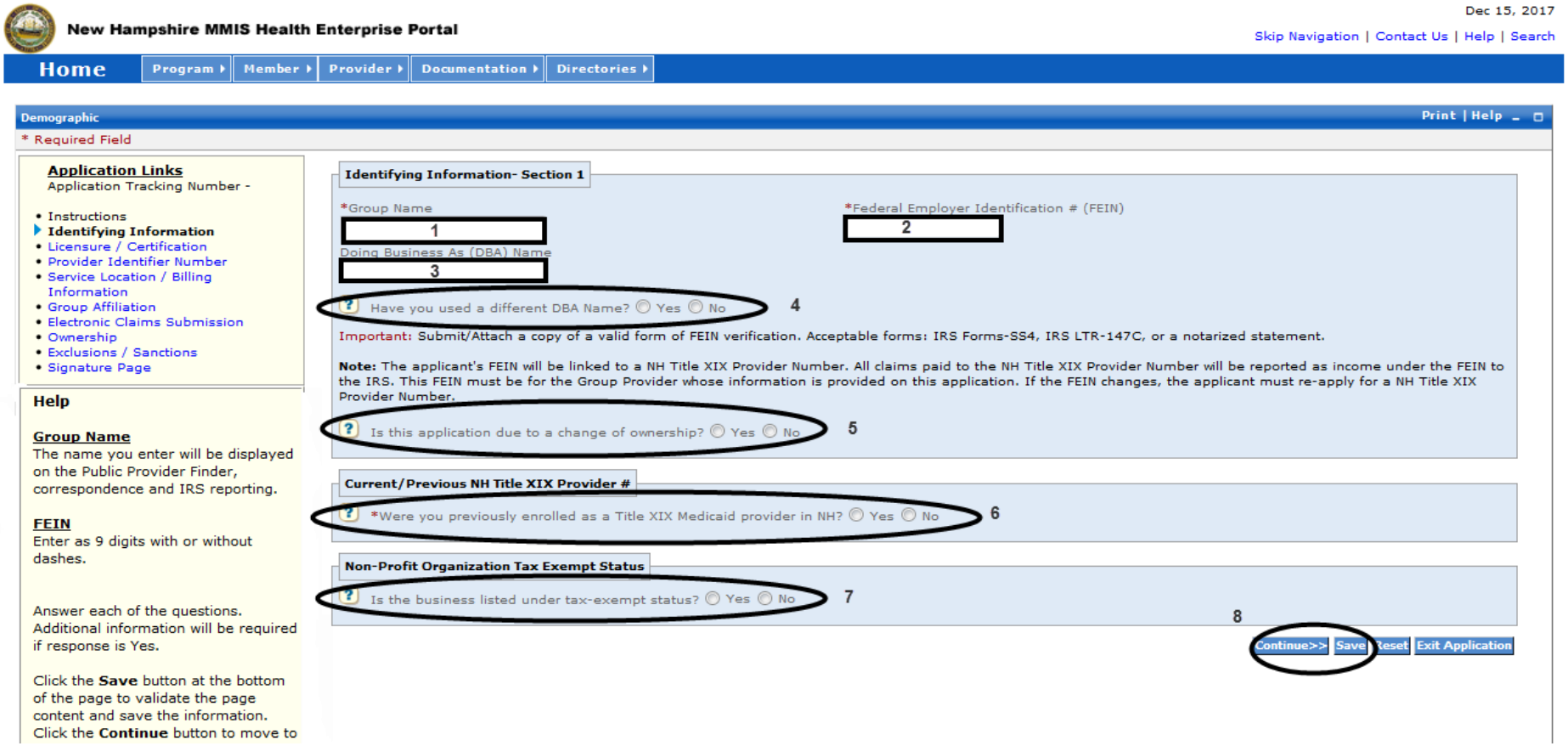
- Please read the following information and then click "**Continue**"

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



Identifying Information – Section 1

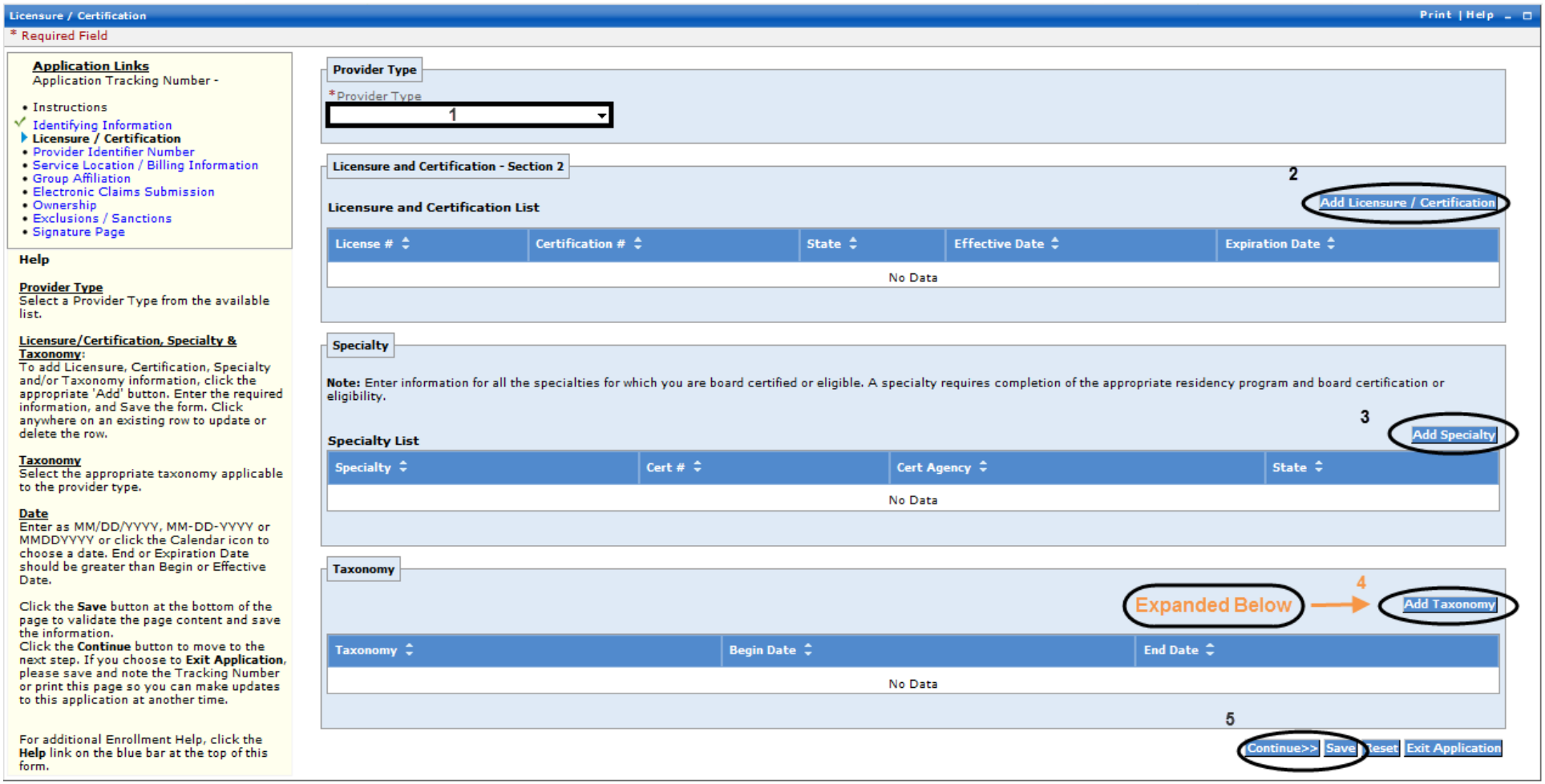
1. Enter the Legal group name
2. Enter the Tax ID – **NOTE:** You will need to provide proof of the Tax ID as a part of required supporting documentation
3. Enter the "Doing Business As" name if appropriate
4. 4-6 Answer Yes or No
7. Answer Yes or No – **NOTE:** If the group is tax exempt, include a copy of the IRS-issued exemption notification as a part of required supporting documentation. If a non-profit, please include all board members in the Ownership section #7, pages 22-26
8. Review your answers, when correct select "**Save**" first, then "**Continue**" – Your Application Tracking Number will be displayed in the upper left corner of the web page. **NOTE:** It is very important to write this number down.



Licensure/Certification – Section 2

1. Select “Provider Type” from the drop-down
2. Medical billing groups do not require licenses
3. Medical billing groups do not require a specialty
4. Medical billing groups do require the Taxonomy code(s) - Add the taxonomy by selecting the “Add Taxonomy” button and entering requested information – see page 6: **4 – Taxonomy Expanded Breakout View**

   TIP - The taxonomy information can be found with the NPI information on the NPI Registry website: https://npiregistry.cms.hhs.gov/registry/
5. Review your answers, when correct select “**Save**” first, then “**Continue**”



Section 2: 4 - Taxonomy Expanded Breakout View

4. Medical billing groups do require the Taxonomy code(s) - Add the taxonomy by selecting the "Add Taxonomy" button and entering requested information

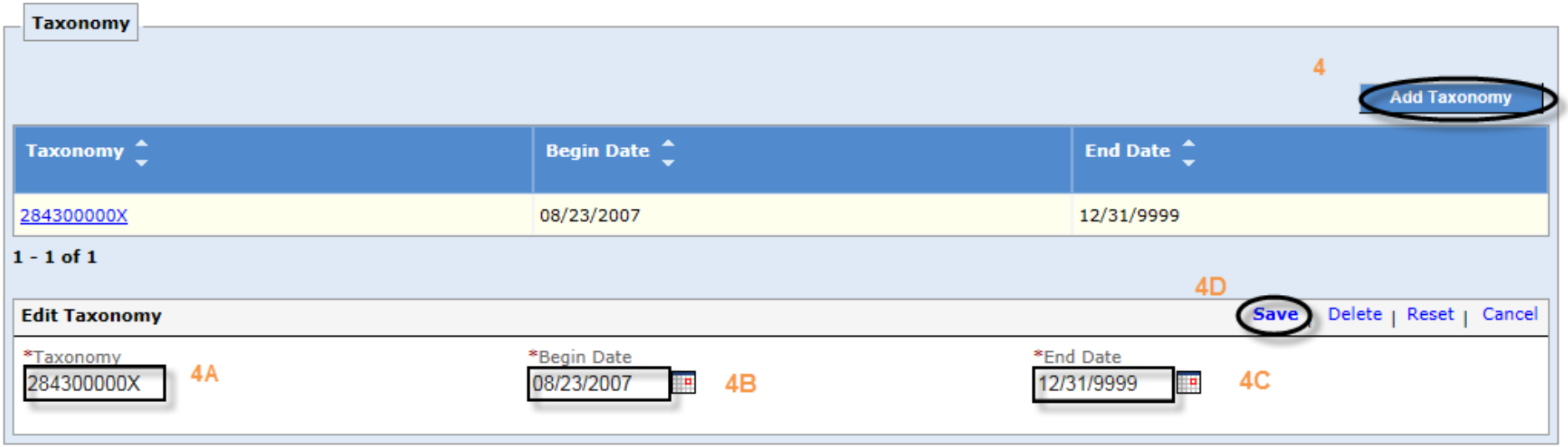
TIP - The taxonomy information can be found with the NPI information on the NPI Registry website: https://npiregistry.cms.hhs.gov/registry/

4A. Enter the Taxononomy code

4B. Enter the Begin date which is also the NPI enumeration date

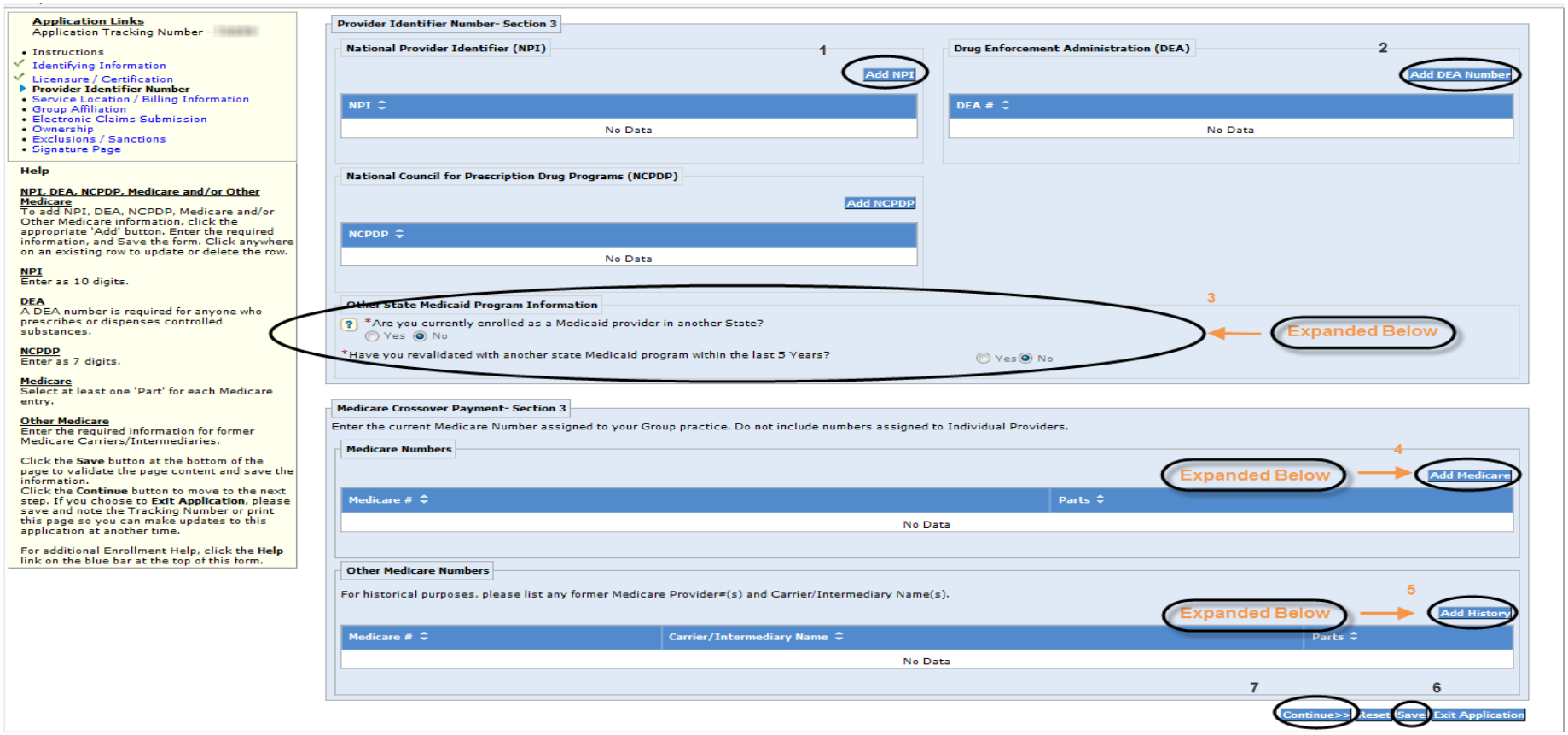
4C. Enter the End Date of 12/31/9999

4D. Review your input, when correct select "**Save**"



Provider Identifier Number – Section 3

1. Add the NPI information by selecting the "Add NPI" button and entering the NPI Number – select the section level **save**
   TIP - The NPI information can be found on the NPI Registry website: https://npiregistry.cms.hhs.gov/registry/
2. Add the DEA License information by selecting the "Add DEA Number" button and entering requested information - end date will be 12/31/9999
3. Answer questions presented with a selection of "Yes" or "No" – if yes, you will need to select the appropriate States from the drop-downs presented – see page 8: **3 – State Selection Expanded Breakout View**
4. Select the "Add Medicare" button and enter requested information as appropriate, then select the "**Save**" in the section – see page 9: **4 – Medicare Numbers Expanded Breakout View**
5. Select the "Add History" button and enter requested information as appropriate, then select the "**Save**" in the section – see page 10: **5 – Other Medicare Numbers Expanded Breakout View**
6. Review your answers, when correct select "**Save**" first, then **7.** "**Continue**"



Section 3: 3 – State Selection Expanded Breakout View

3A. Answer questions presented with a selection of "Yes" or "No" – if yes, you will need to select the appropriate States from the drop-down

3B. If answered Yes, the following State Table selection will appear, select the appropriate State from the drop-down

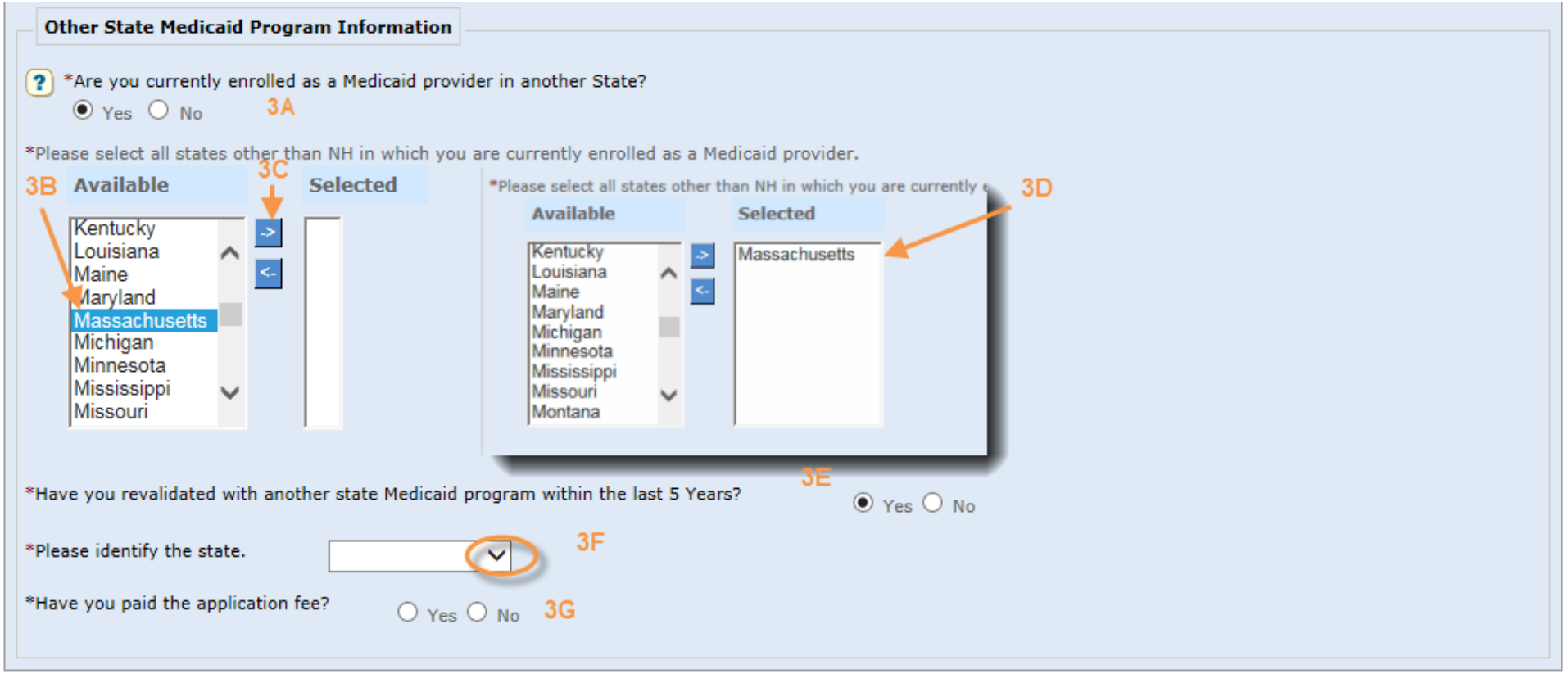
3C. Select the arrow pointing to the right to add to the selected States – if you wish to remove a State from selection, highlight the State and select the arrow pointing to the left to remove it

3D. The enrolled State(s) will present in the "Selected" area

3E. If answered Yes, please go to 3F

3F. Select the correct State name from the drop-down

3G. Answer Yes or No



Section 3: 4 – Medicare Numbers Expanded Breakout View

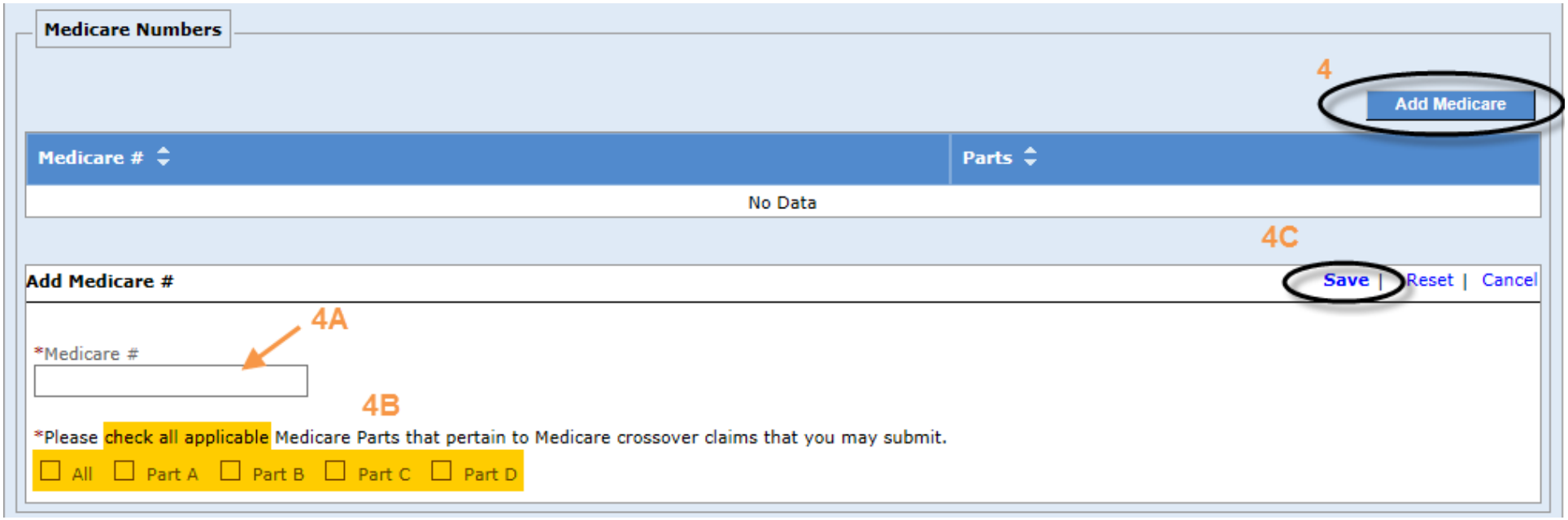
4. Select the "Add Medicare" button

NOTE: If you have more than one Medicare number, repeat the steps

4A. Enter the Medicare number

4B. Select all applicable Medicare Parts

4C. Review your input, when correct select "**Save**"



Section 3: 5 – Other Medicare Numbers Expanded Breakout View

5. Select the "Add History" button

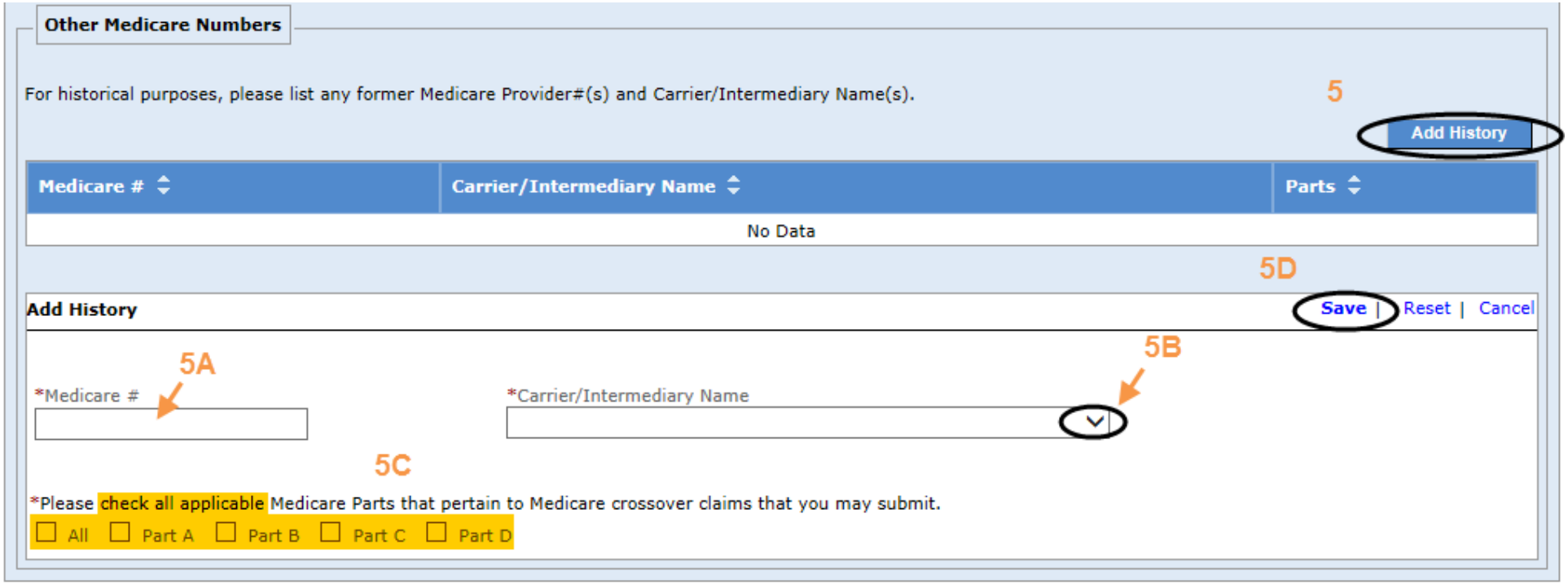
NOTE: If you have more than one former Medicare Provider number and Carrier/Intermediary Name, repeat the steps

5A. Enter Medicare number

5B. Select the appropriate carrier from the drop-downs presented

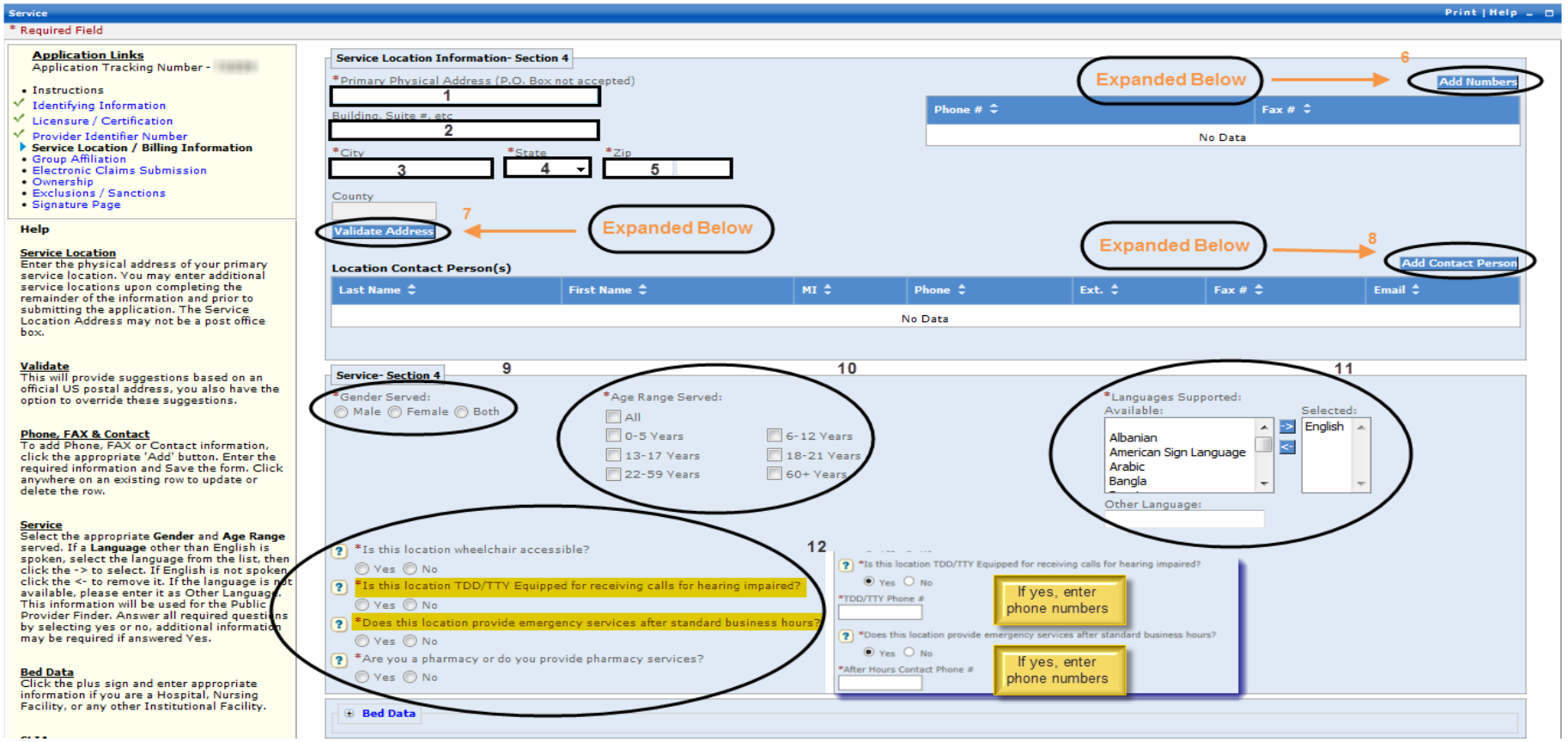
5C. Select all applicable Medicare Parts

5D. Review your input, when correct select "**Save**"



Service Location / Billing Information – Section 4 (1 of 3)

1. 1 – 5 Enter the primary Service Location physical address
   NOTE: Pg 1 of the **Provider Participation Agreement** (PPA) must reflect the **same** Service Address as the application
6. Add Service Location phone numbers – see page 14: **6 – Phone Numbers Expanded Breakout View**
   NOTE: The Service Location phone number is required (Billing and Mailing Locations also require this information)
7. Select the **Validate Address** button to ensure the address meets postal standards – see page 15: **7 – Validate Address**
   NOTE: When validating the address, if it is needed to be as you entered – select override
8. Enter the Service Location Contact information – see page 16: **8 – Location Contact Person(s) Expanded Breakout View**
   NOTE: The Service Location Contact is required (Billing and Mailing Locations also require this information)
9. 9 – 12 Select the appropriate answers to questions presented



Service Location / Billing Information – Section 4 (2 of 3)

10. Medical billing groups do not enter Bed Data
11. If the Medical billing group has CLIA certificates, select the blue hyperlink – see page 17: **11 – Clinical Laboratory Improvement Amendments (CLIA)**
12. If the Mailing address is the same as the Service Location Address then select yes and continue to 13, if not follow instructions provided under Service Location address
13. 13 – 14 Follow instructions provided under the Service Location Phone #'s (6) and Service Location Contact (8)
    NOTE: The Billing and Mailing Location phone number and Location Contact are required
15. Answer Yes or No; if Yes EFT Application displays in a new window pop up – see page 18: **15 – Electronic Funds Transfer (EFT) Application Breakout View**
    NOTE: The Electronic Funds Transfer Agreement form and a voided check or Bank letter is also needed and must be submitted as a part of required supporting documentation

Bed Data
Click the plus sign and enter appropriate information if you are a Hospital, Nursing Facility, or any other Institutional Facility.

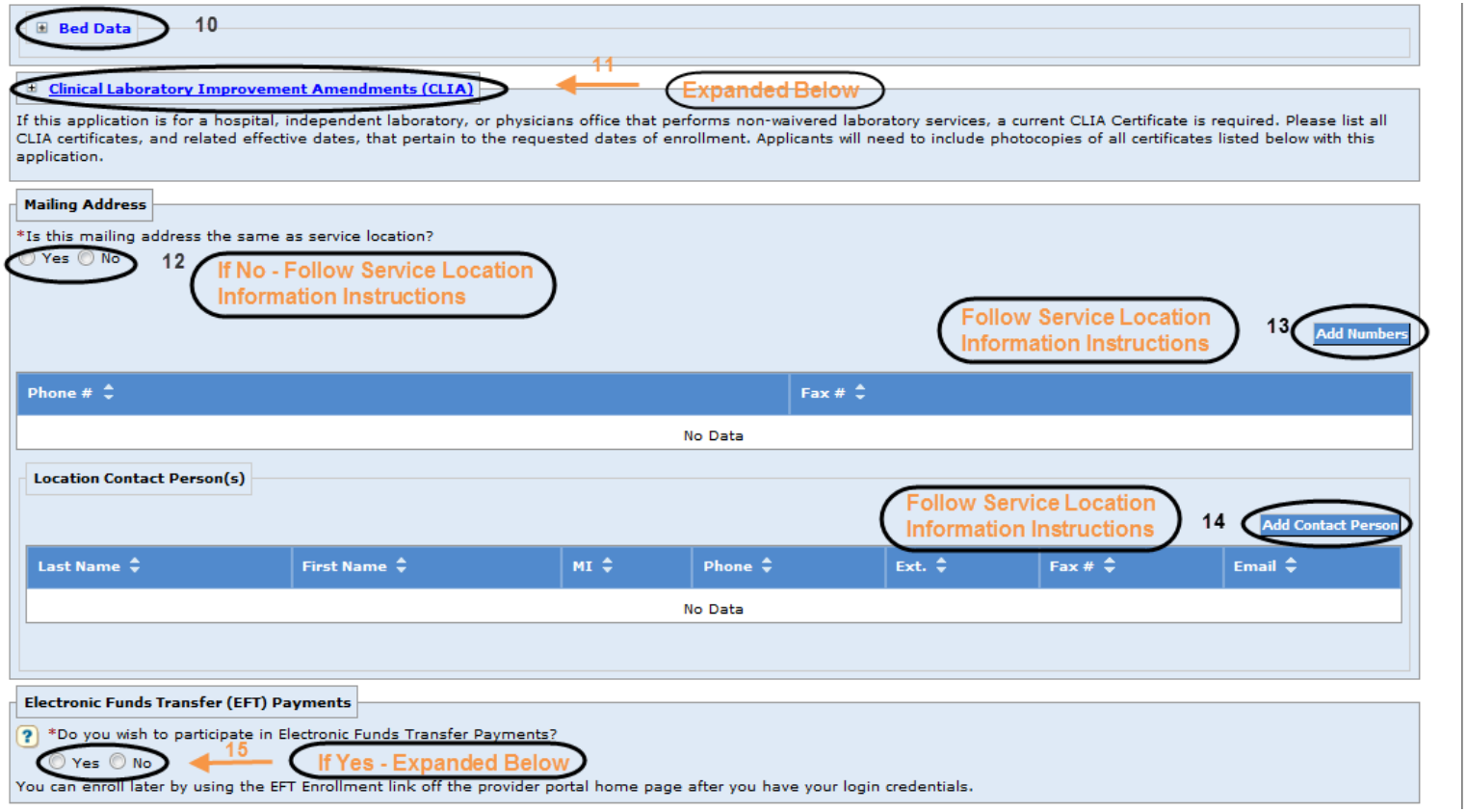
CLIA
To enter CLIA information click on the plus sign. Click the appropriate Add button and then enter the required information, and Save the form. Click anywhere on an existing row to update or delete the row.

Effective/Expiration
Enter as MM/DD/YYYY, MM-DD-YYYY or MMDDYYYY or click the Calendar icon to choose a date. End or Expiration Date should be greater than Begin or Effective Date.

Mailing Address
Enter the address that you prefer to receive correspondence. If the Mailing Address is identical to the Service Location Address entered above, answer Yes. Otherwise, answer No to enter a different address.

Electronic Funds
If you plan to use EFT and have the banking information available, answer Yes and enter the required information now. If you do not have the information available now, answer No to continue the enrollment application. You may update the information at a later time.

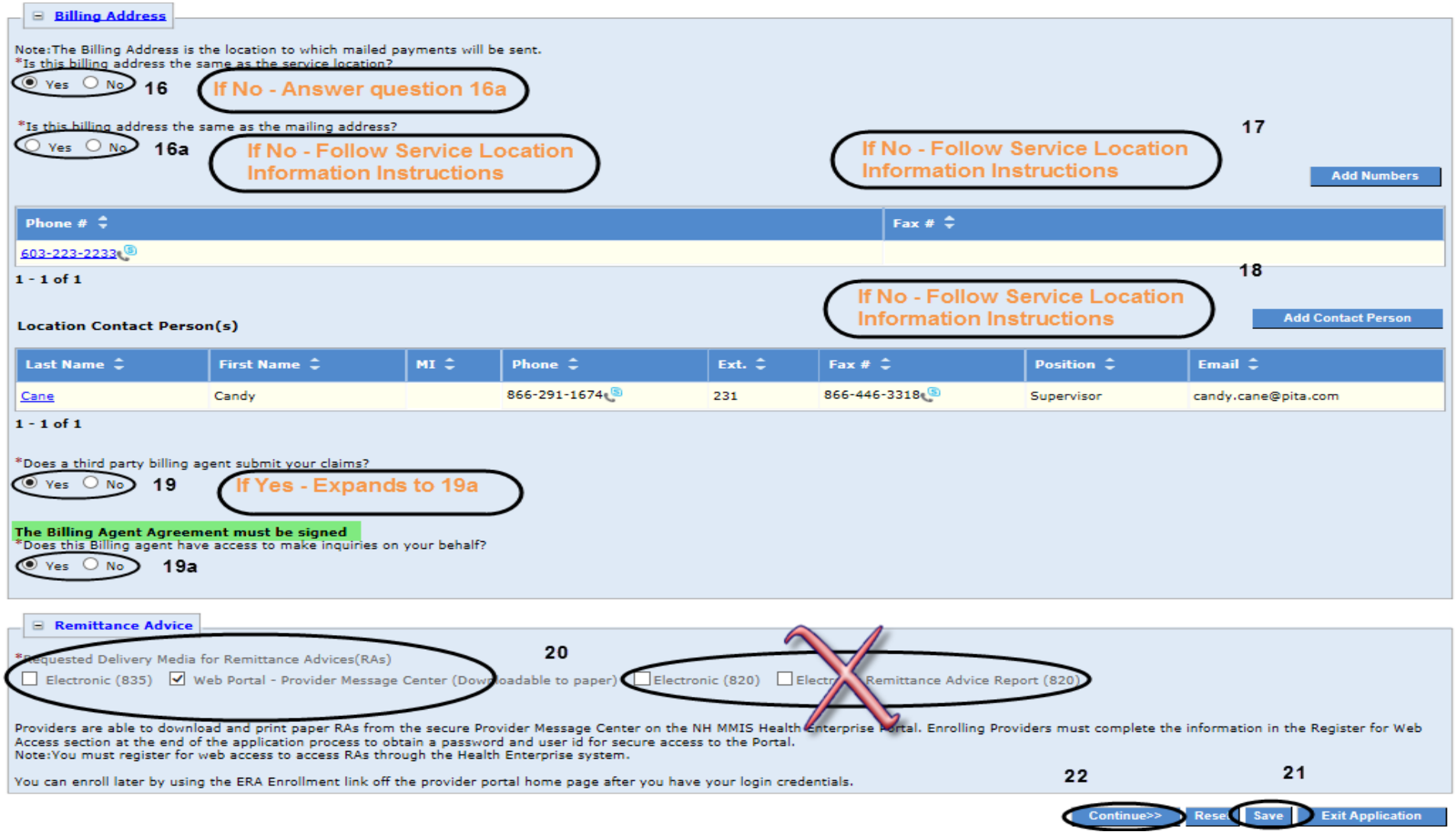
Billing Address
Enter the address that you prefer to



Service Location / Billing Information – Section 4 (3 of 3)

16. 16 and 16a - Answer Yes or No and if necessary follow the Service Location information instructions for entering addresses
17. 17 and 18 Follow the Service Location information instructions for entering Phone Numbers and Contact Person(s)
19. Answer Yes or No; if Yes Answer 19a

    NOTE: The Billing Agent Agreement must be signed if using a third party billing agent to submit your claims
20. Select either Web Portal or (electronic) 835, but NEVER either 820 option
21. Review your answers, when correct select "**Save**" first, then 22. "**Continue**"



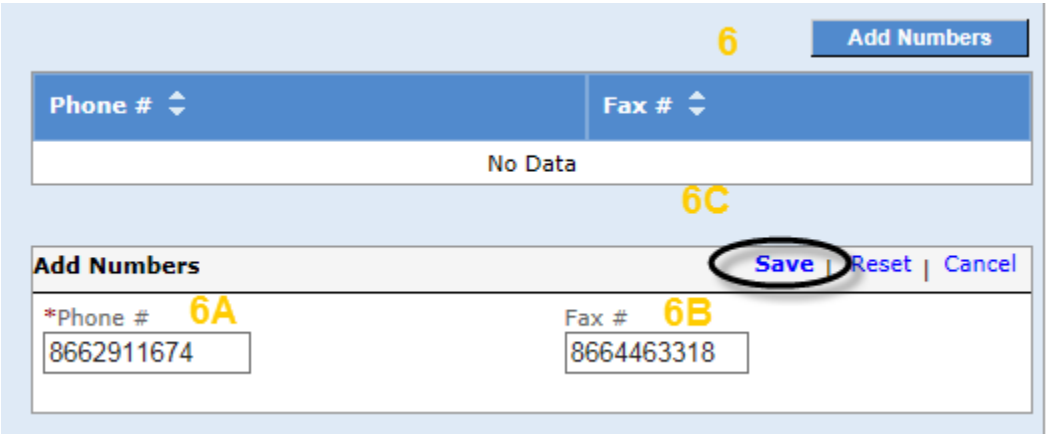
Section 4: 6 – Phone Numbers Expanded Breakout View

6. Add Service Location phone numbers

6A. Enter current service location phone number

6B. Enter current service location fax number

6C. Review your input, when correct select "**Save**"

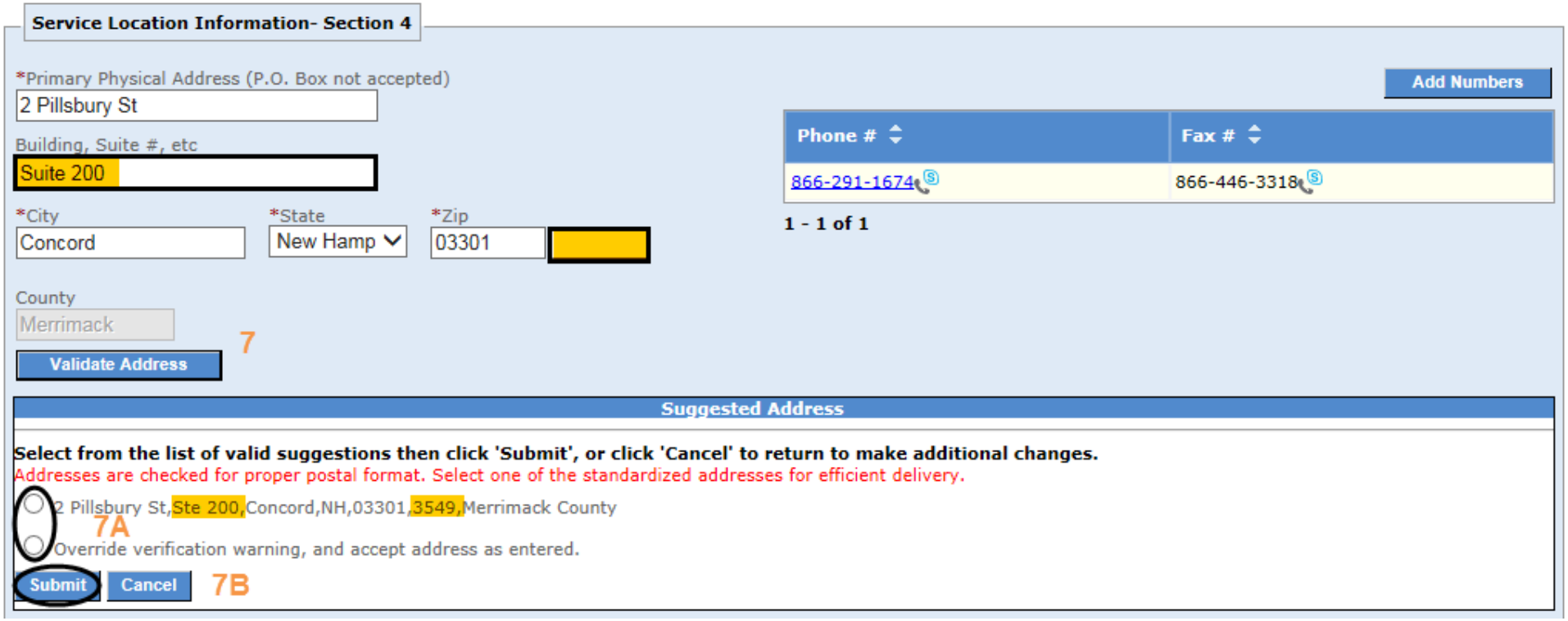


Section 4: 7 – Validate Address

7. Select "**Validate Address**" button once you have entered Service Location Address information

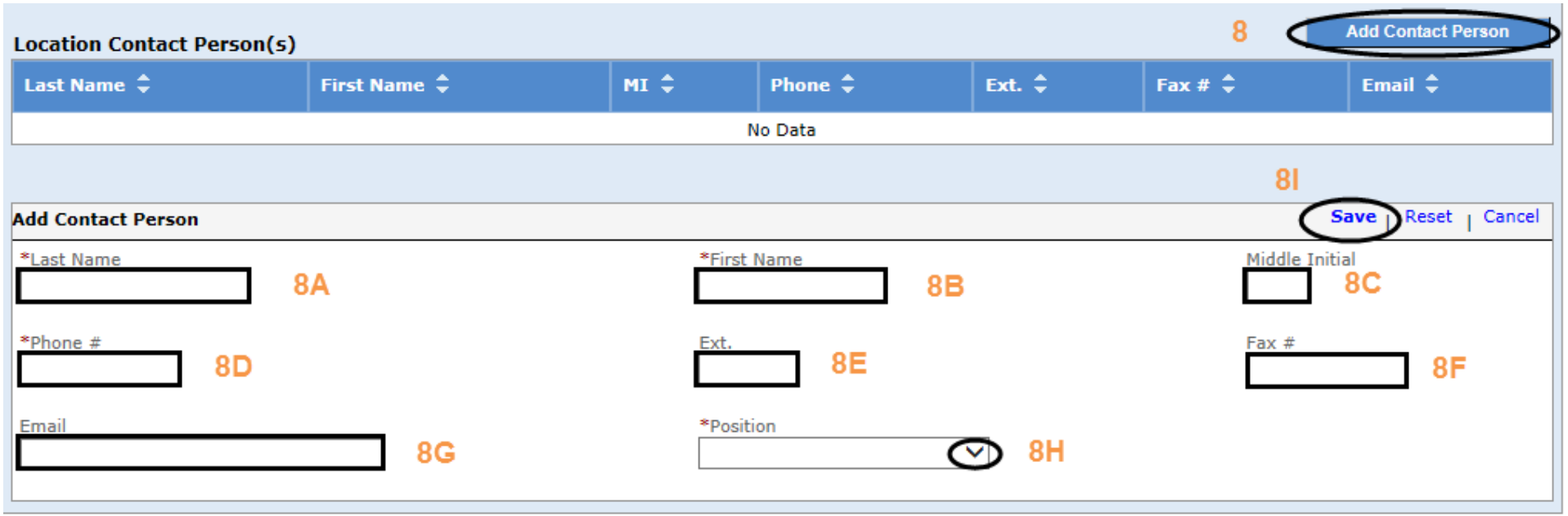
7A. Select either the standardized address if accurate or override the verification if the address is required to be as entered

7B. Review your input, when correct select "**Submit**"



Section 4: 8 – Location Contact Person(s) Expanded Breakout View

8. Enter the Service Location Contact information
8A. Required
8B. Required
8C. Optional
8D. Required
8E. Optional
8F. Strongly suggest including
8G. Required
8H. Required – Select from drop-down
8I. Review your input, when correct select "**Save**"



Section 4: 11 – Clinical Laboratory Improvement Amendments (CLIA)

11. Select the blue Clinical Laboratory Improvement Amendments (CLIA) link

11A. Select Add CLIA

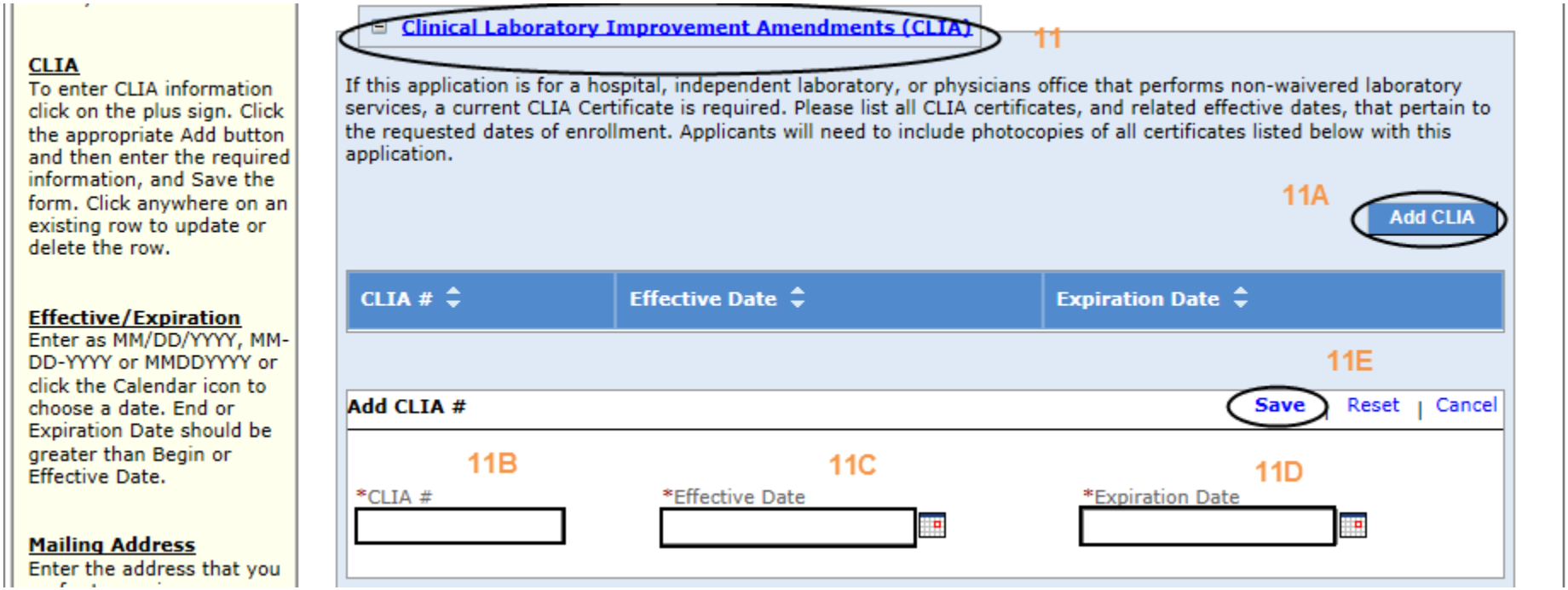
11B. Enter the CLIA Certificate number

11C. Enter the Effective Date

11D. Enter the Expiration Date

11E. Select the "Save"

NOTE: Repeat steps 11A thru 11E as many times as necessary to add additional certificates

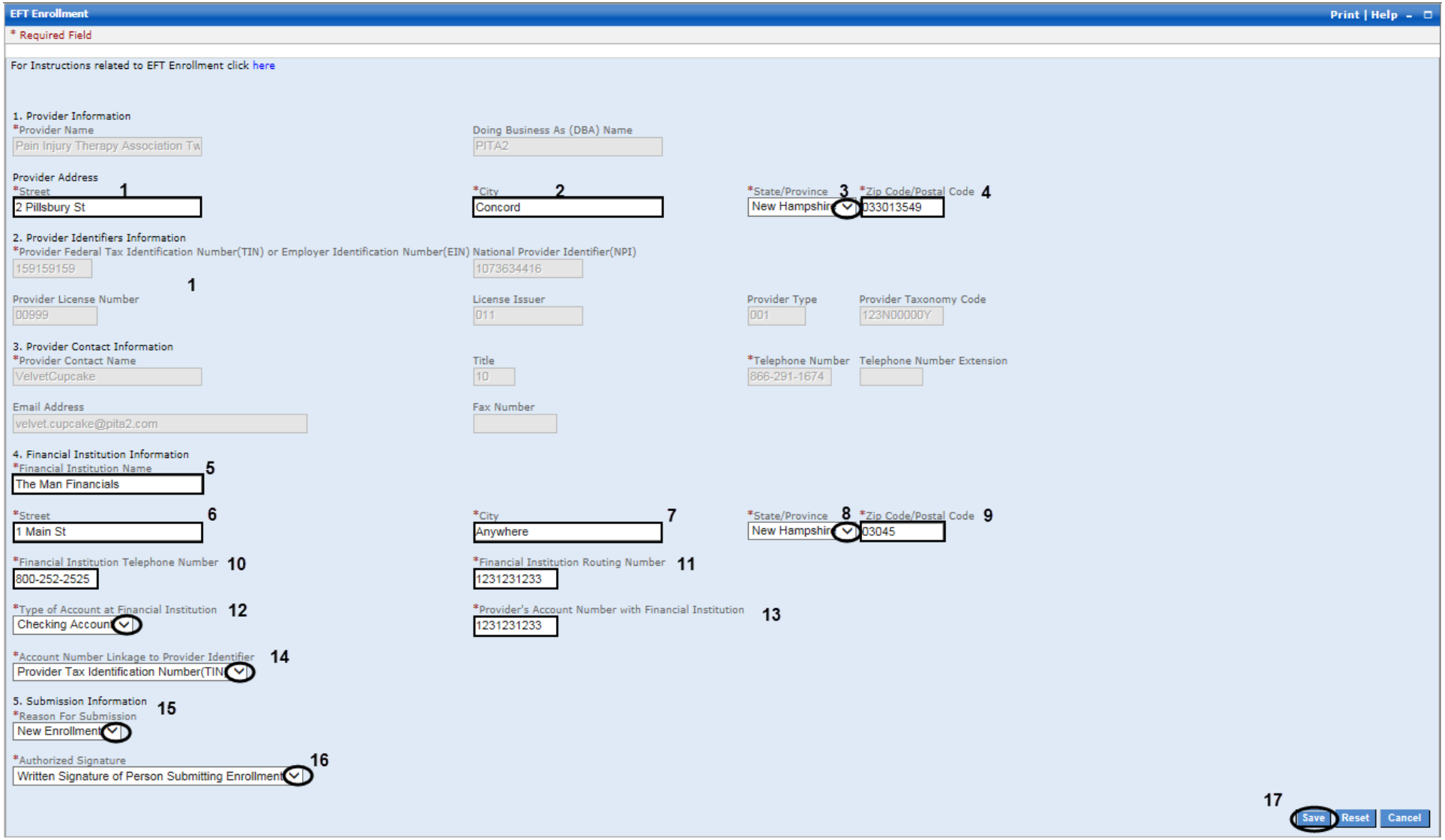


Section 4: 15 - Electronic Funds Transfer (EFT) Application Breakout View

a. 1, 2, 4-7, 9-11, 13 input the appropriate information

b. 3, 8, 12, 14-16 select the appropriate information from the drop-downs as presented

NOTE: The email address identified in the billing address contact panel will be used to send EFT notifications



Group Affiliation(s) – Section 5

1. Select Add Affiliation button

1A. Add Individual Provider ID number OR if the provider is “To Be Enrolled”, enter their ATN or the words ”New Enrollment”

1B. Add Provider Name whether they are an existing NH Medicaid Provider or “To Be Enrolled”

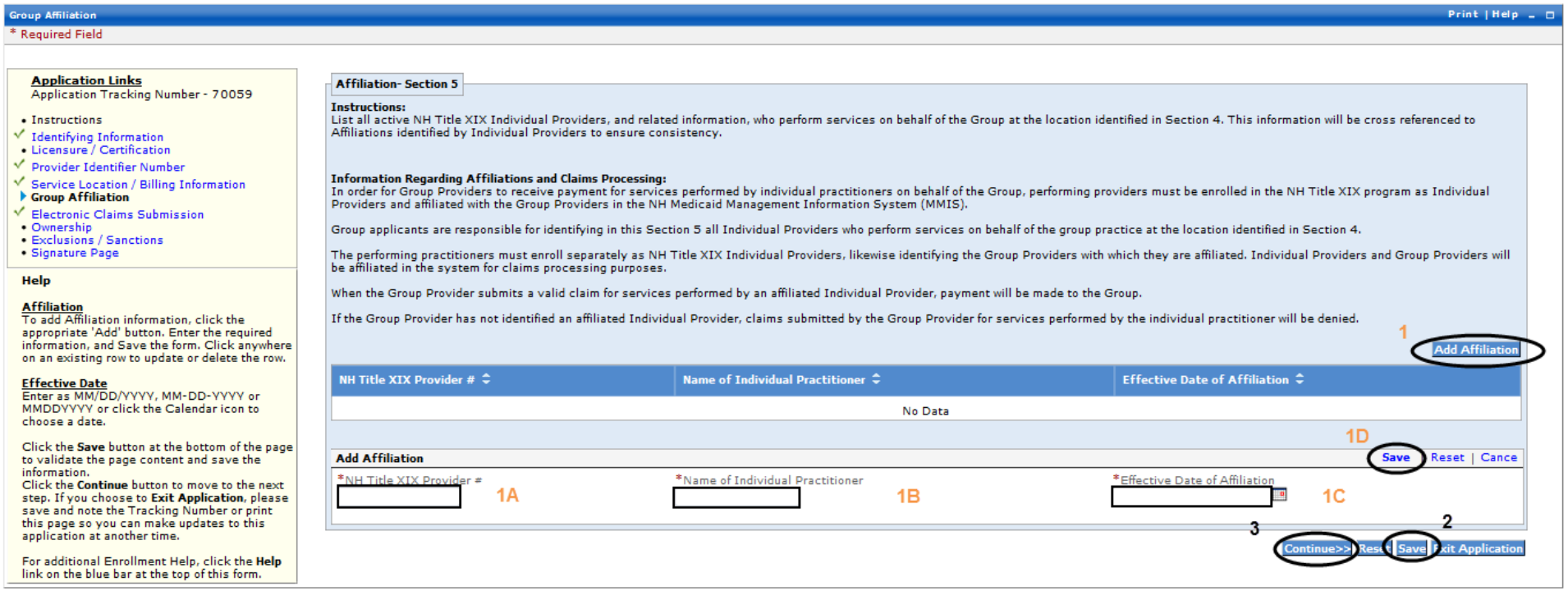
1C. Enter Affiliation Date whether they are an existing NH Medicaid Provider or “To Be Enrolled”

1D. Review your input, when correct select section “**Save**”

2. Review your answers, when correct select “**Save**” first

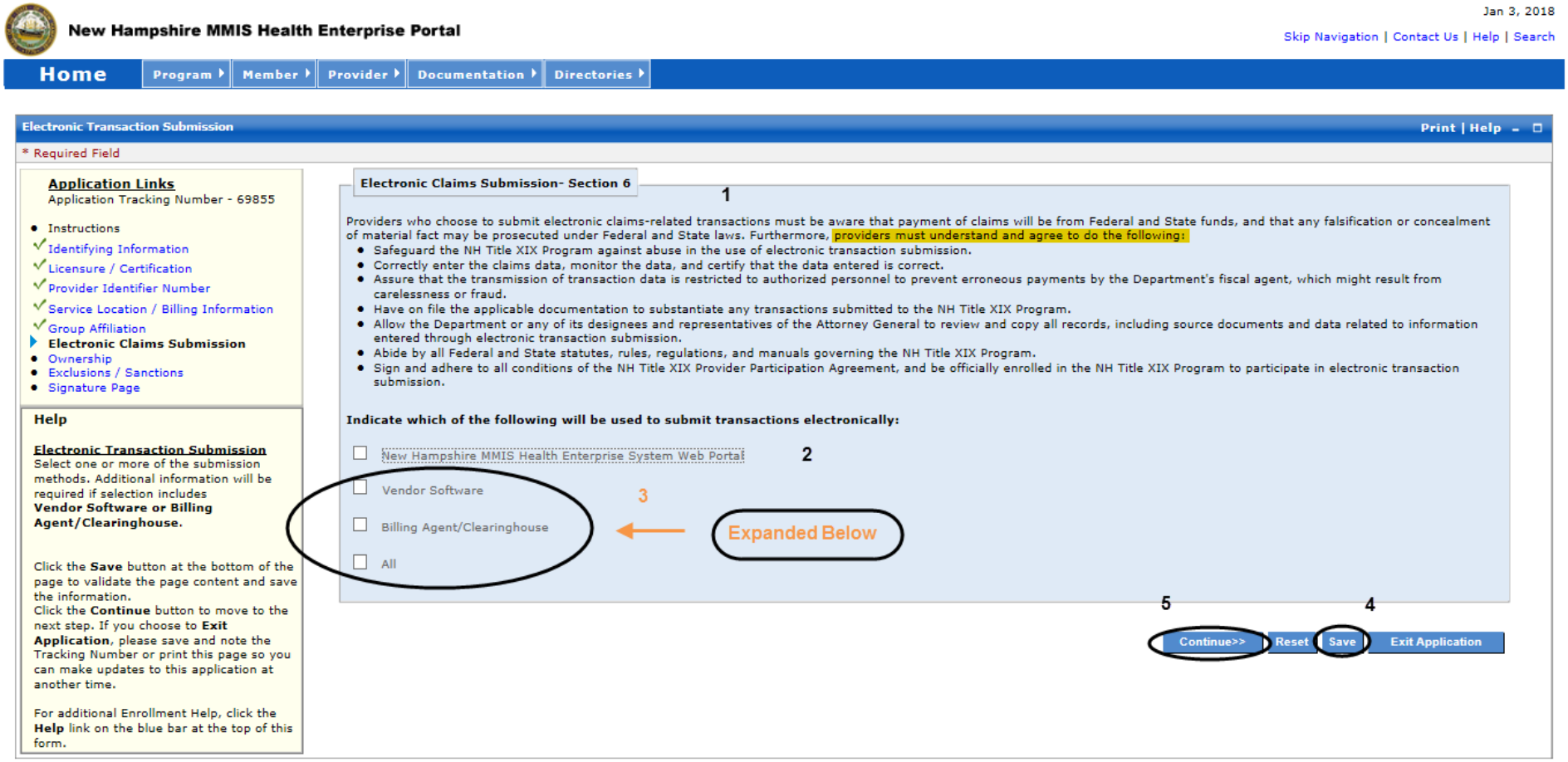
3. Then select “**Continue**”

NOTE: Repeat steps **1-1D** until all Individual Providers associated with the Group practice have been added



Electronic Claims Submission – Section 6

1. Read the Electronic Claims Submission agreement
2. Select to submit claims through the NH MMIS Portal – no additional information needed
3. Select one or more of these options for electronic claims submission - complete information presented upon selection – see page 21: **3 – Electronic Claims Expanded Breakout View**
4. Review your answers, when correct select "**Save**" first
5. Then select "**Continue**"



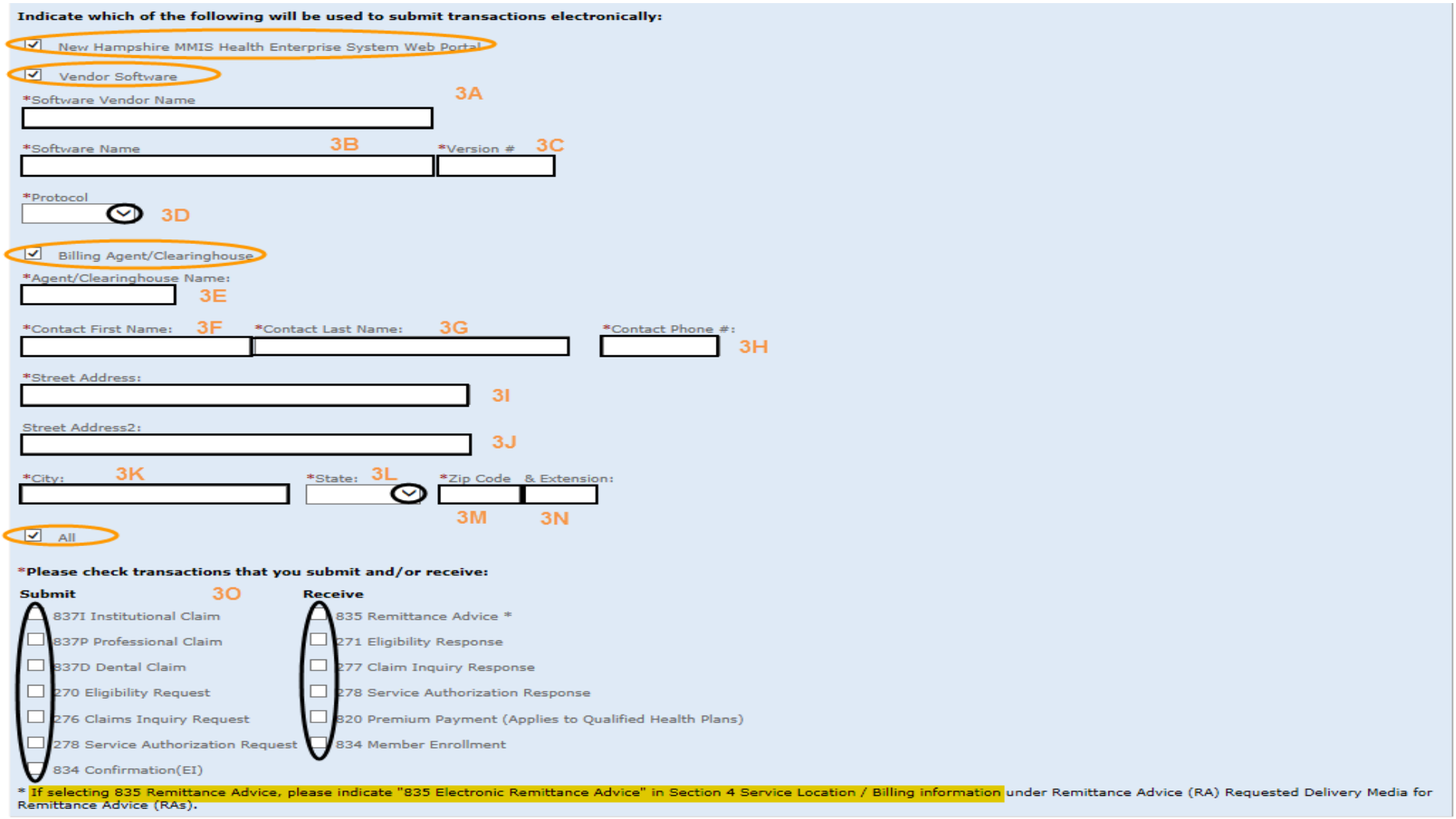
Section 6: 3 – Electronic Claims Expanded Breakout View

3A. – 3D. Enter the requested information for Vendor Software Selection

3E. – 3N. Enter the requested information for Billing Agent/Clearinghouse Selection

3O. Select the appropriate transactions required for either Vendor Software Selection or Billing Agent/Clearinghouse Selection

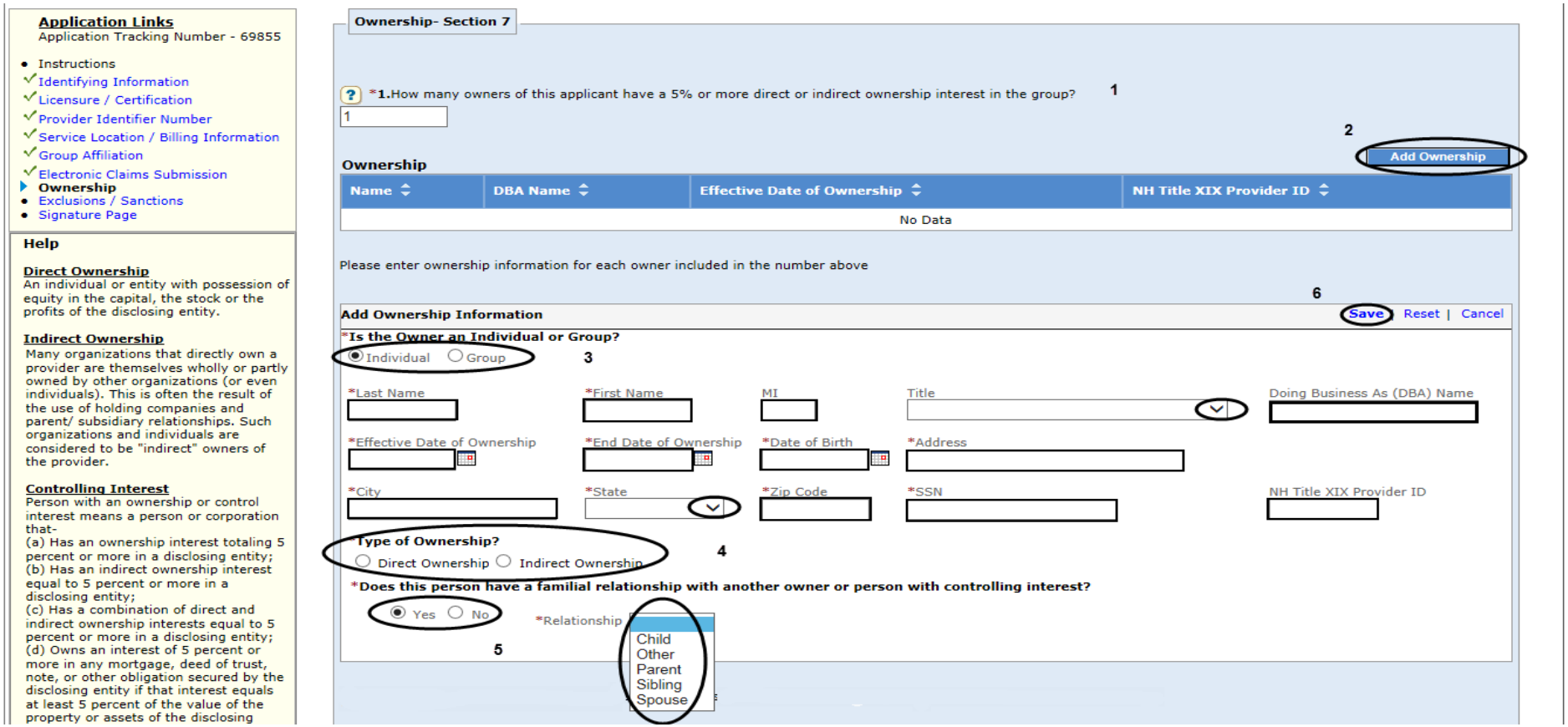
NOTE: If selecting 835 Remittance Advice, please indicate "835 Electronic Remittance Advice" in Section 4 Service Location / Billing Information



Ownership/Controlling Interest (Question 1 of 5) – Section 7

NOTE: Information will be checked against CMS PECOS Medicare and other National Databases – please ensure the information is consistent

1. If there is more than one (1) owner, with 5% or more ownership, you will be required to enter each owner's information
   NOTE: Tax Exempt Providers [501(c)(3)] are required to input their Board of Directors (BOD) information under question 2 below
2. Select Add Ownership for both profit and non-profit providers
3. Select Individual Owner or Group Owner – Individual Owner is displayed here. If ownership is a Group, the FEIN and Business Name would be required versus the individual's First/Last Name and SSN – Complete all data fields as appropriate
4. If unsure of type of ownership, default to Direct Ownership
5. Answer as appropriate
6. Review your answers, when correct select "**Save**"

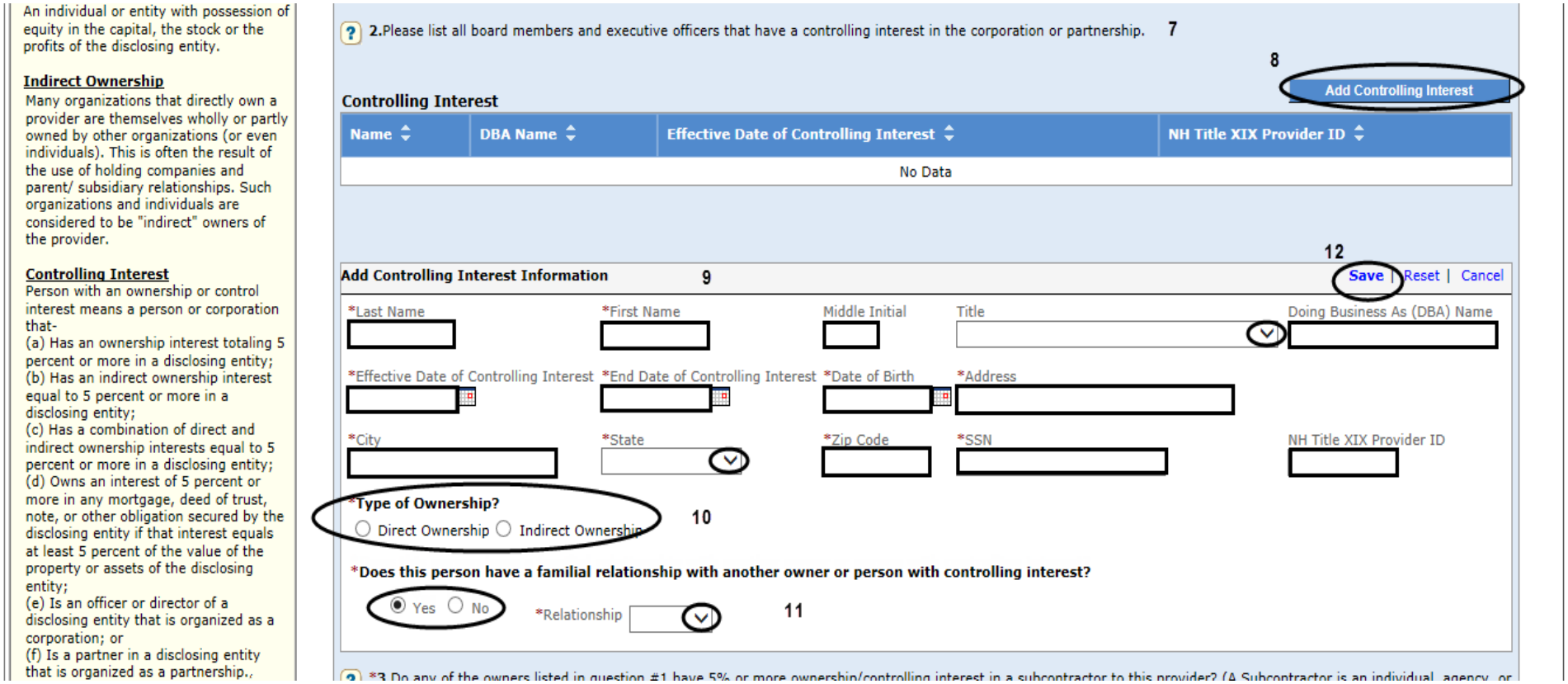


Ownership (Question 2 of 5) – Section 7

NOTE: Tax Exempt Providers [501(c)(3)] must fill in all their Board of Directors (BOD) members and Executive Officers in question 2

7. Enter in all board members and executive officers who have a controlling interest in the corporation or partnership
8. Select "Add Controlling Interest" button, required information will start to display
9. Complete all data fields as appropriate
10./11. Answer questions as presented, if unsure of type of ownership, default to Direct Ownership
12. Review your answers, when correct select "**Save**"

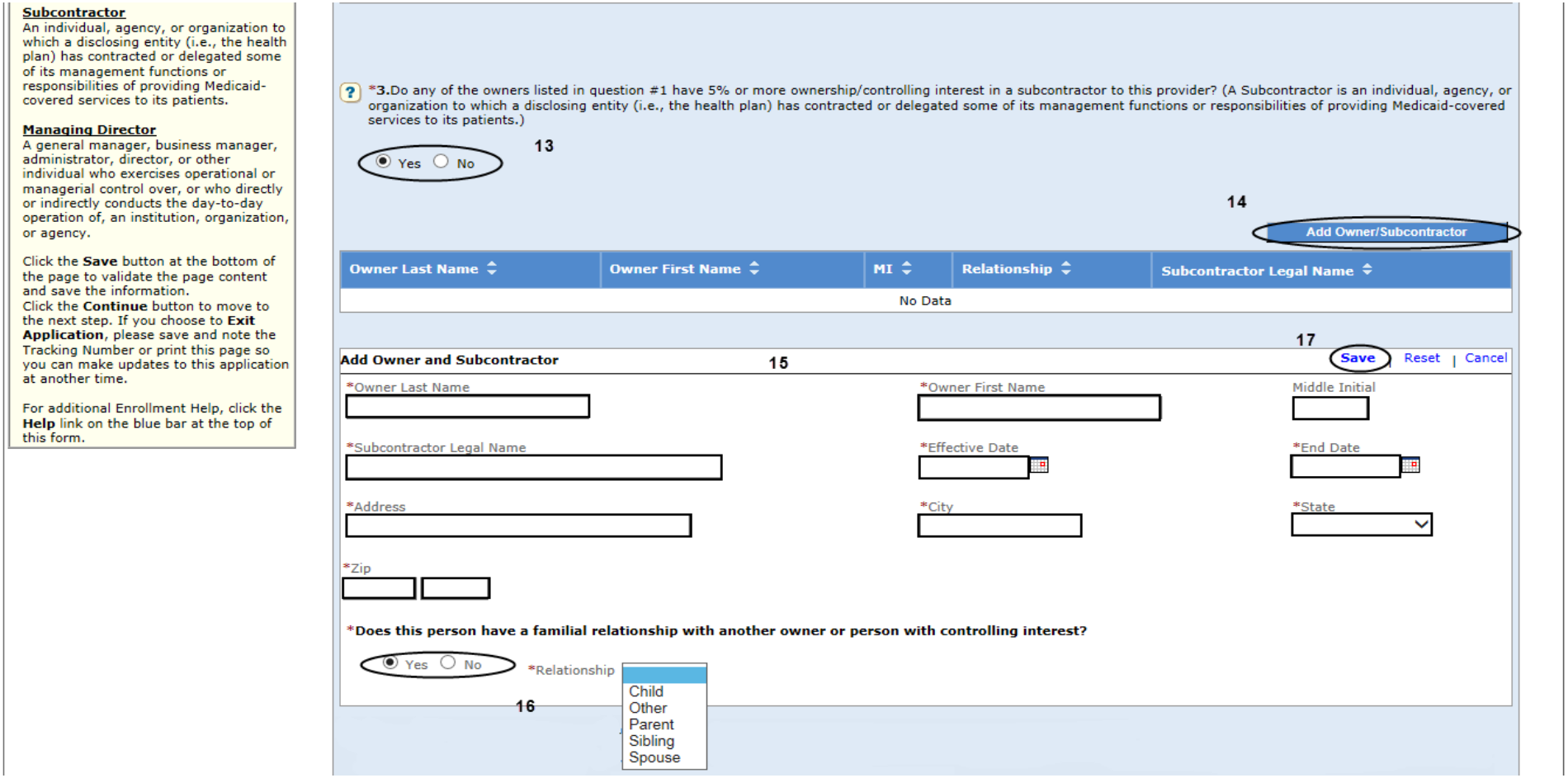
NOTE: Repeat steps 8-12 until all owners have been entered



Ownership (Question 3 of 5) – Section 7

13. Select the appropriate answer – if yes required information will start to display
14. Select the Add Owner/subcontractor button to enter all subcontractor owner information
15. Complete all data fields as appropriate
16. Select the appropriate answer
17. Review your answers, when correct select "**Save**"

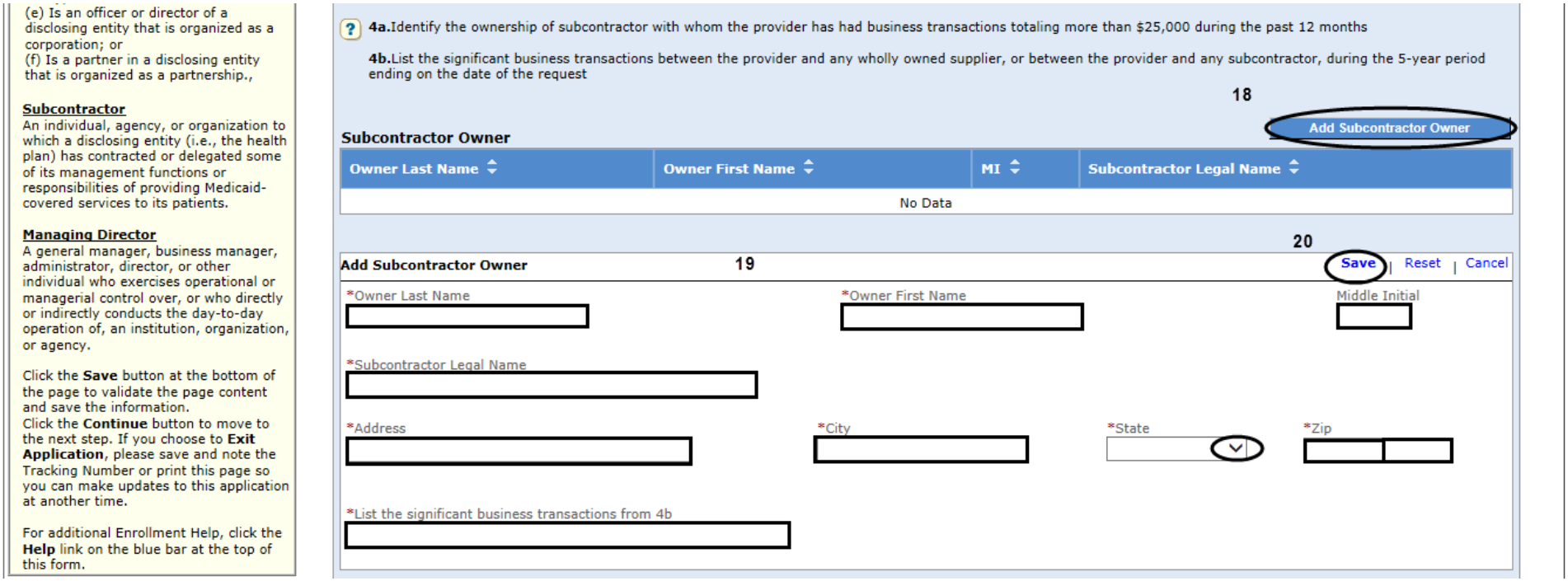
NOTE: Repeat step 14-17 until all Owner/Subcontractor information has been entered



Ownership (Question 4 of 5) – Section 7

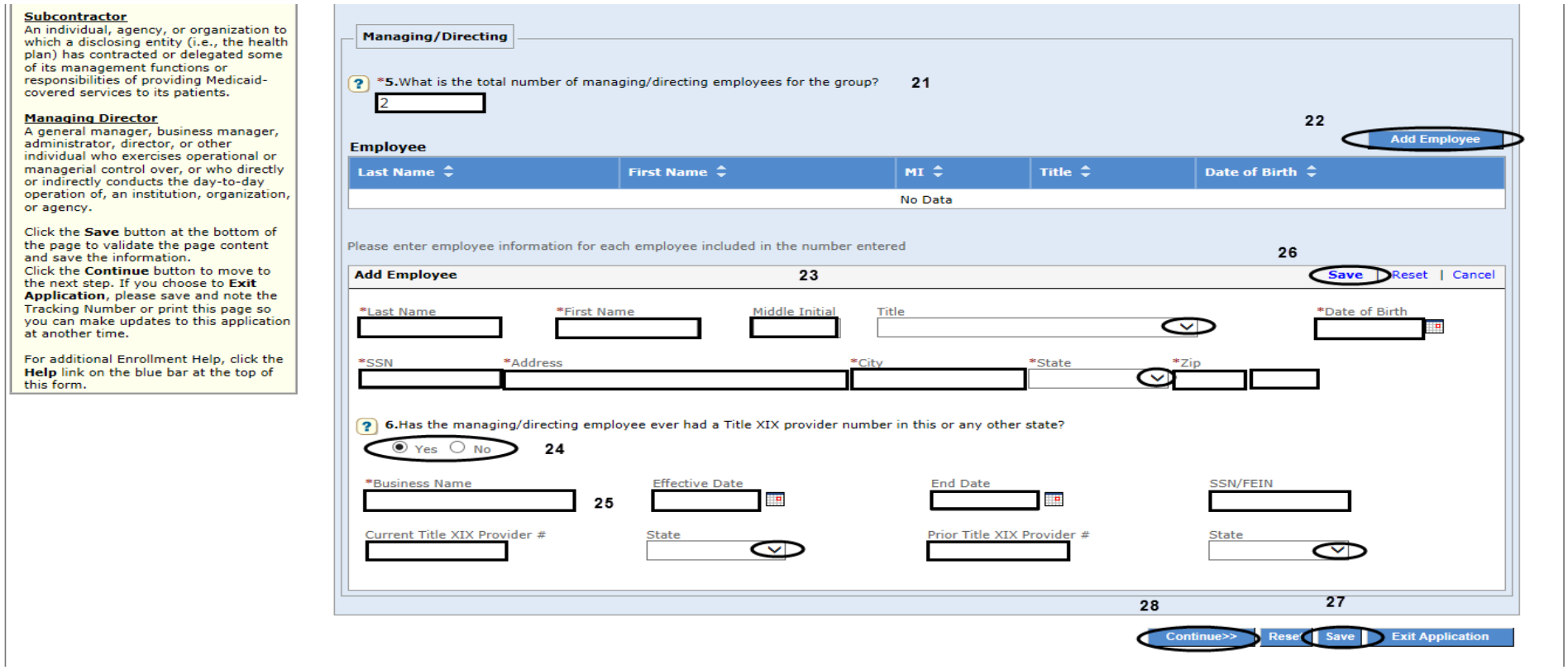
18. If the answer to question 4a or 4b is yes, select the Add Subcontractor Owner button and required information will start to display
19. Complete all data fields as appropriate
20. Review your answers, when correct select "**Save**"

NOTE: Repeat step 18-20 until all significant business transactions have been listed/entered



Ownership (Question 5 of 5) – Section 7

21. If there is more than one (1) managing/directing employee, you will be required to enter each employee's information
    NOTE: All applicants are required to enter <u>at least one</u> managing/directing employee
22. Select Add Employee button
23. Complete all data fields as appropriate
24. Answer Yes or No – If answer is Yes, additional data fields will be presented
25. Complete all data fields as appropriate
    NOTE: Add their NH Medicaid Provider ID for the employee, if applicable
26. Review your answers, when correct select "Save"
    NOTE: Repeat step 22-26 until all Managing/Directing have been entered
27. Review your answers, when correct select "Save" first, then 28. "Continue"



Exclusion/Sanction – Section 7

Answer all questions – if you answer Yes on any question, additional data fields will be presented that must be completed

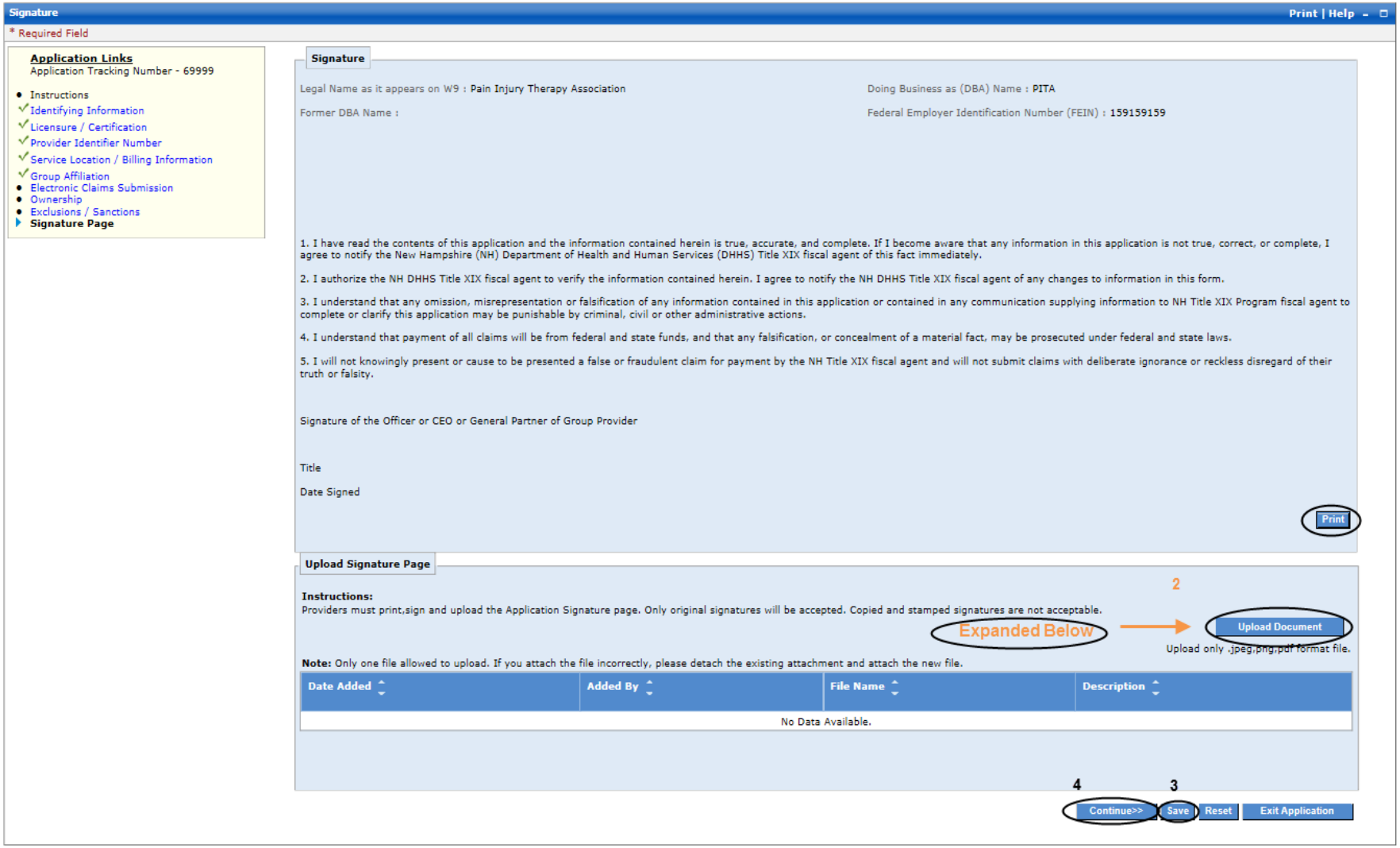
NOTE: Any Exclusion/Sanction question answered with "Yes" will require a copy of the original adverse action or a dated signed statement from the provider which must be submitted with the application

Review your answers, when correct select "**Save**" first, then select "**Continue**"

Signature Page / Upload Documentation

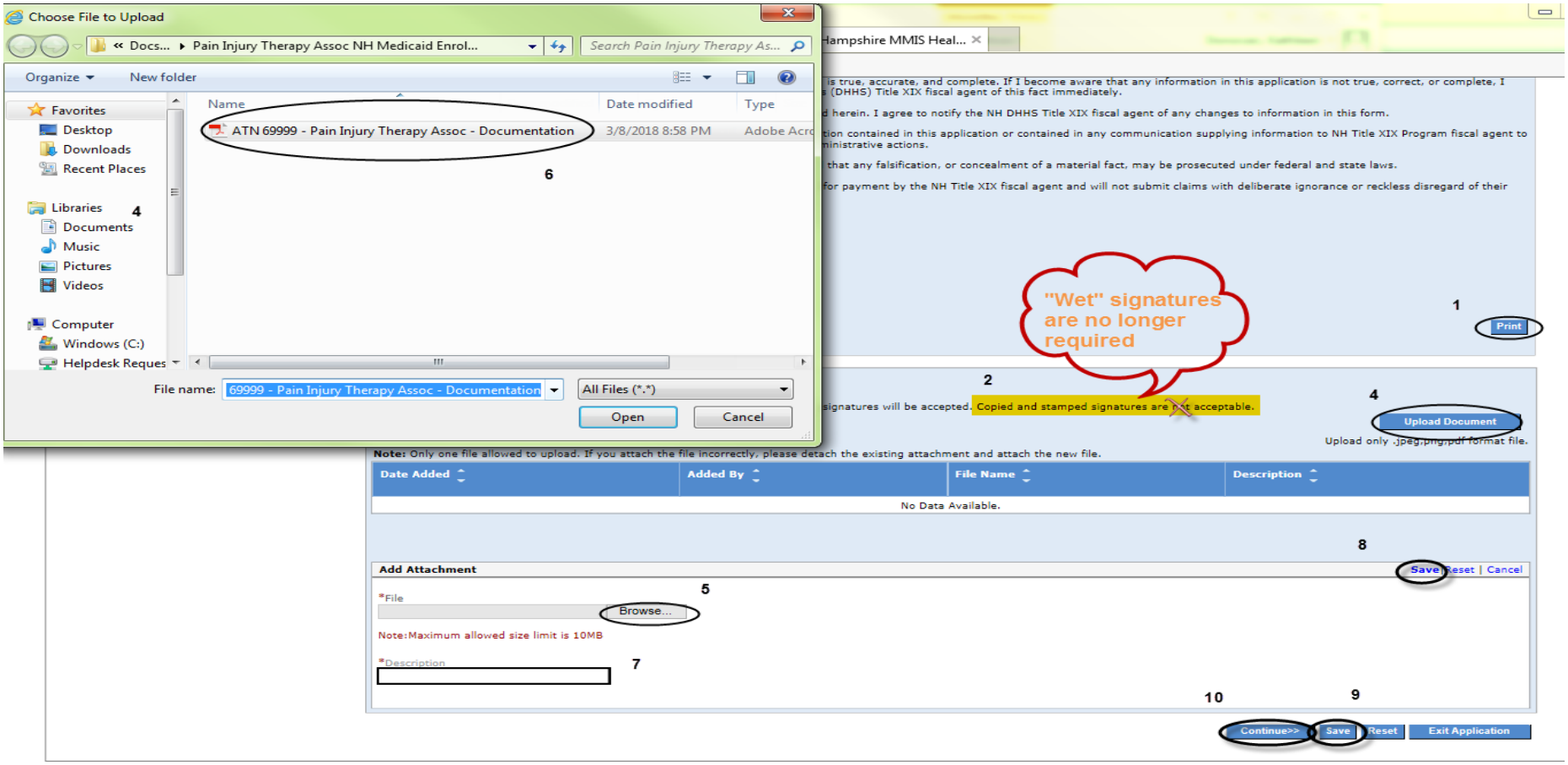
1. Select "**Print**" button. Owner, CEO, General Partner or identified Managing/Directing Employee of Group Provider must sign the signature page
2. Once the document is signed, scan or take a picture of it and save it as one file on your desktop – see page 29: **2 - Upload Signature/Documentation Instructions Breakout View**

   Note: Add all the other required documentation needed to support your answers and application to your saved file
3. Ensure your file has been uploaded and named, when ready select "**Save**" first, then select "**Continue**"



Signature Page: 2 - Upload Signature/Documentation Instructions Breakout View

1. Print: Press the **Print** button
2. Have the appropriate individual sign the Signature Page as well as any other required documents as applicable
3. Scan all the documents and save as a one new file on your computer
4. Press the "**Upload Document**" button
5. Select **Browse** and navigate to the saved file on your computer
6. Once you have located the file, double click on it and the file will be added to the **File** box
7. Fill in Description – **NOTE:** Recommend naming file/description as "ATN 12345 – (group name) – Documentation
8. Click on "**Save**" within the panel/section
9. Ensure your file has been uploaded and named, when ready select "**Save**"
10. Select "**Continue**"

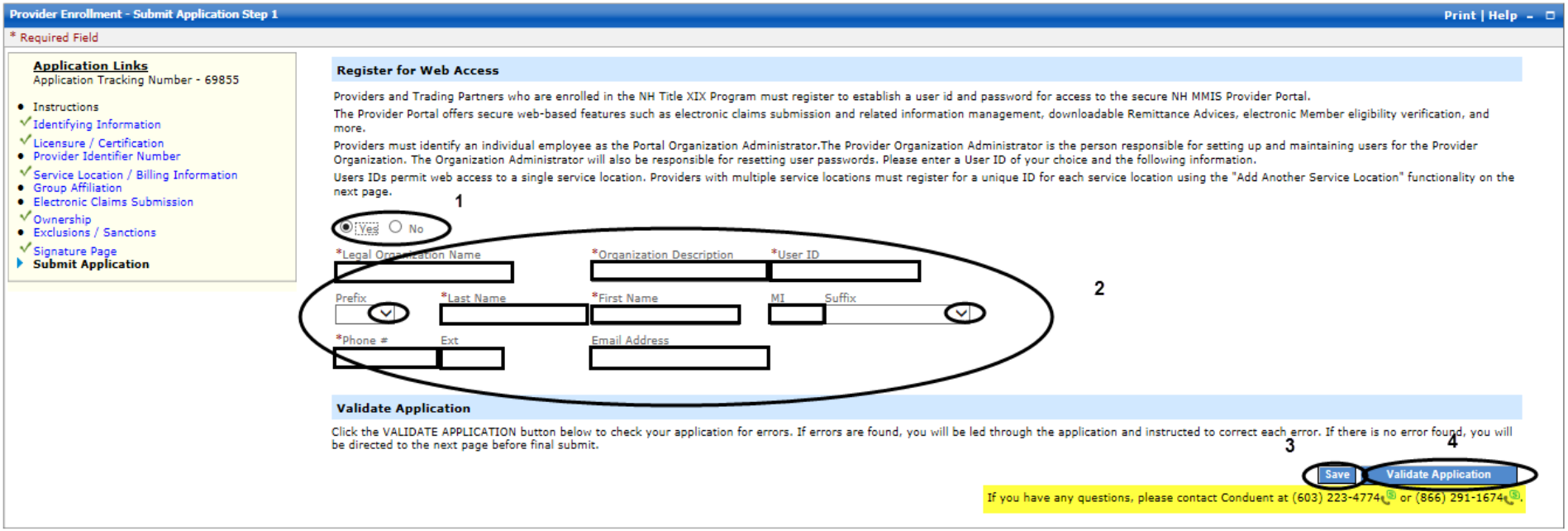


Submit Application / Register for Web Access– Step 1

1. Always select **Yes**
2. Complete all data fields as appropriate

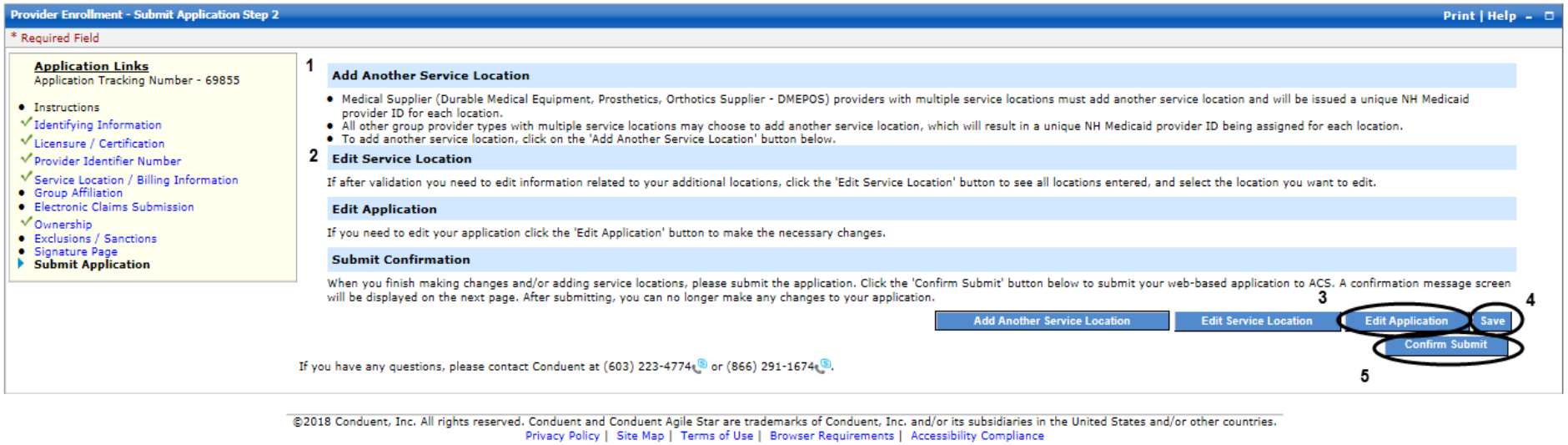
   NOTE: Email Address is Required!
3. Review your responses, when correct select "**save**"
4. Select the **Validate Application** button

   NOTE: Once you select the **Validate Application** button, any missing required information as well as incorrect information (ex: SSN is 9 digits however only 8 were entered) will be noted at the top of the page so that it can be corrected



Submit Application / Add Another Service Location / Edits / & Submit Confirm – Step 2

1. 1-2 Read the page for Add "Another Service Location" and "Edit Service Location"
   NOTE: Additional service locations will result in each service location having a unique Medicaid ID
3. If no additional service locations are required, Select **Save**
4. If you want to Edit the application, select the "**Edit Application**" button
   TIP: This is your last chance to edit any of your answers or correct your entries – you can select the section you wish to check by clicking on it in the left side Application Links
5. Once you are ready, select the "**Confirm Submit**" button - The Submit Complete page will display



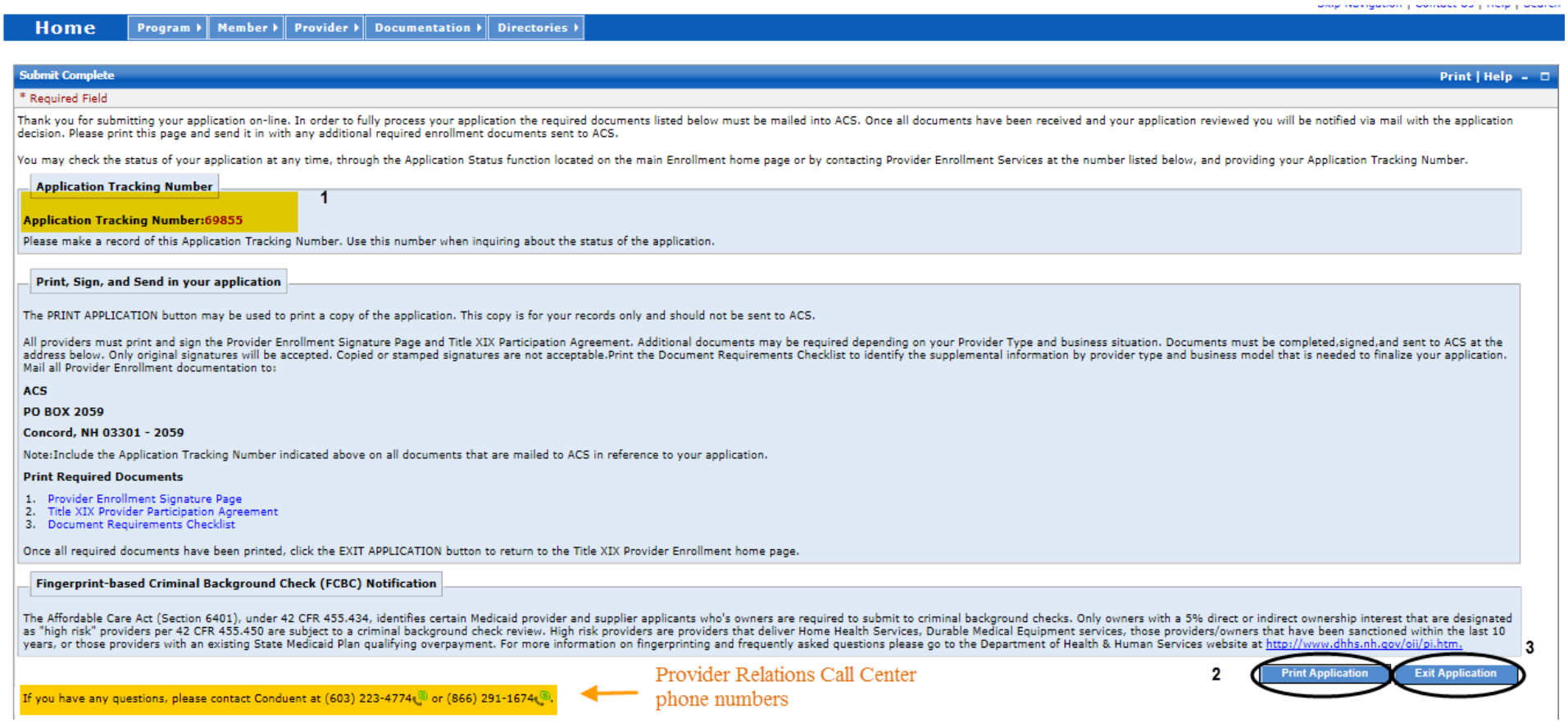
Submit Complete Page

1. Note the Application Tracking Number
2. Select the Print application so that you can maintain a copy for your records

   NOTE: Once you leave this page, you do not have another option to print out the application
3. Select Exit Application button

   NOTE: It is not necessary to print the additional documents as you have already submitted them during the Signature/Document Upload Process

   TIP: The Provider Relations Call Center is available to you toll free @ 1-866-291-1674 from 8:00 am to 5:00 pm; Mon-Fri



Tips, Notes, & Important Information

Provider Relations Call Center – 1-866-291-4366

General Information:

INFO: Providers who will be billing with their FEIN, will need to complete a Group Application

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

TIP: The "Required Enrollment Documents to Upload with Application" can be found under the "Documents and Forms" quick Link on the NHMMIS home page

NOTE: Providers are to use the "Signature Page" upload to submit all required and supporting documents for this enrollment

NOTE: The Application Tracking Number will display in red at the top of the page. It is very important to write this number down

NOTE: The Application can be saved prior to submitting - Should you need to step away from the application, you can go back to it (Recall) by entering the ATN and FEIN in the Recall Section and select submit

NOTE: You can also check on the status of the application, enter the Application Tracking Number (ATN) and select submit

INFO: If at any time you need to go back to a section, go to the "Application Links" box to the left of the application and click on the appropriate section's blue hyperlink title

INFO: ALWAYS include the appropriate valid email address when an email address is requested – whether or not it is indicated as "* required"

INFO: The group is the billing entity for the individual Rendering/Non-Billing provider(s) affiliated to the group

TIP: The Provider Relations Call Center is available to you toll free @ 1-866-291-1674 from 8:00 am to 5:00 pm; Mon-Fri

Application Sections:

Section 1 - Identifying Information:

NOTE: The Application Tracking Number will be displayed in the upper left corner of the web page. It is very important to write this number down

NOTE: You will need to provide proof of the Tax ID as a part of required supporting documentation

NOTE: If the group is tax exempt, include a copy of the IRS issued exemption notification as a part of required supporting documentation

NOTE: The Service Location phone number is required (Billing and Mailing Locations also require this information)

NOTE: The Service Location Contact is required (Billing and Mailing Locations also require this information)

NOTE: The email address identified in the billing address contact panel will be used to send EFT notifications

Section 2 - Licensure/Certification:

TIP - The taxonomy information can be found with the NPI information on the NPI Registry website: https://npiregistry.cms.hhs.gov/registry/

INFO: Use the default date of 12/31/9999 where there is not a current end date indicated/applicable

Section 3 - Provider Identifier Number:

TIP: The taxonomy information can be found with the NPI information on the NPI Registry website: https://npiregistry.cms.hhs.gov/registry/

INFO: Use the default date of 12/31/9999 where there is not a current end date indicated/applicable

NOTE: If you have more than one Medicare number, include them on the application

NOTE: If you have more than one former Medicare Provider number and Carrier/Intermediary Name, include them on the application

INFO: Never select either of the 820 options for Remittance Advice - NEVER

Section 4 – Service Location/Billing Information:

NOTE: Pg 1 of the **Provider Participation Agreement** (PPA) must reflect the **same** Service Address as the application

NOTE: The Service Location phone number is required (Billing and Mailing Locations also require this information)

NOTE: When validating the address, if it is needed to be as you entered – select override

NOTE: The Service Location Contact is required (Billing and Mailing Locations also require this information)

NOTE: The Billing and Mailing Location phone number and Location Contact are required

NOTE: The Electronic Funds Transfer Agreement form and a voided check or Bank letter is also needed and as such should be submitted as a part of required supporting documentation

NOTE: The email address identified in the billing address contact panel will be used to send EFT notifications

NOTE: The Billing Agent Agreement must be signed if using a third party billing agent to submit your claims

Section 5 – Group Affiliation:

NOTE: Include all Individual Providers associated with the Group practice and repeat the steps as many times as necessary

Section 6 – Electronic Claims Submission:

NOTE: The email address identified in the billing address contact panel will be used to send EFT notifications

NOTE: If selecting 835 Remittance Advice, please indicate "835 Electronic Remittance Advice" in Section 4 Service Location / Billing Information

INFO: Never select 820 options for Receive Transactions – NEVER

Section 7 – Ownership Questions & Exclusion/Sanction:

NOTE: Information will be checked against CMS PECOS Medicare and other National Data Bases – please ensure the information is consistent

NOTE: Tax Exempt Providers [501(c)(3)] must fill in all the Board of Directors (BOD) members and Executive Officers in question 2

NOTE: Any Exclusion/Sanction question answered with "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

NOTE: Add all required documentation needed to support your answers and application to your saved file

NOTE: All applicants are required to enter at least one managing/directing employee

NOTE: Add the NH Medicaid Provider ID for any managing/directing employee, if applicable

Signature Page – Upload Documentation:

NOTE: Recommend naming saved file/description as "ATN XXXXX – (group name) – Documentation

INFO: Refer to Upload Signature Instructions for Enrollment Application for additional instructions if needed

INFO: The document file must be saved as a .pdf

Submit Application - Step 1:

Register for Web Access:

NOTE: Email Address is Required!

NOTE: Once you select the **Validate Application** button, any missing required information as well as incorrect information (ie: SSN is 9 digits however only 8 were entered) will be noted at the top of the page so that it can be corrected

INFO: If at any time you need to go back to a section, go to the "Application Links" box to the left of the application and click on the appropriate section's blue hyperlink title

Submit Application – Step 2:

Add Another Service Location / Edits / & Submit Confirm:

NOTE: Additional service locations will result in each service location to have a unique Medicaid ID

TIP: This is your last chance to edit any of your answers or correct your entries – you can select the section you wish to check by clicking on it in the left side Application Links

Submit complete Page:

NOTE: Once you leave this page, you do not have another option to print out the application

NOTE: It is not necessary to print the additional documents as you have already submitted them during the Signature/Document Upload Process

TIP: The Provider Relations Call Center is available to you toll free @ 1-866-291-1674 from 8:00 am to 5:00 pm; Mon-Fri

Documentation:

NOTE: Providers are to use the "Signature Page" upload to submit all required and supporting documents for this enrollment

INFO: Refer to the "Required Enrollment Documents to Upload with Application" for specific documentation requirements

TIP - The taxonomy information can be found with the NPI information on the NPI Registry website: https://npiregistry.cms.hhs.gov/registry/

NOTE: You will need to provide proof of the Tax ID as a part of required supporting documentation

NOTE: If the group is tax exempt, include a copy of the IRS issued exemption notification as a part of required supporting documentation

NOTE: Pg 1 of the **Provider Participation Agreement** (PPA) must reflect the **same** Service Address as the application

NOTE: The Electronic Funds Transfer Agreement form and a voided check or Bank letter is also needed and as such should be submitted as a part of required supporting documentation

NOTE: Any Exclusion/Sanction question answered with Yes will require supporting documentation to be submitted with the application, add all required documentation needed to support your answers and application to your saved file

INFO: Providers electronically upload the file of all required documents with the Group Application Signature Page. The documents required for a group application are as follows:

- Provider Participation Agreement (PPA) signed and dated
- Signature Page signed and dated
- W-9 with Tax ID/FEIN - signed
- IRS Tax ID/FEIN verification – ex: correspondence with IRS seal
- NPI Verification Page

If applicable, the following are also required:

- Electronic Funds Transfer Forms
  - EFT Agreement Form
  - EFT Application Form
  - Bank Letter or copy of voided check
- Billing Agent Agreement Form
- Trading Partner Agreement Signature Page
- CLIA Certificate
- Additional Documents Supporting the YES answers to Exclusion/Sanctions