

**STATE OF NEW HAMPSHIRE**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**New Hampshire Medicaid Program**

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**NH Medicaid Change of Provider Information Form**

* Providers who are enrolled in the NH Medicaid Program who wish to change information on their provider record must complete and sign this form.
* To complete this form, enter the required information in the Provider Information section. Then select the updates you would like to make by clicking the arrow on the left side of each applicable update. Complete the fields in each section, print the document, and sign the certification statement at the bottom of the form.
* Providers are responsible for notifying NH DHHS Medicaid’s fiscal agent, Conduent, of any changes to information on your account within 30 days of the effective date of the change.
* All necessary forms can be found on the [NH MMIS Documents & Forms Page](https://nhmmis.nh.gov/portals/wps/portal/!ut/p/c5/04_SB8K8xLLM9MSSzPy8xBz9CP0os3hXX-cwF3cfQwMLAz9LAyNjC0fvIFcDg0ALI6B8pFm8AQ7gaEBAdzjIPtwq3M0h8njM9_PIz03VL8iNMMgycVQEADqTPrw!/dl3/d3/L2dJQSEvUUt3QS9ZQnZ3LzZfRU1DVkRHTDEwODBOOTAyMzhBS1JFMDA2NTY!/)
* Please complete all applicable information and send it to NH Provider Relations via one of the options below:

**Fax** **To**: NH Provider Relations Fax (secure) 1-866-446-3318

**Send an Encrypted Email** **To**: [NHProviderRelations@conduent.com](mailto:NHProviderRelations@conduent.com)

**Mail To**:  NH Provider Relations

Provider Data Maintenance Request

P.O. Box 2059

Concord, NH 03301

* If you have any questions, please contact the NH Provider Relations Call Center at 1-866-291-1674.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **PROVIDER INFORMATION** | | | | | | | |
| Date\*: |  | | NH Medicaid Provider Number or Application Tracking Number (ATN)\*: | | |  | |
| Provider Name\*: | |  | | Tax ID (EIN or SSN)\*: |  | | |
| Email Address\*: | |  | | | | | |
|  | |  | |  | | |  |

# UPDATE PROVIDER NAME – Provide documentation for the name change. (Example for individuals: Professional license reflecting the name change. Examples for organizations: W-9 or IRS letter.) Note: If the provider name change relates to a tax ID change, you must complete a new application.

|  |  |
| --- | --- |
| New Provider Name: |  |
| Comment: |  |
|  |  |

# UPDATE NATIONAL PROVIDER IDENTIFIER (NPI) OR TAXONOMY – Provide print out from NPPES with the new NPI.

|  |  |  |  |
| --- | --- | --- | --- |
| Add  End | | | |
| NPI: |  | Taxonomy: |  |
| Effective Date: |  | Comment: |  |
|  |  |  |  |
| Add  End | | | |
| NPI: |  | Taxonomy: |  |
| Effective Date: |  | Comment: |  |
|  |  |  |  |

# UPDATE LICENSURE, CERTIFICATION, CLIA, OR DEA – Provide documentation for the item being updated. Submitted documentation must come from the issuing board. License copies or online verifications are accepted.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Documentation Submitted: |  | Copy of Updated License  Copy of CLIA |  | Copy of Updated Certification  Copy of DEA |  |

# UPDATE ADDRESS OR LOCATION CONTACT PERSONS – Update addresses or location contact persons.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please note that all crucial provider information is sent to the contact person e-mail addresses. Ensure these are kept up to date and consider using a shared email address to avoid issues with turnover or out-of-office emails. | | | | | |
| Physical – (P.O. Box not acceptable) | | Billing – Paper checks are sent to this address | | Mailing – Used for correspondence | |
| The physical address is also known as the service location address. | | The billing address does not pertain to Non-Billing Providers. | | The mailing address is where all letters from NH Medicaid are sent. | |
| Primary Physical Address: | | P.O. Box/Street Address: | | P.O. Box/Street Address: | |
|  | |  | |  | |
| Building, Suite #, Etc.: | | Building, Suite #, Etc.: | | Building, Suite #, Etc.: | |
|  | |  | |  | |
| City: | | City: | | City: | |
|  | |  | |  | |
| State: Zip Code: | | State: Zip Code: | | State: Zip Code: | |
|  |  |  |  |  |  |
| Phone Number: | | Phone Number: | | Phone Number: | |
|  | |  | |  | |
| Fax Number: | | Fax Number: | | Fax Number: | |
|  | |  | |  | |
| Contact Person Name: | | Contact Person Name: | | Contact Person Name: | |
|  | |  | |  | |
| Contact Person E-mail: | | Contact Person E-mail: | | Contact Person E-mail: | |
|  | |  | |  | |
| Contact Person Phone Number: | | Contact Person Phone Number: | | Contact Person Phone Number: | |
|  | |  | |  | |

# ADD AFFILIATION(S) – The Provider ID is required, only currently enrolled providers can be affiliated. Add affiliation(s) to provider file (attach additional sheets if needed). Effective date must be within 1 year of the current date and cannot be future dated.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Provider ID: |  | | Name: |  | Eff. Date: |  |
| Provider ID: |  | | Name: |  | Eff. Date: |  |
| Provider ID: |  | | Name: |  | Eff. Date: |  |
| Provider ID: |  | | Name: |  | Eff. Date: |  |
| Provider ID: |  | | Name: |  | Eff. Date: |  |
|  |  |  | |  |  |  |

# END AFFILIATION(S) – End affiliation(s) from provider file (attach additional sheets if needed).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Provider ID: |  | | Name: |  | End Date: |  |
| Provider ID: |  | | Name: |  | End Date: |  |
| Provider ID: |  | | Name: |  | End Date: |  |
| Provider ID: |  | | Name: |  | End Date: |  |
| Provider ID: |  | | Name: |  | End Date: |  |
|  |  |  | |  |  |  |

# AUTHORIZED REPRESENTATIVE APPOINTMENT OR REMOVAL – Add or remove an Authorized Representative to provider file.

|  |  |  |  |
| --- | --- | --- | --- |
| Appoint Below Authorized Representative  Remove Below Authorized Representative | | | |
| Print Authorized Representative Name: |  | Title/Position: |  |
| Signature of Authorized Representative: |  | Date: |  |
|  |  |  |  |
| Appoint Below Authorized Representative  Remove Below Authorized Representative | | | |
| Print Authorized Representative Name: |  | Title/Position: |  |
| Signature of Authorized Representative: |  | Date: |  |
|  |  |  |  |

# MANAGING/DIRECTING EMPLOYEE APPOINTMENT OR REMOVAL – Add or remove a Managing/Directing Employee to provider file. Note: The address must be the individual’s address, not the business address.

|  |  |  |  |
| --- | --- | --- | --- |
| Appoint Below Managing/Directing Employee  Remove Below Managing/Directing Employee | | | |
| Print Managing/Directing Employee Name: |  | Title/Position: |  |
| Date of Birth: |  | SSN: |  |
| Effective Date: |  | End Date: |  |
| Street Address: |  | City: |  |
| State: |  | Zip Code: |  |
| Signature of Managing/Directing Employee: |  | Date: |  |
|  |  |  |  |
| Appoint Below Managing/Directing Employee  Remove Below Managing/Directing Employee | | | |
| Print Managing/Directing Employee Name: |  | Title/Position: |  |
| Date of Birth: |  | SSN: |  |
| Effective Date: |  | End Date: |  |
| Street Address: |  | City: |  |
| State: |  | Zip Code: |  |
| Signature of Managing/Directing Employee: |  | Date: |  |
|  |  |  |  |

# UPDATE PHARMACIST IN CHARGE – Update the Pharmacist in Charge on the provider file.

|  |  |  |  |
| --- | --- | --- | --- |
| Appoint Below Pharmacist in Charge  Remove Below Pharmacist in Charge | | | |
| Print Pharmacist in Charge’s Name: |  | | |
|  |  |  |  |
| Appoint Below Pharmacist in Charge  Remove Below Pharmacist in Charge | | | |
| Print Pharmacist in Charge’s Name: |  | | |
|  |  |  |  |

# BACKDATE ENROLLMENT – A copy of a completed claim reflecting the requested backdate is required to be included (claim is for verification purposes only and will not be processed). The state will determine the approval or denial of the request. Approval or denial of the request will be communicated via email.

|  |  |  |  |
| --- | --- | --- | --- |
| Requested Backdate: |  | Email Address: |  |
|  |  |  |  |

# UPDATE TRADING PARTNER – Select the desired transactions to submit and receive. Complete and send the below Billing Agent Agreement. If selecting the 835 transaction, complete and send the ERA Application as well.

|  |  |
| --- | --- |
| Submitting Transactions:  270 Eligibility Inquiry  276 Claim Inquiry  837D Dental Claims  837I Institutional Claims  837P Professional Claims | Receiving Transactions:  271 Eligibility Response  277 Claim Inquiry Response  835 Remittance Advice (ERA Application Required) |
| [Billing Agent Agreement](https://nhmmis.nh.gov/portals/wps/wcm/connect/cadbbf45-86d4-4c51-8f4d-afe0e3f932bc/Individual+Billing+Agent+Agreement_View+1+Rebrand.pdf?MOD=AJPERES&CVID=m9e4OvQ) [ERA Application](https://nhmmis.nh.gov/portals/wps/wcm/connect/31644368-3f86-4aec-9f07-6ae1da761881/ELECTRONIC+REMITTANCE+ADVICE+ENROLLMENT+APPLICATION.pdf?MOD=AJPERES&CVID=kOL-1km) | |

# EFT ENROLLMENT OR UPDATE – Complete and send the below EFT Agreement, EFT Enrollment Application, and include a voided check or bank letter.

|  |
| --- |
| [EFT Agreement](https://nhmmis.nh.gov/portals/wps/wcm/connect/3ed40d68-f45b-4dae-8dc2-a70b0231b87f/ELECTRONIC+FUNDS+TRANSFER+AGREEMENT.pdf?MOD=AJPERES&CVID=kOLZMhF) [EFT Enrollment Application](https://nhmmis.nh.gov/portals/wps/wcm/connect/b688b6cc-d7ef-4b83-897a-21b715b84252/ELECTRONIC+FUNDS+TRANSFER+ENROLLMENT+APPLICATION.pdf?MOD=AJPERES&CVID=kOLZY11) |

# UPDATE PROVIDER SPECIALTY – Update the specialty that is listed on the provider file.

|  |  |  |  |
| --- | --- | --- | --- |
| Add Below Specialty  Remove Below Specialty | | | |
| Specialty: |  | Effective Date: |  |
|  |  |  |  |
| Add Below Specialty  Remove Below Specialty | | | |
| Specialty: |  | Effective Date: |  |
|  |  |  |  |

# NH MMIS HEALTH ENTERPRISE PORTAL REGISTRATION – Register to establish a user ID and password for access to the secure NH MMIS portal.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Portal Administrator Information  This is the information of the person being assigned a User ID as a Portal Administrator.  The User ID is used to log into the MMIS portal and is created by you. It must be between 6-16 alphanumeric characters and can contain hyphens, underscores, and/or periods. | | | | | |
| Is this request for Provider Revalidation? | | Yes  No | | User ID: |  |
| First Name: |  | | Last Name: | |  |
| Phone Number: |  | | Email Address: | |  |
|  |  | |  | |  |

# CONTROLLING INTEREST UPDATE – Update the board members and executive officers that have a controlling interest in the corporation or partnership on the provider record (attach additional sheets if needed).

|  |  |  |  |
| --- | --- | --- | --- |
| Add Below Individual  Remove Below Individual | | | |
| Full Legal Name: |  | | |
| Date of Birth: |  | Social Security Number (SSN): |  |
| Title: |  | Effective Date (if adding) or End Date (if removing): |  |
| Home Address or Primary Office Location: |  | If related to another board member or corporate officer, enter the individual’s relationship to that person: |  |
|  |  |  |  |
| Add Below Individual  Remove Below Individual | | | |
| Full Legal Name: |  | | |
| Date of Birth: |  | Social Security Number (SSN): |  |
| Title: |  | Effective Date (if adding) or End Date (if removing): |  |
| Home Address or Primary Office Location: |  | If related to another board member or corporate officer, enter the individual’s relationship to that person: |  |
|  |  |  |  |
| Add Below Individual  Remove Below Individual | | | |
| Full Legal Name: |  | | |
| Date of Birth: |  | Social Security Number (SSN): |  |
| Title: |  | Effective Date (if adding) or End Date (if removing): |  |
| Home Address or Primary Office Location: |  | If related to another board member or corporate officer, enter the individual’s relationship to that person: |  |
|  |  |  |  |

# OWNERSHIP CHANGE – If the ownership of the provider has changed, a new application is required to be submitted.

|  |
| --- |
| If an indirect or direct owner of the provider who has 5% or more controlling interest in the group has been added or removed, a new application is required to be submitted on the MMIS portal: <https://nhmmis.nh.gov/portals/wps/portal/ProviderEnrollment>  On the Identifying Information section of the application, ensure you answer Yes to the question “Is this application due to a change of ownership?”  When the application is approved, a new Medicaid ID will be assigned, replacing the previous owner’s Medicaid ID. |

# UPDATE TAX INFORMATION – Provide documentation for any changes. It will be communicated if a new provider enrollment application is required.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| TAX ID (EIN or SSN): |  | | Effective Date: |  |
|  | | | | |
| **BUSINESS TYPE** | | | | |
| Corporation | | Limited Liability Company | | |
| Individual/Sole Proprietor | | Non-corporate Business Entity | | |
| Partnership/Professional Association | | Government Entity or Public School | | |

# TERMINATE ENROLLMENT – Indicate the reason(s) for termination and effective date. Note: Office records must be stored/maintained for at least 6 years.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| No Longer in Practice | | | | | |
| No Longer Accepting Medicaid Patients | | | | Provider deceased | |
| Other Reason/Comment: | |  | | | |
| Effective date of termination: | |  | | | |
| Contact Name: |  | | Telephone Number: | |  |
| Email Address: | | |  | | |
| Physical Address of location where office records are stored: | | |  | | |
|  | | |  | | |

# OTHER UPDATE – Briefly describe in the comment section below.

|  |  |
| --- | --- |
| Comment: |  |
|  | |

# CERTIFICATION STATEMENT – Please read the following, sign, and date.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I certify by my signature below that I am fully authorized to sign and execute this Enrollment Update on behalf of the aforementioned Provider. I understand that any information requested and provided on this form does not change or alter the terms of my executed Provider Participation Agreement. I further understand that any false claims, statements, documents, or concealment of material fact may be grounds for termination as a New Hampshire Medicaid Provider, and/or may be prosecuted under applicable federal and state laws. | | | | |
| Name\*: |  | | Email\*: |  |
| Title\*: |  | | | |
| Signature\*: | |  | Date\*: |  |
|  | | | | |
| An owner or managing director must sign for an organizational provider, or the actual provider must sign if you are an individual provider. | | | | |
| *Unsigned forms will not be processed and will be returned.* | | | | |
|  | | | | |