

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

The screenshot shows the New Hampshire MMIS Health Enterprise Portal. The browser address bar displays <https://nhmmis.nh.gov/portals/wps/portal/lut/p/c5/0>. The page title is "New Hampshire MMIS Health Enterprise Portal". The date "Apr 2, 2018" is shown in the top right corner. The navigation menu includes "Home", "Program", "Member", "Provider", "Documentation", and "Directories". The "Quick Links" section is highlighted, and the "Enrollment" link is circled in blue. Other links in the "Quick Links" section include "Documents and Forms", "Find a Health Care Provider", "Department of Health and Human Services", "Report Fraud & Abuse", "ICD10 Resources", and "Provider Revalidation". The "Sign In" section includes "Log into the system based upon your role:", "Providers", "Members", and "Internal Users". The "Provider Registration" section includes "Register". The "Welcome" section includes a message about system maintenance.

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**

The screenshot displays the 'New Hampshire MMIS Health Enterprise Portal' interface. At the top, there is a navigation bar with 'Home', 'Program', 'Member', 'Provider', 'Documentation', and 'Directories'. The main content area is titled 'Provider Enrollment' and includes a 'Print | Help' option. A red asterisk indicates a 'Required Field'. The 'Become a Provider' section contains text about applying for the Title XIX Program and lists links for 'FAQ', 'Instructions', 'Group Provider Enrollment' (circled), 'Individual Provider Enrollment', 'Download a PDF Provider Enrollment Package', and 'Request a Provider Enrollment Package in the Mail'. The 'Application Status' section provides instructions on checking application status and includes an input field for '*Application Tracking #' and a 'Submit' button. The 'Recall Provider Application' section instructs on recalling a partially completed application and includes input fields for '*Application Tracking #' and '*SSN/ FEIN', along with a 'Submit' button. The 'Recall Trading Partner Application' section follows a similar format for trading partners.

➤ 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

The screenshot displays the New Hampshire MMIS Health Enterprise Portal. At the top left is the state seal and the text "New Hampshire MMIS Health Enterprise Portal". At the top right, the date "Dec 15, 2017" and navigation links "Skip Navigation | Contact Us | Help | Search" are visible. A blue navigation bar contains "Home" and dropdown menus for "Program", "Member", "Provider", "Documentation", and "Directories". The main content area is titled "Group Provider Enrollment Instructions" and includes a "Print | Help" link. A sidebar on the left has "Application Links" and "Instructions". The main content is divided into three sections: "Group Provider Enrollment", "Group Application Instructions", and "Fingerprint-based Criminal Background Check (FCBC) Notification". The "FCBC" section contains text about the Affordable Care Act and a link to a website. At the bottom right, there are "Continue>>" and "Cancel" buttons, with "Continue>>" circled in red.

Group Provider Enrollment

- This application is for a corporation, a partnership, or another group-type business entity or sole proprietorship with a Federal Employer ID Number (FEIN). A FEIN is required for a group application. If you only have an SSN you cannot enroll as a group provider, you must enroll as an individual provider. Individual providers must complete the Individual Provider Enrollment Application.
- 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.
- Medical Supplier (Durable Medical Equipment, Prosthetics, Orthotics Supplier - DMEPOS) providers with multiple service locations must complete an Additional Service Location section 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 complete an Additional Service Location section, which will result in a unique NH Medicaid provider ID being assigned for each location.
- Signature pages must be printed, signed and mailed in order to complete the MMIS electronic Application. Copied or stamped signatures are unacceptable.
- Supplemental documentation may also be required to be submitted as outlined on the Document Requirements Checklist accessible at the end of the MMIS electronic submission process.

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 certain Medicaid provider and supplier applicants who's owners are required to submit to criminal background checks. Only owners with a 5% direct or indirect ownership interest that are designated as "high risk" providers per 42 CFR 455.450 are subject to a criminal background check review. High risk providers are providers that deliver Home Health Services, Durable Medical Equipment services, those providers/owners that have been sanctioned within the last 10 years, or those providers with an existing State Medicaid Plan qualifying overpayment. For more information on fingerprinting and frequently asked questions please go to the Department of Health & Human Services website at <http://www.dhhs.nh.gov/oii/pi.htm>.

Continue>> Cancel

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.

New Hampshire MMIS Health Enterprise Portal Dec 15, 2017
Skip Navigation | Contact Us | Help | Search

Home Program Member Provider Documentation Directories

Demographic 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

Group Name
The name you enter will be displayed on the Public Provider Finder, correspondence and IRS reporting.

FEIN
Enter as 9 digits with or without dashes.

Answer each of the questions. Additional information will be required if response is Yes.

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

Identifying Information- Section 1

*Group Name *Federal Employer Identification # (FEIN)

Doing Business As (DBA) Name

4 Have you used a different DBA Name? Yes No

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 Title XIX Provider Number. All claims paid to the NH Title XIX 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 Title XIX Provider Number.

5 Is this application due to a change of ownership? Yes No

Current/Previous NH Title XIX Provider #

6 *Were you previously enrolled as a Title XIX Medicaid provider in NH? Yes No

Non-Profit Organization Tax Exempt Status

7 Is the business listed under tax-exempt status? Yes No

8

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

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”

Licensure / Certification 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

Provider Type
Select a Provider Type from the available list.

Licensure/Certification, Specialty & Taxonomy:
To add Licensure, Certification, Specialty and/or Taxonomy 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.

Taxonomy
Select the appropriate taxonomy applicable to the provider type.

Date
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.

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 Type

*Provider Type

1

Licensure and Certification - Section 2 2

Licensure and Certification List [Add Licensure / Certification](#)

License #	Certification #	State	Effective Date	Expiration Date
No Data				

Specialty

Note: Enter information for all the specialties for which you are board certified or eligible. A specialty requires completion of the appropriate residency program and board certification or eligibility.

3 [Add Specialty](#)

Specialty List

Specialty	Cert #	Cert Agency	State
No Data			

Taxonomy

Expanded Below 4 [Add Taxonomy](#)

Taxonomy	Begin Date	End Date
No Data		

5

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

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 Taxonomy 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”

Taxonomy

4

Add Taxonomy

Taxonomy	Begin Date	End Date
284300000X	08/23/2007	12/31/9999

1 - 1 of 1

4D

Edit Taxonomy **Save** | Delete | Reset | Cancel

*Taxonomy 284300000X 4A	*Begin Date 08/23/2007 4B	*End Date 12/31/9999 4C
----------------------------	------------------------------	----------------------------

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**”

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

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) 1

Add NPI

NPI ↕
 No Data

Drug Enforcement Administration (DEA) 2

Add DEA Number

DEA # ↕
 No Data

National Council for Prescription Drug Programs (NCPDP)

Add NCPDP

NCPDP ↕
 No Data

Other State Medicaid Program Information 3

Are you currently enrolled as a Medicaid provider in another State?
 Yes No

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

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 4

Expanded Below → Add Medicare

Medicare # ↕ Parts ↕
 No Data

Other Medicare Numbers 5

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

Expanded Below → Add History

Medicare # ↕ Carrier/Intermediary Name ↕ Parts ↕
 No Data

7 6

Continue>> Reset Save Exit Application

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

Other State Medicaid Program Information

? *Are you currently enrolled as a Medicaid provider in another State?
 Yes No **3A**

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

3B Available **3C** **Selected**

Available	Selected
Kentucky	
Louisiana	
Maine	
Maryland	
Massachusetts	
Michigan	
Minnesota	
Mississippi	
Missouri	

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

Available	Selected
Kentucky	Massachusetts
Louisiana	
Maine	
Maryland	
Michigan	
Minnesota	
Mississippi	
Missouri	
Montana	

3E **3D**

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

*Please identify the state.
 3F

*Have you paid the application fee?
 Yes No **3G**

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”

The screenshot shows a web interface for managing Medicare numbers. At the top, there is a tab labeled "Medicare Numbers". Below the tab is a table with two columns: "Medicare #" and "Parts". The table currently displays "No Data". To the right of the table is a blue button labeled "Add Medicare", which is circled in red and annotated with the number "4". Below the table is a form titled "Add Medicare #". The form contains a text input field for the Medicare number, annotated with "4A" and an arrow. Below the input field is a list of checkboxes for Medicare Parts: "All", "Part A", "Part B", "Part C", and "Part D". The text "Please check all applicable Medicare Parts that pertain to Medicare crossover claims that you may submit." is displayed above the checkboxes. The "Part B" checkbox is highlighted in yellow and annotated with "4B". To the right of the form are three buttons: "Save", "Reset", and "Cancel". The "Save" button is circled in red and annotated with "4C".

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”

Other Medicare Numbers

For historical purposes, please list any former Medicare Provider#(s) and Carrier/Intermediary Name(s). 5

Add History

Medicare #	Carrier/Intermediary Name	Parts
No Data		

5D

Add History **Save** | Reset | Cancel

*Medicare # *Carrier/Intermediary Name

5C

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

All Part A Part B Part C Part D

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 Information - Section 4

*** 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

Help

Service Location
 Enter the physical address of your primary service location. You may enter additional service locations upon completing the remainder of the information and prior to submitting the application. The Service Location Address may not be a post office box.

Validate
 This will provide suggestions based on an official US postal address, you also have the option to override these suggestions.

Phone, FAX & Contact
 To add Phone, FAX or Contact 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.

Service
 Select the appropriate Gender and Age Range served. If a Language other than English is spoken, select the language from the list, then click the -> to select. If English is not spoken click the <- to remove it. If the language is not available, please enter it as Other Language. This information will be used for the Public Provider Finder. Answer all required questions by selecting yes or no, additional information may be required if answered Yes.

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

Primary Physical Address (P.O. Box not accepted)

1 [REDACTED]
 Building, Suite #, etc. [REDACTED]
 2 [REDACTED]
 *City [REDACTED] 3 *State [REDACTED] 4 *Zip [REDACTED] 5
 County [REDACTED]

Validate Address 7

Location Contact Person(s)

Last Name	First Name	MI	Phone	Ext.	Fax #	Email
No Data						

Expanded Below → **Add Numbers** 6

Expanded Below → **Add Contact Person** 8

Service - Section 4 9

*Gender Served:
 Male Female Both

*Age Range Served:

<input type="checkbox"/> All	<input type="checkbox"/> 6-12 Years
<input type="checkbox"/> 0-5 Years	<input type="checkbox"/> 18-21 Years
<input type="checkbox"/> 13-17 Years	<input type="checkbox"/> 22-59 Years
<input type="checkbox"/> 22-59 Years	<input type="checkbox"/> 60+ Years

*Languages Supported:

Available:	Selected:
Albanian	English
American Sign Language	
Arabic	
Bangla	
Other Language:	

12

*Is this location wheelchair accessible?
 Yes No

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

*Does this location provide emergency services after standard business hours?
 Yes No

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

*Is this location TDD/TTY Equipped for receiving calls for hearing impaired?
 Yes No
 *TDD/TTY Phone # [REDACTED]

*Does this location provide emergency services after standard business hours?
 Yes No
 *After Hours Contact Phone # [REDACTED]

If yes, enter phone numbers

If yes, enter phone numbers

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

Bed Data 10

Clinical Laboratory Improvement Amendments (CLIA) 11 Expanded Below

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.

Mailing Address

*Is this mailing address the same as service location?

Yes No 12 Follow Service Location Information Instructions

Phone #	Fax #
No Data	

Location Contact Person(s) 13 Follow Service Location Information Instructions

Last Name	First Name	MI	Phone	Ext.	Fax #	Email
No Data						

14 Add Contact Person

Electronic Funds Transfer (EFT) Payments

? *Do you wish to participate in Electronic Funds Transfer Payments?

Yes No 15 If Yes - Expanded Below

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

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”

Billing Address

Note: The Billing Address is the location to which mailed payments will be sent.
 *Is this billing address the same as the service location?

Yes No 16
If No - Answer question 16a

*Is this billing address the same as the mailing address?
 Yes No 16a
If No - Follow Service Location Information Instructions
If No - Follow Service Location Information Instructions
17

[Add Numbers](#)

Phone #	Fax #
603-223-2233	

1 - 1 of 1 18

Location Contact Person(s) [Add Contact Person](#)

Last Name	First Name	MI	Phone	Ext.	Fax #	Position	Email
Cane	Candy		866-291-1674	231	866-446-3318	Supervisor	candy.cane@pita.com

1 - 1 of 1 18

Yes No 19
If Yes - Expands to 19a

The Billing Agent Agreement must be signed

*Does this Billing agent have access to make inquiries on your behalf?
 Yes No 19a

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)
 20
X

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.

22 21

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

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”

6 Add Numbers

Phone #	Fax #
No Data	

6C

Add Numbers Save | Reset | Cancel

*Phone # 6A 8662911674

Fax # 6B 8664463318

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**”

Service Location Information- Section 4

*Primary Physical Address (P.O. Box not accepted)
2 Pillsbury St

Building, Suite #, etc
Suite 200

*City: Concord *State: New Hamp *Zip: 03301

County: Merrimack

Validate Address

Phone #: 866-291-1674 **Fax #**: 866-446-3318

1 - 1 of 1

Suggested Address

Select from the list of valid suggestions then click 'Submit', or click 'Cancel' to return to make additional changes.
Addresses are checked for proper postal format. Select one of the standardized addresses for efficient delivery.

2 Pillsbury St, Ste 200, Concord, NH, 03301, 3549, Merrimack County

Override verification warning, and accept address as entered.

Submit **Cancel**

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”

Location Contact Person(s) 8						
Last Name	First Name	MI	Phone	Ext.	Fax #	Email
No Data						
Add Contact Person 8I						
Save Reset Cancel						
*Last Name 8A	*First Name 8B	Middle Initial 8C				
*Phone # 8D	Ext. 8E	Fax # 8F				
Email 8G	*Position 8H					

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

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

Clinical Laboratory Improvement Amendments (CLIA) 11

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.

11A **Add CLIA**

CLIA #	Effective Date	Expiration Date
--------	----------------	-----------------

11E **Add CLIA #** **Save** | **Reset** | **Cancel**

11B *CLIA #

11C *Effective Date

11D *Expiration Date

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

EFT Enrollment Print | Help -

* Required Field

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

1. Provider Information

*Provider Name Doing Business As (DBA) Name

Provider Address

*Street **1** *City **2** *State/Province **3** *Zip Code/Postal Code **4**

2. Provider Identifiers Information

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

Provider License Number **1** 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. Financial Institution Information

*Financial Institution Name **5**

*Street **6** *City **7** *State/Province **8** *Zip Code/Postal Code **9**

*Financial Institution Telephone Number **10** *Financial Institution Routing Number **11**

*Type of Account at Financial Institution **12** *Provider's Account Number with Financial Institution **13**

*Account Number Linkage to Provider Identifier **14**

5. Submission Information

*Reason For Submission **15**

*Authorized Signature **16**

17

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

Group Affiliation Print | Help

* Required Field

Application Links
Application Tracking Number - 70059

- 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 Title XIX 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 Title XIX 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 Title XIX 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 Title XIX Provider #	Name of Individual Practitioner	Effective Date of Affiliation
No Data		

1D **Save** | **Reset** | **Cancel**

Add Affiliation

*NH Title XIX Provider #	*Name of Individual Practitioner	*Effective Date of Affiliation
<input type="text"/> 1A	<input type="text"/> 1B	<input type="text"/> 1C

3 **Continue>>** | **Reset** | **Save** | **Exit Application**

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**”

New Hampshire MMIS Health Enterprise Portal Jan 3, 2018
Skip Navigation | Contact Us | Help | Search

Home Program Member Provider Documentation Directories

Electronic Transaction Submission Print | Help

* Required Field

Application Links
Application Tracking Number - 69855

- 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 Title XIX 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 Title XIX 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 Title XIX Program.
- Sign and adhere to all conditions of the NH Title XIX Provider Participation Agreement, and be officially enrolled in the NH Title XIX 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
- Vendor Software
- Billing Agent/Clearinghouse
- All

Buttons: Continue>> Reset Save Exit Application

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

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

New Hampshire MMIS Health Enterprise System Web Portal

Vendor Software

***Software Vendor Name** 3A

***Software Name** 3B ***Version #** 3C

***Protocol** 3D

Billing Agent/Clearinghouse

***Agent/Clearinghouse Name:** 3E

***Contact First Name:** 3F ***Contact Last Name:** 3G ***Contact Phone #:** 3H

***Street Address:** 3I

Street Address2: 3J

***City:** 3K ***State:** 3L ***Zip Code & Extension:** 3M 3N

All

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

Submit 3O	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).

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”

Application Links
Application Tracking Number - 69855

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

Help

Direct Ownership
An individual or entity with possession of equity in the capital, the stock or the profits of the disclosing entity.

Indirect Ownership
Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/ subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the provider.

Controlling Interest
Person with an ownership or control interest means a person or corporation that:
 (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
 (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
 (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
 (d) Owns an interest of 5 percent or more in 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

Ownership- Section 7

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

1

Add 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

6 **Save** | **Reset** | **Cancel**

Add Ownership Information

*Is the Owner an Individual or Group?
 Individual Group 3

*Last Name *First Name MI Title Doing Business As (DBA) Name

*Effective Date of Ownership *End Date of Ownership *Date of Birth *Address

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

Type of Ownership? 4
 Direct Ownership Indirect Ownership

*Does this person have a familial relationship with another owner or person with controlling interest?
 Yes No 5 *Relationship

Child
Other
Parent
Sibling
Spouse

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

An individual or entity with possession of equity in the capital, the stock or the profits of the disclosing entity.

Indirect Ownership

Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/ subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the provider.

Controlling Interest

Person with an ownership or control interest means a person or corporation that-

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- (d) Owns an interest of 5 percent or more in 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;
- (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- (f) Is a partner in a disclosing entity that is organized as a partnership.

2. Please list all board members and executive officers that have a controlling interest in the corporation or partnership. 7

8 Add Controlling Interest

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

12 Save | Reset | Cancel

Add Controlling Interest Information 9

*Last Name	*First Name	Middle Initial	Title	Doing Business As (DBA) Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
*Effective Date of Controlling Interest	*End Date of Controlling Interest	*Date of Birth	*Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
*City	*State	*Zip Code	*SSN	NH Title XIX Provider ID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
*Type of Ownership? 10				
<input type="radio"/> Direct Ownership <input type="radio"/> Indirect Ownership				
*Does this person have a familial relationship with another owner or person with controlling interest? 11				
<input checked="" type="radio"/> Yes <input type="radio"/> No *Relationship <input type="text"/>				

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

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

Subcontractor
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.

Managing Director
A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

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.

13 Yes No

14 [Add Owner/Subcontractor](#)

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

17 [Save](#) [Reset](#) | [Cancel](#)

15 **Add Owner and Subcontractor**

*Owner Last Name

*Subcontractor Legal Name

*Address

*Zip

*Owner First Name

*Effective Date

*City

Middle Initial

*End Date

*State

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

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

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
 (f) Is a partner in a disclosing entity that is organized as a partnership.,

Subcontractor

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.

Managing Director

A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

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.

18

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

[Add Subcontractor Owner](#)

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

20

Add Subcontractor Owner 19 [Save](#) | [Reset](#) | [Cancel](#)

*Owner Last Name *Owner First Name Middle Initial

*Subcontractor Legal Name

*Address *City *State *Zip

*List the significant business transactions from 4b

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 at least one 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”

Subcontractor
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.

Managing Director
A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

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.

Managing/Directing

? *5. What is the total number of managing/directing employees for the group? 21

22 [Add Employee](#)

Employee

Last Name	First Name	MI	Title	Date of Birth
No Data				

Please enter employee information for each employee included in the number entered 26

23 [Save](#) | [Reset](#) | [Cancel](#)

*Last Name *First Name Middle Initial Title *Date of Birth

*SSN *Address *City *State *Zip

? 6. Has the managing/directing employee ever had a Title XIX provider number in this or any other state? 24

Yes No

*Business Name 25 Effective Date End Date SSN/FEIN

Current Title XIX Provider # State Prior Title XIX Provider # State

28 27

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

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”

Application Links
Application Tracking Number - 69855

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

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.

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

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

* Required Field

Application Links
Application Tracking Number - 69999

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

Signature

Legal Name as it appears on W9 : Pain Injury Therapy Association
Former DBA Name :
Doing Business as (DBA) Name : PITA
Federal Employer Identification Number (FEIN) : 159159159

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

2. I authorize the NH DHHS Title XIX fiscal agent to verify the information contained herein. I agree to notify the NH DHHS Title XIX fiscal agent of any changes to information in this form.

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

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

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

Signature of the Officer or CEO or General Partner of Group Provider

Title

Date Signed

Print

Upload Signature Page

Instructions:
Providers must print, sign and upload the Application Signature page. Only original signatures will be accepted. Copied and stamped signatures are not acceptable.

Note: Only one file allowed to upload. If you attach the file incorrectly, please detach the existing attachment and attach the new file.

Expanded Below → **Upload Document**
Upload only .jpeg, .png, .pdf format file.

Date Added	Added By	File Name	Description
No Data Available.			

4 **3**

Continue>> **Save** **Reset** **Exit Application**

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”**

The screenshot displays a web application interface for uploading documentation. A Windows file explorer window is open, showing a file named "ATN 69999 - Pain Injury Therapy Assoc - Documentation" selected. The file explorer's address bar shows the path "Pain Injury Therapy Assoc NH Medicaid Enrol...". The file name field in the file explorer contains "69999 - Pain Injury Therapy Assoc - Documentation".

The web application interface includes a "Print" button (1), an "Upload Document" button (4), a "Browse..." button (5), a "Description" text box (7), and "Save", "Reset", and "Cancel" buttons (8). A red speech bubble notes that "Wet" signatures are no longer required. A yellow box indicates that "Copied and stamped signatures are not acceptable." A table below the interface shows "No Data Available." The bottom of the interface has "Continue", "Save", "Reset", and "Exit Application" buttons (9, 10).

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

Provider Enrollment - Submit Application Step 1 Print | Help - □

* Required Field

Application Links
Application Tracking Number - 69855

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

Register for Web Access

Providers and Trading Partners who are enrolled in the NH Title XIX Program must register to establish a user id and password for access to the secure NH MMIS Provider Portal. The Provider Portal offers secure web-based features such as electronic claims submission and related information management, downloadable Remittance Advices, electronic Member eligibility verification, and more.

Providers must identify an individual employee as the Portal Organization Administrator. The Provider Organization Administrator is the person responsible for setting up and maintaining users for the Provider Organization. The Organization Administrator will also be responsible for resetting user passwords. Please enter a User ID of your choice and the following information.

Users IDs permit web access to a single service location. Providers with multiple service locations must register for a unique ID for each service location using the "Add Another Service Location" functionality on the next page.

1 Yes No

*Legal Organization Name *Organization Description *User ID

Prefix *Last Name *First Name MI Suffix

*Phone # Ext Email Address

Validate Application

Click the VALIDATE APPLICATION button below to check your application for errors. If errors are found, you will be led through the application and instructed to correct each error. If there is no error found, you will be directed to the next page before final submit.

3 4

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

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

- 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

Provider Enrollment - Submit Application Step 2 Print | Help - □

* Required Field

Application Links
Application Tracking Number - 69855

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- ▶ **Submit Application**

- 1 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.
- 2 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 ACS. A confirmation message screen will be displayed on the next page. After submitting, you can no longer make any changes to your application.

3 **4**

Add Another Service Location Edit Service Location **Edit Application** **Save**

Confirm Submit

5

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

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

Home Program Member Provider Documentation Directories

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 mailed into ACS. Once all documents have been received and your application reviewed you will be notified via mail with the application decision. Please print this page and send it in with any additional required enrollment documents sent to ACS.

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 1

Application Tracking Number:69855

Please make a record of this Application Tracking Number. Use this number when inquiring about the status of the application.

Print, Sign, and Send in your application

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 sent to ACS.

All providers must print and sign the Provider Enrollment Signature Page and Title XIX Participation Agreement. Additional documents may be required depending on your Provider Type and business situation. Documents must be completed, signed, and sent to ACS at the address below. Only original signatures will be accepted. Copied or stamped signatures are not acceptable. Print the Document Requirements Checklist to identify the supplemental information by provider type and business model that is needed to finalize your application. Mail all Provider Enrollment documentation to:

ACS
PO BOX 2059
Concord, NH 03301 - 2059

Note: Include the Application Tracking Number indicated above on all documents that are mailed to ACS in reference to your application.

Print Required Documents

1. [Provider Enrollment Signature Page](#)
2. [Title XIX Provider Participation Agreement](#)
3. [Document Requirements Checklist](#)

Once all required documents have been printed, click the EXIT APPLICATION button to return to the Title XIX Provider Enrollment home page.

Fingerprint-based Criminal Background Check (FCBC) Notification

The Affordable Care Act (Section 6401), under 42 CFR 455.434, identifies certain Medicaid provider and supplier applicants who's owners are required to submit to criminal background checks. Only owners with a 5% direct or indirect ownership interest that are designated as "high risk" providers per 42 CFR 455.450 are subject to a criminal background check review. High risk providers are providers that deliver Home Health Services, Durable Medical Equipment services, those providers/owners that have been sanctioned within the last 10 years, or those providers with an existing State Medicaid Plan qualifying overpayment. For more information on fingerprinting and frequently asked questions please go to the Department of Health & Human Services website at <http://www.dhhs.nh.gov/oli/pi.htm>.

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

Provider Relations Call Center phone numbers

2 Print Application Exit Application 3

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