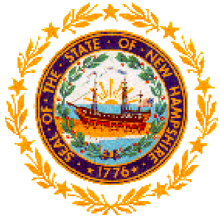

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

New Hampshire Medicaid Program

NH Medicaid Individual Billing Provider Enrollment Instructions

Completing the Individual Billing Provider Enrollment Application

www.nhmmis.nh.gov

- Select "Enrollment" under Quick Links
- Additional assistance is located in the blue "Help" hyperlink at the top of each page
- Please prepare all documentation needed for this application by first referring to the Required Enrollment Documents to Upload with New Applications document located in the "Documents and Forms" quick link on the NHMMIS home page

New Hampshire MMIS Health Enterprise Portal

Jun 22, 2022

Skip Navigation | Contact Us | Help | Search

Home | Program | Member | Provider | Documentation | Directories

Welcome

Welcome to the Conduent Government Solutions Health Enterprise Portal. This system supports all of your State Medicaid and Decision Support needs.

NH MMIS has established a maintenance window from 12:01 A.M. to 12:00 P.M. every Sunday to apply scheduled system upgrades. During the maintenance window, the system may not be accessible.

Provider Registration

For providers to obtain a user name and password to use the Health Enterprise portal, they must be a current provider for Medicaid. For trading partners to obtain a username and password, they must be a current Trading Partner with a trading partner ID. To begin the registration process, they must have their enrollment form ready.

Register

Quick Links

- Enrollment
- Documents and Forms
- Find a Health Care Provider
- Department of Health and Human Services
- Report Fraud & Abuse
- ICD10 Resources
- Provider Revalidation
- Interoperability Exchange

Sign In

Log into the system based upon your role:

- Providers
- Internal Users

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- Select the "Individual Billing Provider Enrollment" link

  NOTE: You can also check the status of an application on the below page by entering the Application Tracking Number (ATN) in the Application Status section and selecting "Submit"

  NOTE: To return to a partially completed application, enter the ATN and FEIN in the Recall Provider Application section and select "Submit"

New Hampshire MMIS Health Enterprise Portal

Jul 15, 2022

Skip Navigation | Contact Us | Help | Search

Home | Program | Member | Provider | Documentation | Directories

Provider Enrollment — Print | Help

* Required Field

Become a Billing Provider

If you would like to become a Billing Provider for New Hampshire Medicaid, please complete the appropriate online application. If you are a billing group or individual applying with a Federal Employer Identification Number (FEIN), please select the *Group Provider Enrollment* link below.

If you are an Individual billing provider that does not have an FEIN and would be applying with your Social Security Number (SSN), please select the *Individual Billing Provider Enrollment* link below.

If you have questions, please contact Provider Enrollment at (603) 223-4774 or (866) 291-1674, Monday through Friday, 8 am - 5 pm EST.

FAQ
Instructions
Group Provider Enrollment
Individual Billing Provider Enrollment

Become a Non-Billing Provider

If you would like to become a Non-Billing Provider for New Hampshire Medicaid, please complete the appropriate online application.

Non-Billing Individual Rendering Providers are providers who, through an affiliation with a billing provider, render services for New Hampshire Medicaid members. Please select the *Non-Billing Rendering Provider Enrollment* link below.

Non-Billing Individual Ordering/Referring/Prescribing (ORP) Providers are providers who enroll for the sole purpose of ordering, referring or prescribing supplies, services and/or pharmaceuticals for New Hampshire Medicaid members. Please select the *Non-Billing ORP Provider Enrollment* link below.

If you have questions, please contact Provider Enrollment at (603) 223-4774 or (866) 291-1674, Monday through Friday, 8 am - 5 pm EST.

FAQ
Instructions
Non-Billing Rendering Provider Enrollment
Non-Billing ORP Provider Enrollment

Become a Trading Partner

If you would like to become a Trading Partner (EDI) to electronically exchange data with New Hampshire Medicaid, please complete the online Trading Partner application. Select the *Trading Partner Enrollment* link below.

If you have questions, please contact Provider Enrollment at (603) 223-4774 or (866) 291-1674, Monday through Friday, 8 am - 5 pm EST.

FAQ
Instructions
Trading Partner Enrollment

Application Status

To check the status of your New Hampshire Title XIX Program Provider or Trading Partner Application, use your Application Tracking # and click the SUBMIT button.

*Application Tracking # [ ] Submit

Recall Provider Application

To recall an application that you have partially completed, enter your Application Tracking Number, and SSN / FEIN and click the SUBMIT button.

*Application Tracking # [ ]
*SSN/ FEIN [ ]
Submit

Recall Trading Partner Application

To recall an application that you have partially completed, enter your Application Tracking Number and SSN / FEIN and click the SUBMIT button.

*Application Tracking # [ ]
*SSN/FEIN [ ]
Submit

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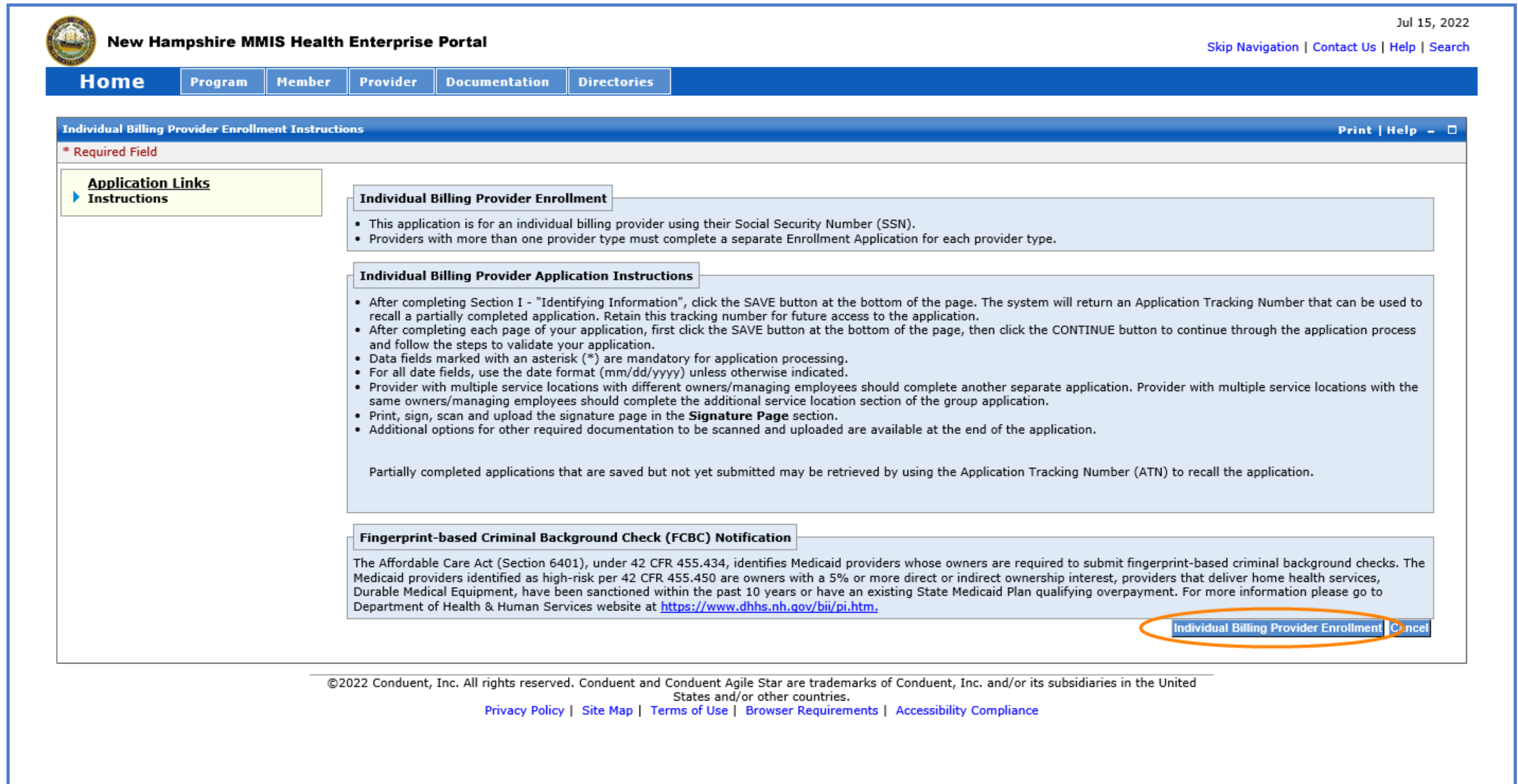
- Please read the following information and select "Individual Billing Provider Enrollment"

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



Identifying Information – Section 1

NOTE: The left side of the application will show the links to each section of the application, as well as instructions for each section.

1. Service Authorization Letters are sent to your provider inbox. If you would like this changed, contact NH Medicaid Provider Relations Call Center at 866-291-1674

2-4. Enter the Provider's Name

5. Select a Suffix from the drop-down list if applicable
6. Select a Title from the drop-down list if applicable
7. Enter the Provider's Date of Birth
8. Enter the Provider's Doing Business As (DBA) Name, if applicable
9. Select Male or Female
10. Select Yes or No
11. Enter the Provider's SSN
12. Select Yes or No NOTE: If you select yes, the field will expand, and you will be required to enter your current or previous Provider Number

- Once all required fields are completed, select "Save" and your Application Tracking Number (ATN) will be displayed in a red message at the top of the screen

NOTE: Note this number somewhere as you will need it to check the status of the application or recall the application

- Select "Continue" to move to the next section

Licensure / Certification – Section 2

1. Select your "Provider Type" from the drop-down menu
2. Select "Add Licensure/Certification" to add a License or Certification NOTE: Please refer to your state's Office of Professional Licensure and Certification (OPLC) for licensing information
   A. Select License or Certification
   B. Enter the License Number or Certification Number
   C. Select a License or Certification Agency from the drop-down list
   D. Enter the License or Certification Effective Date
   E. Enter the License or Certification Expiration Date
   F. Select the License or Certification State from the drop-down list
   G. Select "Save"
3. Select "Add Specialty" if applicable and enter the appropriate fields
4. The Taxonomy code is required for all individual providers. Select "Add Taxonomy" to expand the field and enter the requested information. TIP: You can find your taxonomy information on your NPI, which can be located on the NPI Registry website: https://npiregistry.cms.hhs.gov/
   A. Enter your 10-digit taxonomy code
   B. Enter the Begin Date of the taxonomy NOTE: This date should be the enumeration date that is listed on your NPI
   C. Taxonomies do not expire, so enter the end date of 12/31/9999
   D. Select "Save"

Provider Type
*Provider Type 1

Licensure and Certification - Section 2
Note: Enter information pertaining to your current licensure and/or certification.
The license must be for the state in which services are rendered.
Licensure and Certification List 2 Add Licensure / Certification

License #	Certification #	State	Effective Date	Expiration Date

Add Licensure and Certification G Save | Reset | Cancel
*Are you adding License or Certification information? A
License Certification
*License # B
*Licensing Agency C
*Effective Date D
*Expiration Date E
F *State New Hampshire

Specialty
Note: Enter information for all the specialties for which you are board certified. A specialty requires completion of the appropriate residency program and board certification.
Specialty List 3 Add Specialty

Specialty	Cert #	Cert Agency	State

Taxonomy
4 Add Taxonomy

Taxonomy	Begin Date	End Date

Add Taxonomy D Save | Reset | Cancel
*Taxonomy (10 digits/alphas) A
*Begin Date B
End Date C

Continue>> Save Reset Exit Application

➢ Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Provider Identifier Number – Section 3

NOTE: Refer to the image on the following page regarding the below numbered instructions

1. Select "Add NPI"
   A. Enter your 10-digit NPI number TIP: You can find your NPI information on the NPI Registry website: https://npiregistry.cms.hhs.gov/
   B. Select "Save"
2. Select "Add DEA Number" if applicable NOTE: This section is only required for provider types that prescribe or dispense controlled substances
   A. Enter your DEA number
   B. Select "Save"
3. Disclose Medicaid information for other states that you are enrolled with
   A. Select Yes or No. If selecting Yes, an expanded view with options for B and C will appear
   B. Select the additional state that you are enrolled as a Medicaid provider in.
   C. Select the right arrow to move the selected state from the Available box to the Selected box. You can also select a state from the Selected box and use the left arrow to move it back to the Available box NOTE: You can add multiple states to the Selected box as necessary
   D. Select Yes or No. If selecting Yes, an expanded view with options for E and F will appear
   E. Click the dropdown and select the state you've revalidated with within the last 5 years
   F. Select Yes or No
4. Select "Add Medicare" if you are Medicare enrolled and have an assigned Medicare ID NOTE: If you have multiple Medicare numbers, repeat this step
   A. Enter your Medicare number
   B. Check off all Parts that apply
   C. Select "Save"
5. Select "Add History" if you have any former Medicare IDs to enter NOTE: If you have multiple former Medicare IDs, repeat this step
   A. Enter your previous Medicare number
   B. Select a Carrier/Intermediary from the drop-down list
   C. Check off all Parts that apply
   D. Select "Save"

- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Provider Identifier Number – Section 3

Provider Identifier Number- Section 3

National Provider Identifier (NPI)

1 Add NPI

NPI

Add NPI B Save | Reset | Cancel

*NPI A

Drug Enforcement Administration (DEA)

2 Add DEA

DEA #

Add DEA Number B Save | Reset | Cancel

*DEA # A

Other State Medicaid Program Information

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

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

Available C Selected

B Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida

3

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

*Please identify the state. E

*Have you paid the application fee? Yes No F

Medicare Crossover Payment- Section 3

Enter the current Medicare Number assigned to you as an individual practitioner. Do not include numbers assigned to group Providers.

Medicare #

4 Add Medicare

Medicare #	Parts

Add Medicare # C Save | Reset | Cancel

*Medicare # A

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

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

Add History D Save | Reset | Cancel

*Medicare # A

*Carrier/Intermediary Name B

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

Continue>> Save Reset Exit Application

Service Location Information – Section 4

NOTE: Maintenance of an accurate location address is a requirement of participating with NH Medicaid. Providers are responsible for keeping their addresses up to date. Additionally, physical mail to the mailing address on file is the primary method of communicating crucial updates from the Medicaid program to the provider.

NOTE: When entering the provider addresses, ensure you enter the Zip + 4 code to ensure proper claim mapping

1-5. Enter the primary Service Location physical address with the Zip +4 code NOTE: The address entered here should match what is entered on the Provider Participation Agreement (PPA) document

6. Select "Validate Address" to ensure the address is in proper postal format.
   - A. Select the appropriate address from the list NOTE: If none of the addresses are correct, select the Override option to accept the address that you entered
   - B. Select "Submit"
7. Select "Add Numbers" to add a phone and fax number for the service location
   - A. Enter the service location phone number NOTE: The phone number must be entered as a 10-digit number
   - B. Enter the service location fax number if applicable NOTE: The fax number must be entered as a 10-digit number
   - C. Select "Save"
8. Select "Add Contact Person" to add a service location contact person NOTE: Repeat this step if you need to add multiple contact persons
   - A-H. Enter the appropriate information for the service location contact person
   - I. Select "Save"

NOTE: The service location contact person should be someone who can respond to enrollment related issues for this location

NOTE: Please ensure any contact persons listed have their email address entered

NOTE: You should provide contact information for any staff who will need to be apprised of updates to the Medicaid program, including: billing, CFO/CEO, Medicaid administrators, etc. Please add all of these contacts and indicate their role

Service Location Information – Section 4

9. Select the Male, Female, or Both option
10. Check off the age ranges that are served at this service location
11. Select the languages that are supported at this service location. NOTE: Use the left and right arrows to move selections to and from the Available and Selected boxes. You may also enter an Other Language if the language is not listed
12. Select Yes or No
13. Select Yes or No
    A. If Yes is selected, enter the TDD/TTY Phone Number
14. Select Yes or No
    A. If Yes is selected, enter the After Hours Contact Phone Number
15. If you have a CLIA certificate, select "Clinical Laboratory Improvement Amendments (CLIA)"
    A. Select "Add CLIA"
    B. Enter you CLIA number
    C. Enter the Effective Date
    D. Enter the Expiration Date
    E. Select "Save"

Service- Section 4

*Gender Served: 9
Male
Female
Both

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

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

*Is this location Wheelchair accessible? 12
Yes No

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

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

Clinical Laboratory Improvement Amendments (CLIA) 15

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

A Add CLIA

CLIA #	Effective Date	Expiration Date

Add CLIA # — E Save | Reset | Cancel

*CLIA # B
*Effective Date C
*Expiration Date D

Service Location Information – Section 4

16. Select Yes or No. If No is selected, enter the Mailing Address
    - A-E. Enter the Mailing Address Information with the Zip +4 code
    - F. Select "Validate Address" to ensure the address is in proper postal format
    - G. Select the appropriate address from the list. NOTE: If none of the addresses are correct, select the Override option to accept the address that you entered
    - H. Select "Submit"
17. Select "Add Numbers" to add a phone and fax number for the Mailing Address Location
    - A. Enter the mailing address location phone number. NOTE: The phone number must be entered as a 10-digit number
    - B. Enter the mailing address location fax number if applicable. NOTE: The fax number must be entered as a 10-digit number
    - C. Select "Save"
18. Select "Add Contact Person" to add a mailing address location contact person. NOTE: Repeat this step if you need to add multiple contact persons
    - A-H. Enter the appropriate information for the mailing address location contact person
    - I. Select "Save"

NOTE: The mailing address contact person should be someone who handles mailings. They may be contacted for mail related issues

NOTE: Please ensure any contact persons listed have their email address entered

Service Location Information – Section 4

19. Select Yes or No. Selecting Yes will enroll you in EFT payments, allowing you to receive payments via direct deposit. This will open a new screen to disclose the bank account information NOTE: NH Medicaid recommends participating in EFT payments to ensure quicker payment

Electronic Funds Transfer (EFT) Payments

*Do you wish to participate in Electronic Funds Transfer Payments? 19

Yes No

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

A. This information will be pre-filled with the information you have entered in previous sections of the application NOTE: If information is missing or incorrect in this section, you will need to select "Cancel" and return to the previous applicable sections to correct that information

B-G. Enter the Financial Institution Name, address, and phone number

H-J. Enter your bank account information

K-M. There will only be one option for each drop-down menu. Select the one option for each section

N. Select "Save." This will return you to the Service Location / Billing Information page

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

2. Provider Identifiers Information
*Provider Federal Tax Identification Number(TIN) or Employer Identification Number(EIN)
National Provider Identifier(NPI)

Provider License Number
License Issuer
Provider Type
Provider Taxonomy Code

3. Provider Contact Information
*Provider Contact Name
Title
*Telephone Number
Telephone Number Extension

Email Address
Fax Number

A

4. Financial Institution Information
*Financial Institution Name B

*Street C
*City D
*State/Province E
*Zip Code/Postal Code F

*Financial Institution Telephone Number G
*Financial Institution Routing Number H

*Type of Account at Financial Institution I
*Provider's Account Number with Financial Institution J

*Account Number Linkage to Provider Identifier K

5. Submission Information
*Reason For Submission L

*Authorized Signature M

N Save Reset Cancel

Service Location Information – Section 4

20. Select Yes or No. If No is selected, it will ask if the billing address is the same as the mailing address
    - A. Select Yes or No. If No is selected, enter the Billing Address
    - B-F. Enter the Billing Address information with the Zip +4 code
    - G. Select "Validate Address" to ensure the address is in proper postal format
    - H. Select the appropriate address from the list NOTE: If none of the addresses are correct, select the Override option to accept the address that you entered
    - I. Select "Submit"
21. Select "Add Numbers" to add a phone and fax number for the Billing Address Location
    - A. Enter the billing address location phone number NOTE: The phone number must be entered as a 10-digit number
    - B. Enter the billing address location fax number if applicable NOTE: The fax number must be entered as a 10-digit number
    - C. Select "Save"
22. Select "Add Contact Person" to add a billing address location contact person NOTE: Repeat this step if you need to add multiple contact persons
    - A-H. Enter the appropriate information for the billing address location contact person
    - I. Select "Save"

NOTE: The billing address contact person should be someone who can respond to billing, claims, or payment related issues

NOTE: Please ensure any contact persons listed have their email address entered

23. Select Yes or No. If Yes is selected, it will ask if the billing agent has access to make inquiries on your behalf
    - A. Select Yes or No

Service Location Information – Section 4

24. Select the medium you wish to receive remittance advices. Do not select either 820 option. If the 835 option is selected, the Electronic Remittance Advice (ERA) Enrollment screen will appear NOTE: You should always select Web Portal, so your remittance advices are available to download in the portal

Remittance Advice

*Requested Delivery Media for Remittance Advices(RAs)

☐ Electronic (835) ☑ Web Portal - Provider Message Center (Downloadable to paper) ☐ Electronic (820) ☐ Electronic Remittance Advice Report (820) 24

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

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

Continue>> Save Reset Exit Application

A. This information will be pre-filled with the information you have entered in previous sections of the application NOTE: If information is missing or incorrect in this section, you will need to go to the previous applicable sections to correct that information

B-D. There will only be one option for each drop-down menu. Select the one option for each section

E. Select "Save." This will return you to the Service Location / Billing Information page

ERA Enrollment — Print | Help

* Required Field

For Instructions related to ERA Enrollment click here

1. Provider Information
   *Provider Name — Doing Business As (DBA) Name

Provider Address
*Street — *City — *State/Province — *Zip Code/Postal Code

2. Provider Identifiers Information
   *Provider Federal Tax Identification Number(TIN) or Employer Identification Number(EIN) — National Provider Identifier(NPI)
   Provider License Number — License Issuer — Provider Type — Provider Taxonomy Code

3. Provider Contact Information
   *Provider Contact Name — Title — *Telephone Number — Telephone Number Extension
   Email Address
   Fax Number

(A)

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

5. Submission Information
   *Reason For Submission (C)
   *Authorized Signature (D)

(E) Save Reset Cancel

➢ Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Group Affiliation – Section 5

NOTE: All individual affiliated providers, in addition to the group and facility/entity providers, are required to maintain their own provider account information and revalidate every 5 years.

1. If you are rendering services under a group provider in addition to your private practice, select "Add Group" to add the group providers who you are rendering services under NOTE: Repeat this step as needed to add multiple groups
   A. Enter the affiliated group's 7-digit Medicaid ID NOTE: If you do not have the group's Medicaid ID, enter the group's NPI
   B. Enter the affiliated group's name
   C. Enter the effective date of the providers' affiliation
   D. Select "Save"

Group Affiliation | Print | Help

* Required Field

Application Links
Application Tracking Number -

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

Help

Group Affiliation
To add Group 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.

Group Affiliation- Section 5

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

If you do not perform services on behalf of any group practice, leave this section blank.

Information Regarding Affiliations and Claims Processing:
Individual Providers may perform services on their own behalf and/or on behalf of a group practice to which they are affiliated.

When performing services as a member of a group practice, the Individual Provider must be identified as an affiliated provider by the enrolled NH Title XIX Group Provider and the Group Provider must submit the claim. The Individual Provider is responsible for verifying with the Group Provider that the affiliation has been indicated on the Group Provider's NH Title XIX provider enrollment application. If the Group Provider has not identified the Individual Provider applicant,claims submitted by the Group Provider for services performed by the Individual Provider will be denied.

If a claim is submitted by an Individual Provider, the claim will be paid directly to the Individual Provider regardless of any working relationship that Provider may have with a group practice.The Individual Provider is then responsible for reporting payments as income for IRS purposes.

1 Add Group

Name of Group Practice	New Hampshire Title XIX Provider #	Effective Date of Affiliation

Add Group D Save | Reset | Cancel

*Name of Group Practice	*New Hampshire Title XIX Provider #	*Effective Date of Affiliation
A	B	C

Continue>> Save Reset Exit Application

➢ Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Electronic Claims Submission – Section 6

1. Always select the New Hampshire MMIS Health Enterprise System Web Portal. This will allow you to submit claims on the portal
2. Select Vendor Software if you are using a software that generates an X12 batch file that you will upload to the portal NOTE: This selection will create a Trading Partner Self application that will create a new trading partner ID once approved
    - A. Enter the Software Vendor Name
    - B. Enter the Software Name
    - C. Enter the Version Number of the Software
    - D. Select the Software Protocol from the drop-down menu
3. Select Billing Agent / Clearinghouse if a third-party submits your claims. This selection means that the third-party will be submitting X12 batch files on your behalf
    - A. Enter the Name of the Clearinghouse or Billing Agent
    - B-D. Enter the Billing Agent / Clearinghouse contact name and phone number
    - E-I. Enter the address of the Billing Agent / Clearinghouse
4. Select All if you utilize all the options to submit and receive transactions
5. If you selected Vendor Software or Billing Agent / Clearinghouse, you would need to select the transactions you submit and receive.

Electronic Claims Submission- Section 6

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

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

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

☑ New Hampshire MMIS Health Enterprise System Web Portal (1)

☑ Vendor Software (2)

*Software Vendor Name (A)

*Software Name (B) *Version # (C)

*Protocol (D)

☑ Billing Agent/Clearinghouse (3)

*Agent/Clearinghouse Name: (A)

*Contact First Name: (B) *Contact Last Name: (C) *Contact Phone #: (D)

*Street Address: (E)

Street Address2: (F)

*City: (G) *State: (H) *Zip Code & Extension: (I)

☑ All (4)

***Please check transactions that you submit and/or receive:** (5)

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

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

Continue>> Reset Save Exit Application

- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Ownership – Section 7

1. Check off the box confirming that what you are entering is complete and accurate
2. Select Yes or No, if Yes is selected, fields for A-L will appear
   - A. If Yes was selected, select "Add Ownership"
   - B. Enter the Organization's Legal Business Name
   - C. Ender the Effective Date of ownership
   - D. Enter the End Date of ownership, if applicable
   - E-H. Enter the Organization's Address
   - I. Enter the FEIN for the organization
   - J. Select Medicare or Medicaid
   - K. Enter the Medicare or Medicaid ID number
   - L. Select "Save"

Ownership | Print | Help

* Required Field

Application Links
Application Tracking Number :

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

Help

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

Ownership, Managing / Directing, Subcontractor & Relative
To add Ownership, Managing/Directing, Subcontractor and/or Relative 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/Expiration 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

Ownership- Section 7

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

*1. Have you ever had ownership in any organization that has billed, or is currently billing Medicare or NH Title XIX Program services?

(2) ◉ Yes ○ No

(A) Add Ownership

Business Name	NH Title XIX #	Medicare #	Effective Date	End Date	State

Add Ownership Information (L) Save | Reset | Cancel

*Organization's Legal Business Name (B)
*Effective Date (C)
End Date (D)
*Address (E)
*City (F)
*State (G)
*Zip (H)
*FEIN # (I)
*Please enter a Medicare and/or NH Title XIX # (J) ☐ Medicare ☑ Medicaid
*Current NH Title XIX # (K)

Ownership – Section 7

3. Select Yes or No, if Yes is selected, fields for A-L will appear
   - A. If Yes was selected, select "Add Manage/Directing Information"
   - B. Enter the Organization's Legal Business Name
   - C. Enter the Effective Date of managing or directing
   - D. Enter the End Date of managing or directing, if applicable
   - E-H. Enter the Organization's Address
   - I. Enter the FEIN for the organization
   - J. Select Medicare or Medicaid
   - K. Enter the Medicare or Medicaid ID number
   - L. Select "Save"

4. Select Yes or No, if Yes is selected, fields for A-G will appear
   - A. If Yes was selected, select "Add Subcontractor"
   - B. Enter the Subcontractor Name
   - C-F. Enter the Subcontractor's Address
   - G. Select "Save"

Ownership – Section 7

5. Select Yes or No, if Yes is selected, fields for A-K will appear
    - A. If Yes was selected, select “Add Relative”
    - B-D. Enter the Relative’s Name
    - E. Select a Relationship from the drop-down list
    - F. Enter the Subcontractor Name
    - G-J. Enter the Subcontractor Address
    - K. Select “Save”

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

Exclusion/Sanction – Section 7

- Select Yes or No for each question. If you select Yes for any question, additional required fields will appear NOTE: Any question answered Yes will require a copy of the original adverse action or a dated signed statement from the provider which must be submitted with the application

Jul 18, 2022

New Hampshire MMIS Health Enterprise Portal

Skip Navigation | Contact Us | Help | Search

Home | Program | Member | Provider | Documentation | Directories

Exclusion / Sanction — Print | Help

* Required Field

Application Links
Application Tracking Number -

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

Help

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

Name & Federal Program
To add Name 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

Continue>> | Save | Reset | Exit Application

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- Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Signature Page Section

1. Select "Print" to print a pre-filled signature page that requires the signature of the provider
   NOTE: You will need to have the signed signature page scanned back onto your computer and saved as a .jpeg, .png, or .pdf file format
2. Select "Upload Document" to open the Add Attachment section
   A. Select Browse to browse your files for the signature page you saved
   B. Add a Description for the attachment
   C. Select "Save"

NOTE: Only one file can be uploaded here. Additional documentation must be submitted with the application in the **Submit Complete Section**

Signature — Print | Help

* Required Field

Application Links
Application Tracking Number -

- Instructions
- Identifying Information
- Licensure / Certification
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- Service Location Billing
- Group Affiliation
- Electronic Claims Submission
- Ownership
- Exclusion / Sanction
- **Signature Page**

Signature Page Instructions

- Please print, sign, and upload this signature page with your Enrollment Application or Revalidation.
- Additional Options for other required documentation to be scanned and uploaded are available at the end of the application.
- You may also fax it to the secure NH Medicaid Provider Relations fax: 1-866-446-3318.
- If you need assistance with uploading the signature page, please contact NH Medicaid Provider Relations Call Center: 1-866-291-1674.

1 Print

Upload Signature Page

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

2 Upload Document

Upload only .jpeg,png,pdf format file.

Date Added	Added By	File Name	Description
No Data Available.			

Add Attachment — C Save | Reset | Cancel

*File — Browse... A

Note:Maximum allowed size limit is 10MB

*Description — B

Continue>> Save Reset Exit Application

➢ Select "Save" at the bottom of the section, then select "Continue" to move to the next section

Submit Application Section

1. Select Yes to create a User ID for the Portal Organization Administrator, who is responsible for utilizing the portal to set up and maintain users for the Provider Organization
   - A. Enter the Legal Organization Name for the Provider
   - B. Enter the Organization Description
   - C. Enter a User ID. This will be the User ID that you use to log into the MMIS portal NOTE: The User ID must be between 6 and 16 alpha-numeric characters and can contain hyphens, underscores, and/or periods
   - D. Select a Prefix from the drop-down list if applicable
   - E-G. Enter the Organization Administrator's Name
   - H. Select a Suffix from the drop-down list if applicable
   - I. Enter the Organization Administrator's Phone Number
   - J. Enter the Phone Number Extension if applicable
   - K. Enter the Organization Administrator's Email Address

Submit Application Step 1 Print | Help

* Required Field

Application Links
Application Tracking Number -

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- Signature Page
- **Submit Application**

Register for Web Access

Providers and Trading Partners who are enrolled in the NH Medicaid 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.

Yes No (1)

*Legal Organization Name (A) | *Organization Description (B) | *User ID (C)

Prefix (D) | *Last Name (E) | *First Name (F) | MI (G) | Suffix (H)

*Phone # (I) | Ext (J) | Email Address (K)

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.

Save | Validate Application

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

- Select "Save" at the bottom of the section, then select "Validate Application" NOTE: Validating the application will check the application for errors. If any errors are found, it will bring you to the sections that contain the error where you will need to correct it before being able to submit

Submit Application Section

1. If you have additional service locations to enroll, select "Add Another Service Location" NOTE: Selecting this option will bring you to a shortened application for the additional service location.
   NOTE: If this is selected by accident, you will not be able to delete the additional service location. You will need to start a new application
2. If you need to edit any of the additional service locations, select "Edit Service Location"
3. If you need to edit the current service location, select "Edit Application"
4. Select "Save" to save the application
5. Select "Confirm Submit" to submit the application NOTE: You will not be able to make edits to the application after making this selection. If there are any changes needed, you will need to contact the NH Medicaid Provider Relations Call Center at 866-291-1674

Provider Enrollment - Submit Application Step 2 Print | Help

* Required Field

Application Links
Application Tracking Number -

- Instructions
- Identifying Information
- Licensure / Certification
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- Service Location Billing
- Group Affiliation
- Electronic Claims Submission
- Ownership
- Exclusion / Sanction
- Signature Page

Add Another Service Location

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

Edit Service Location

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

Edit Application

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

Submit Confirmation

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

Add Another Service Location (1) | Edit Service Location (2) | Edit Application (3) | Save (4)

Confirm Submit (5)

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

Submit Complete Section

1. Once you submit the application, you will be brought to the Submit Complete page. The required documents for the application will be listed here. When you select the document, you will be able to print and complete it.
2. If you have completed required documents or have any additional documentation, they can be uploaded here. Select "Add Attachment" to upload a document
3. Select "Save All Attachments" to save the attachments once they've been uploaded
4. Select "Print Application" to print a PDF of the entire application that was completed. Then select "Exit Application" to bring you back to the MMIS home page

Submit Complete — Print | Help

* Required Field

Thank you for submitting your application on-line. In order to fully process your application the required documents listed below must be **submitted to NH Medicaid.** Once all documents have been received and your application **has been** reviewed you will be notified via mail with the application decision.

You may check the status of your application at any time, through the Application Status function located on the main Enrollment home page or by contacting Provider Enrollment Services at the number listed below, and providing your Application Tracking Number.

Application Tracking Number

Application Tracking Number:

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

Print, Sign, and Submit your Documents

The PRINT APPLICATION button may be used to print a copy of the application. This copy is for your records only and should not be submitted to **NH Medicaid.**

All providers must print and sign the **Provider Enrollment/Revalidation Signature Page and NH Medicaid Provider Participation Agreement.** Additional documents may be required depending on your provider type and business situation. Documents must be completed, signed and submitted to **NH Medicaid via upload or mailed to** the address below. Copied or stamped signatures are not acceptable. Print the **Required Enrollment Documents** Checklist to identify the supplemental information by provider type and business model that **are required** to finalize your application. **Submit all provider enrollment documentation via upload or by mail to:**

NH Medicaid Program

PO BOX 2059

Concord, NH 03301 - 2059

NOTE:Include the Application Tracking Number indicated above on any documents mailed to **NH Medicaid** in reference to your application.

Upload or Mail the following required documents:

1. Enrollment/Revalidation Signature Page
2. NH Medicaid Provider Participation Agreement (PPA)
3. Document Requirements Checklist

(1)

Attachments

System successfully saved the Information

(2) Add Attachment (3) Save All Attachments

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

Date Added	Added By	File Name	Description
07/13/2022 04:49 PM	GUESTUSER	Blank PPA.pdf	PPA

1 - 1 of 1

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

Fingerprint-based Criminal Background Check (FCBC) Notification

The Affordable Care Act (Section 6401), under 42 CFR 455.434, identifies Medicaid providers whose owners are required to submit fingerprint-based criminal background checks. The Medicaid providers identified as high-risk per 42 CFR 455.450 are owners with a 5% or more direct or indirect ownership interest, providers that deliver home health services, Durable Medical Equipment, have been sanctioned within the past 10 years or have an existing State Medicaid Plan qualifying overpayment. For more information please go to Department of Health & Human Services website at https://www.dhhs.nh.gov/bii/pi.htm.

(4) Print Application Exit Application

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