



STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

New Hampshire Medicaid Program

**NH Medicaid Non-Billing Rendering Provider Enrollment Instructions**  
**Completing the Non-Billing Rendering Provider Enrollment Application**

[www.nhmmis.nh.gov](http://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

The screenshot shows the 'New Hampshire MMIS Health Enterprise Portal' interface. At the top right, the date 'Jun 22, 2022' is displayed, along with links for 'Skip Navigation', 'Contact Us', 'Help', and 'Search'. A blue navigation bar contains the following menu items: Home, Program, Member, Provider, Documentation, and Directories. Below the navigation bar is a banner image with five panels depicting healthcare scenes: a newborn baby, a doctor examining an elderly patient, hands being held, a doctor's stethoscope, and a doctor examining a patient's mouth. Below the banner are four panels: 'Welcome' with a maintenance notice, 'Provider Registration' with a 'Register' button, 'Quick Links' with a list of links where 'Enrollment' is circled in red, and 'Sign In' with options for 'Providers' and 'Internal Users'. At the bottom, there is a copyright notice for Conduent, Inc. and a footer with links for Privacy Policy, Site Map, Terms of Use, Browser Requirements, and Accessibility Compliance.

➤ Select the “Non-Billing Rendering 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 SSN in the Recall Provider Application section and select “Submit”

The screenshot shows the 'New Hampshire MMIS Health Enterprise Portal' with a navigation menu including Home, Program, Member, Provider, Documentation, and Directories. The main content area is titled 'Provider Enrollment' and includes a 'Print | Help' icon. A red asterisk indicates a required field. The page is divided into three main sections: 'Become a Billing Provider', 'Become a Non-Billing Provider', and 'Become a Trading Partner'. Each section contains instructions and links for 'FAQ', 'Instructions', and specific enrollment links. The 'Non-Billing Rendering Provider Enrollment' link is circled in orange. To the right, there are three 'Application Status' sections: 'Application Status', 'Recall Provider Application', and 'Recall Trading Partner Application'. Each of these sections has input fields for 'Application Tracking #' and 'SSN / FEIN', and a 'Submit' button, which is also circled in orange in each section.

➤ Please read the following information and select “Enroll as Non-Billing Rendering Provider”

**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

**New Hampshire MMIS Health Enterprise Portal** Jul 12, 2022  
[Skip Navigation](#) | [Contact Us](#) | [Help](#) | [Search](#)

**Home** | Program | Member | Provider | Documentation | Directories

**Non-Billing Rendering Provider Enrollment Instructions** Print | Help - □

\* Required Field

**Application Links Instructions**

**Individual Provider Enrollment for Non-Billing Rendering**  
This application is for an Individual Provider that is performing the service being submitted on the claim but is not billing directly.

**Individual Provider Enrollment Instructions for Non-Billing Rendering**

- 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 mandatory for application processing.
- For all date fields, use the date format (mm/dd/yyyy) unless otherwise indicated.
- Providers with different owners/managing employees should complete another separate application. Providers with the same owners/managing employees should complete additional service location section of the group application.
- Print, sign, scan and upload the signature page in the **Signature Page** section.
- Additional options for other required documentation to be scanned and uploaded are available at the end of the application.

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 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>.

**Enroll as Non-Billing Rendering Provider** | Cancel

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## 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. Select Male or Female
9. Select Yes or No
10. Enter the Provider’s SSN
11. 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

The screenshot shows a web application window titled "Identifying Information". On the left is a sidebar with "Application Links" (Instructions, Identifying Information, Licensure / Certification, Provider Identifier Number, Service Location, Group Affiliation, Exclusion / Sanction, Signature Page) and "Help" (Name, Date of Birth, SSN). The main form area is titled "Identifying Information- Section 1" and includes:
 

- SA Waiver Medium:** A section with a radio button for "Inbox" (selected) and "Mail". A note states: "Letters will be sent to your provider inbox. If this will create a provider hardship please contact Provider Relations." This section is circled in orange and labeled with a '1'.
- Identifying Information- Section 1:** A section with several fields:
  - \*Last Name (2): Text input field.
  - \*First Name (3): Text input field.
  - MI (4): Text input field.
  - Suffix (5): Drop-down menu.
  - Title (6): Drop-down menu.
  - \*Date of Birth (7): Calendar icon.
  - \*Gender (8): Radio buttons for "Male" and "Female".
  - \*May gender information be shared with members? (9): Radio buttons for "Yes" and "No".
  - \*SSN (10): Text input field. A note below states: "SSN is equivalent to Provider Tax Identification Number(TIN). Note:The applicant's SSN will be linked to a NH Medicaid Provider Number. This SSN must be for the Individual Provider whose information is provided on this application."
- Current/Previous NH Medicaid Provider #:** A section with a question: "\*Were you previously enrolled as a Medicaid provider in NH?" (11) with radio buttons for "Yes" and "No". This section is circled in orange.

 At the bottom right of the form are buttons for "Continue>>", "Save", "Reset", and "Exit Application". The "Save" button is circled in orange.

➤ 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”

The screenshot shows a web form for provider enrollment. The 'Licensure and Certification - Section 2' section is the focus. It includes a table for existing licenses and a form to add a new one. The 'Add Licensure and Certification' form has the following fields: License # (B), Licensing Agency (C), Effective Date (D), Expiration Date (E), and State (F, set to New Hampshire). The 'Specialty' section has an 'Add Specialty' button (3). The 'Taxonomy' section has an 'Add Taxonomy' button (4) and a form with fields for Taxonomy (10 digits/alphas) (A), Begin Date (B), and End Date (C). At the bottom of the form, there are buttons for 'Continue', 'Save', 'Reset', and 'Exit Application'. The 'Save' button is circled in red in the original image.

➤ 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. 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
  3. 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”
  4. 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

**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

\*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 #**

3 **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).

4 **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

The screenshot shows the 'Service Location Information - Section 4' web form. It includes sections for entering the primary physical address, a suggested address list, adding phone and fax numbers, and adding contact persons. Red circles and numbers 1-8 are overlaid on the form to highlight specific fields and buttons mentioned in the instructions.



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

**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 #

? \*Does this location provide emergency services after standard business hours? 14

Yes     No

\*After Hours Contact Phone #

### Service Location Information – Section 4

15. 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”
16. 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”
17. 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

The screenshot shows a web form titled "Mailing Address" with the following sections and highlighted elements:

- Question 15:** "Is this mailing address the same as service location?" with radio buttons for "Yes" and "No".
- Address Fields:** "\*P.O. Box / Street Address" (A), "Building, Suite #, etc." (B), "\*City" (C), "\*State" (D), and "\*Zip" (E).
- Validation:** "Validate Address" button (F).
- Suggested Address:** A list of address suggestions with "Override verification warning, and accept address as entered." (G).
- Submission:** "Submit" button (H).
- Phone/Fax Section:** "Phone #", "Fax #", and "Add Numbers" buttons (I).
- Contact Person Section:** "Add Contact Person" button (I).
- Contact Form:** Fields for "\*Last Name" (A), "\*First Name" (B), "Middle Initial" (C), "\*Phone #", "Ext." (E), "\*E-mail" (G), "Fax #", and "\*Position" (H).

➤ 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. 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 - [redacted]

- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Number
- ✓ Service Location
- ▶ **Group Affiliation**
- 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.

1 Add Group

Name of Group Practice ▾	New Hampshire Title XIX Provider # ▾	Effective Date of Affiliation ▾
D <span style="border: 1px solid red; border-radius: 50%; padding: 2px 5px;">Save</span>   <span>Reset</span>   <span>Cancel</span>		
*Name of Group Practice <input style="width: 90%;" type="text" value="(A)"/>	*New Hampshire Title XIX Provider # <input style="width: 90%;" type="text" value="(B)"/>	*Effective Date of Affiliation <input style="width: 90%;" type="text" value="(C)"/>

Continue>> Save | Reset | Exit Application

➤ 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

**Application Links**  
Application Tracking Number [redacted]

- Instructions
- ✓ Identifying Information
- ✓ Licensure / Certification
- ✓ Provider Identifier Number
- ✓ Service Location
- ✓ Group Affiliation
- ▶ **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](#)

➤ 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**

The screenshot shows a web application window titled "Signature". On the left is a sidebar with "Application Links" including "Identifying Information", "Licensure / Certification", "Provider Identifier Number", "Service Location", "Group Affiliation", "Exclusion / Sanction", and "Signature Page". The main content area has three sections:
 

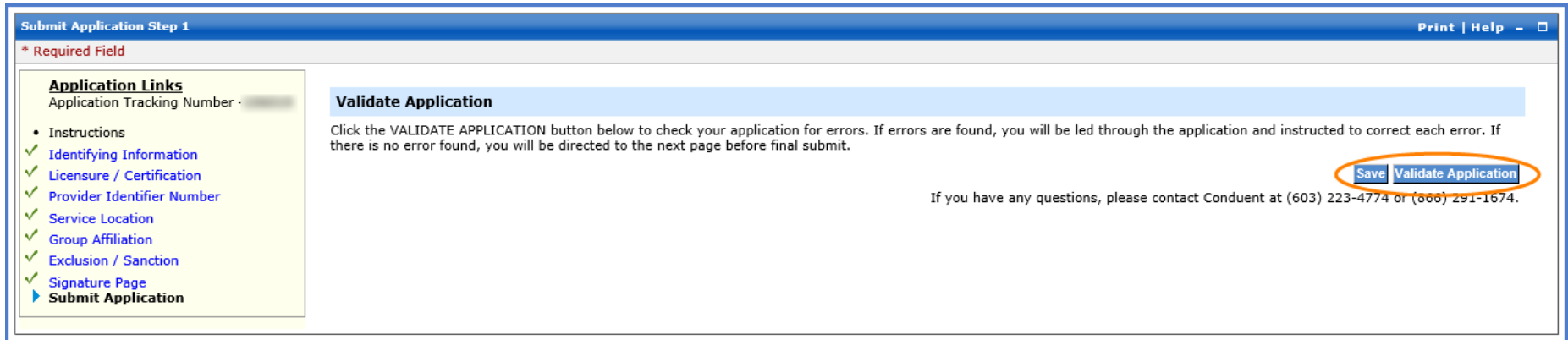
- Signature Page Instructions:** Contains three bullet points and a "Print" button (circled in orange).
- Upload Signature Page:** Includes a note about file uploads, an "Upload Document" button (circled in orange), and a table with columns "Date Added", "Added By", "File Name", and "Description". The table is currently empty with "No Data Available." below it.
- Add Attachment:** Features a "Browse..." button (circled in orange and labeled 'A'), a "Note: Maximum allowed size limit is 10MB", a "Description" text box (circled in orange and labeled 'B'), and "Save", "Reset", and "Cancel" buttons (circled in orange and labeled 'C').

 At the bottom right, there are buttons for "Continue>>", "Save", "Reset", and "Exit Application", with "Continue>>" and "Save" circled in orange.

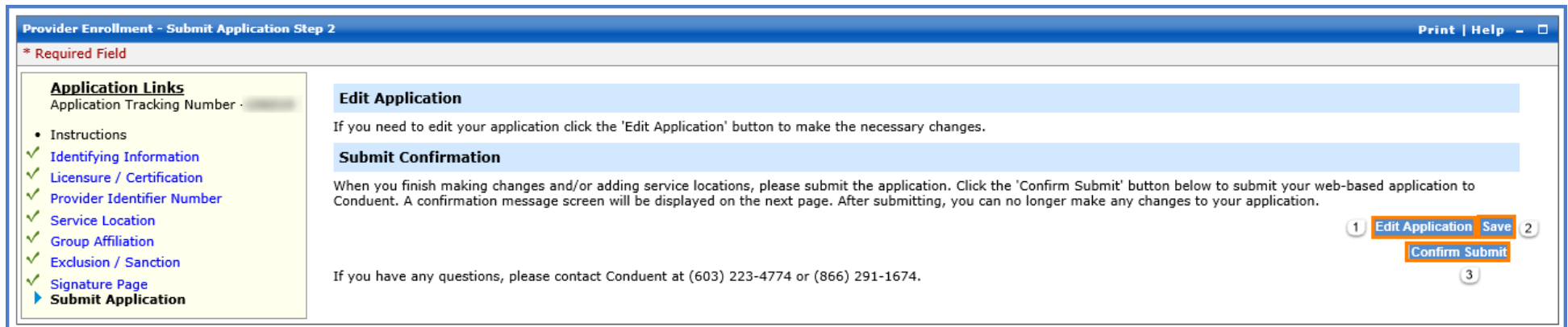
➤ Select “Save” at the bottom of the section, then select “Continue” to move to the next section

### Submit Application Section

- 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



1. If you need to edit the application, select “Edit Application”
2. Select “Save” to save the application
3. 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



### 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

**Attachments**

System successfully saved the Information

Add Attachment
Save All Attachments

Date Added	Added By	File Name	Description
<a href="#">07/13/2022 04:49 PM</a>	GUESTUSER	Blank PPA.pdf	PPA

1 - 1 of 1

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

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/bij/pi.htm>.

Print Application
Exit Application

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