STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

New Hampshire Medicaid Provider Participation Agreement

This is to certify that ____ of ______________________________________
Name of Provider Service Location – Street Address

____Agrees to participate in the NH Medicaid Program, herein after referred to as
City, State, and Zip Code

the NH Medicaid Program.

I agree that my charges for services or items delivered to NH Medicaid Program recipients will not exceed my fees or charges for similar services or items delivered to persons not entitled to receive benefits under the NH Medicaid Program. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to NH Medicaid Program recipients are not greater than charges for services to non-NH Medicaid Program individuals, the New Hampshire Department of Health and Human Services, hereinafter referred to as the Department, or its authorized representatives will make such determination.

I agree to accept payments made by NH Medicaid Program as payments in full for the services or items I may provide, and to retain records supporting each claim on which NH Medicaid Program makes any payment (including crossover claims) for a period of not less than six years.

I agree that in any case or cases where it becomes necessary for State or Federal representatives to ascertain the appropriateness and necessity of care or services, the Department, or its authorized representatives, will determine the appropriateness and necessity of care or services.

I agree to keep such records as are necessary to fully disclose the extent of the care or services provided to individuals under the NH Medicaid Program and to furnish the Department with such information (original or photocopied) regarding any payment claimed, as may be requested. I recognize that, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulation at 45 CFR 164:512(d), such information is a permitted disclosure of personal health information without authorization for oversight of the NH Medicaid Program.

I agree that as a condition of NH Medicaid Program participation, I will disclose, within 35 days of the date on a request by the Secretary or the Department, ownership information including full and complete information about the ownership of any subcontractor or wholly-owned supplier with whom I have had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request, ownership information and any significant business transactions between myself and any wholly owned supplier, or between myself and any contractor, during the 5-year period ending on the date of the request.

I acknowledge that I have an obligation to regularly screen all employees and contractors (utilizing the List of Excluded Individuals/Entities-LEIE-website at http://www.oig.hhs.gov/fraud/exclusions.asp and/or any other exclusion lists or instructions provided by NH Medicaid Program) to determine whether any of them have been excluded from participation in Federal health care programs, to report to Medicaid any exclusion information discovered, and I agree to comply with these obligations.

I agree to maintain current required permits, licenses, certifications, or other documentation that allows me to continue in my practice.

I agree that I will comply with the requirements of Section 1902(a)(68) of the Social Security Act regarding Employee Education About False Claims Recovery and that I have a responsibility to self-identify if I qualify as an "entity" and if I have met the $5,000,000 annual threshold amount, as described in the Act.

I agree to disclose to the Department the name of any owners, officers, directors, agents, and managing employees of my business who have been or who are convicted of fraud against any programs under Titles XVIII, XIX, or XX of the Social Security Act.

I acknowledge that I may be suspended or terminated from participation in the NH Medicaid Program if convicted of a criminal offense under the Medicare or Medicaid Program, or if the Department administratively determines that fraud exists, or for failure to disclose ownership information as required. Moreover, I agree that in the event my license is revoked or I am disqualified through state action, or federal or Department administrative action this Agreement is automatically terminated. All of the above are considered adverse actions. Claims cannot be submitted for any dates of service that occur while an adverse action is in effect.

Revised March 2020

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

I acknowledge and agree that either party may terminate this agreement without cause with a 60 day written notice to the other party.

I agree not to sell or provide my accounts receivable for NH Medicaid Program recipients to bill collection agencies, similar entities, or any other third party.

I agree to abide by all rules, regulations, billing manuals, bulletins and notices promulgated by the US Department of Health and Human Services, the State of NH, or the NH Department of Health and Human Services pertaining to the provision of care or services under NH Medicaid and the claiming of payments for those services.

I agree that I may be required to refund, or have payment recouped by the NH Medicaid program for both the state and federal share of any overpayments, including erroneous payments, erroneously claimed payments, payments made for non-compliant claims, payments in excess of the amount allowed, fraudulent claims or claims identified in accordance with the exclusion provisions of 42 CFR 1001.1901(b).

I agree that payment may be withheld because of a non-conforming claim for whatever cause until such non-conforming claim can be remedied.

I agree to take no action or adopt any procedure that would circumvent or deny the Medicaid recipient's freedom to choose any willing Medicaid provider in accordance with the Freedom of Choice provisions of 42 CFR 431.51.

I agree to provide services or items without discrimination as required by Title VI of the Civil Rights Act of 1964, and without discrimination on the basis of handicap as required by Section 504 of the Rehabilitation Act of 1973 as amended.

I agree that the US Department of Health and Human Services, its authorized representatives, and the Medicaid Fraud Control Unit of the NH Attorney General's Office will have access to the same records and information as does the NH Department of Health and Human Services.

In the event I select electronic direct deposit transfer payments for claims reimbursement, I agree to sign and submit the NH Medicaid Program Electronic Funds Transfer (EFT) Agreement.

In the absence of statements imprinted on all provider claim forms as specified in 42 CFR 455.18, I agree that for each claim I submit to NH Medicaid Program for payment, I am certifying my compliance with the following requirements as stated in 42 CFR 455.18, as though the statements and my signature were present on the claim form:

(1) This is to certify that the foregoing information is true, accurate, and complete.

(2) I understand that payment of this claim 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.

If I am a "performing-only provider," I agree that I will not independently bill and receive payment from the NH Medicaid Program, and that any such payments may be recouped by the Department. ("Performing-only providers" are providers that the Medicaid Program, in accordance with federal and/or state law, does not allow to *independently* enroll and bill. Performing-only providers must be affiliated with a NH Medicaid enrolled Group provider).. Designation as "performing-only" will be determined by the Department.

This agreement becomes effective on the date of enrollment given in the Welcome Letter, which will be mailed upon approval.
I acknowledge that enrollment is not transferable and terminates upon date of sale of practice or ownership transfer.

I declare under penalty of perjury that I have reviewed this application and that to the best of my knowledge the information contained herein is true and accurate.

For Service Providers Only

____
Signature Authorized Provider/Owner/Administrator Date

____
Print Name

____
Title of Authorized Provider/Owner/Administrator

Please keep a copy of this Agreement for your records.