New Hampshire Medicaid Program

Enrollment Application: Group Provider

Group Provider Enrollment Instructions:

- This application is for a *corporation, a partnership, or another group-type business entity* or *sole proprietorship with a Federal Employer ID Number (FEIN)*. Individual providers must complete the Individual Provider Enrollment Application.
- Applicants with multiple service locations must also complete a Group Provider Additional Service Location Form for each distinct location.
- Providers with more than one provider type must complete a separate Enrollment Application for each provider type and must complete a Group Provider Additional Service Location Form for each associated service location.
- This application must be complete and clearly legible. Data fields marked with an asterisk (*) are mandatory for application processing. Do not use correction fluid or tape. Applications which are incomplete, illegible, contain correction fluid or tape will be returned.
- Signature pages must be signed with original signatures. Copied or stamped signatures are unacceptable. Supplemental documentation may also be required as outlined on the Required Documentation worksheet included in the Enrollment Application Packet.

* Required Field

IDENTIFYING INFORMATION

Section 1

This Application is for(check one):

☐ Initial Group Enrollment
An applicant who has never been a NH Title XIX Provider or has never had a NH Title XIX Provider Number

☐ Group Re-enrollment
An applicant who has an existing or previous NH Title XIX Provider Number

☐ Change of Ownership
An applicant who is assuming business ownership and operation of a previous or current NH Title XIX Provider Number

NH Title XIX Provider Number *

Former NH Title XIX Provider Number *

Identifying Information

Group Name *

Doing Business As (DBA) Name *(if applicable)*

Former DBA Name *(if applicable)*

Federal Employer Identification Number (FEIN) *(9 digits)* *

Important: Attach a copy of a valid form of FEIN verification.

Note: The applicant's FEIN will be linked to a NH Title XIX Provider Number. Applicable claims paid to the NH Title XIX Provider Number will be reported as income under the FEIN to the IRS. This FEIN must be for the Group Provider whose information is provided on this application. If the FEIN changes, the applicant must re-apply for a NH Title XIX Provider Number.

Non-Profit Organization Tax-Exempt Status

Is the business listed under a tax-exempt status? ☐ Yes ☐ No
If so, please attach a copy of your IRS-issued exemption.

LICENSURE/CERTIFICATION INFORMATION

Section 2

Complete the information below, as it applies to the Service Location identified in Section 4. If this information does not apply, leave it blank.

Provider Type *

Example: Hospital, Clinic, Nursing Home.
Enter only one Provider Type. A separate application is required for each additional Provider Type. Refer to the enclosed Group Provider Enrollment Instructions for a list of valid Provider Types.

License Information

The license must be for the state in which services are rendered.

License Number | Licensing Agency

Effective Date | Expiration Date | State

Certification Information

Certification Number | Certifying Agency

Effective Date | Expiration Date | State

Specialty Information

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

Specialty Type | Certification Number and Agency | State

Specialty Type | Certification Number and Agency | State

Specialty Type | Certification Number and Agency | State

Taxonomy Information

Taxonomy Number (10 characters) | Begin Date | End Date

Taxonomy Number (10 characters) | Begin Date | End Date

Taxonomy Number (10 characters) | Begin Date | End Date

Taxonomy Number (10 characters) | Begin Date | End Date

Taxonomy Number (10 characters) | Begin Date | End Date

PROVIDER IDENTIFIER NUMBERS

Section 3

Complete the information below, as it applies to the service location identified in Section 4. If this information does not apply to your provider type (identified previously in Section 2), leave it blank.

National Provider Identifier (NPI) Number *(10 digits)*

List all associated NPI Numbers assigned to this applicant

Drug Enforcement Agency (DEA) Number *(9 characters)*

List any DEA numbers assigned to this applicant

1. 2.

National Council for Prescription Drug Programs (NCPDP) Number *(7 digits)*

1. 3.
2. 4.

Other State Title XIX Enrollment:

Are you or have you ever been enrolled as a Title XIX Provider in another state? *

☐ Yes ☐ No

If Yes, in which state(s):

Medicare Crossover Payment:

Group Medicare Number(s)

Enter the current Medicare Number(s) assigned to you as a group practitioner. Do not include numbers assigned to Individual Providers.

Medicare Number	Part
Medicare Number	Part

Other Medicare Number(s)

For historical purposes, list any former Medicare Provider number(s) and carrier/intermediary name(s)

Medicare Number	Carrier/Intermediary	Part
Medicare Number	Carrier/Intermediary	Part

SERVICE LOCATION, MAILING, & BILLING INFORMATION

Section 4

Complete the information below, as it applies to this location. Applicants with more than one service location must complete an Additional Service Location Form for each additional location.

Service Location Address

Physical Address *(PO Boxes are not acceptable)** | Building/Suite *

City, State, and Zip * | County *

Telephone *(Include area code)* | Fax *(Include area code)*

Service Location Contact Person

Contact Name *(Last Name, First Name, MI)* | Telephone *(Include area code)* | Fax *(Include area code)*

E-mail Address | Position

Service Location Accommodations

Gender(s) Served * ☐ Male ☐ Female ☐ Both

Age Range(s) Served *(check all that apply)**

☐ ALL ☐ 0-5 years ☐ 6-12 years ☐ 13-17 years ☐ 18-21 years ☐ 22-59 years ☐ 60+ years

Languages Supported *(check all that apply)*

☐ English ☐ French ☐ Spanish ☐ Albanian ☐ Arabic ☐ Bosnian ☐ Cantonese

☐ Farsi ☐ Greek ☐ Korean ☐ Mandarin ☐ Portuguese ☐ Romanian ☐ Russian

☐ Swahili ☐ Syrian ☐ Ukrainian ☐ Vietnamese ☐ Other

Is this location wheelchair-accessible? * ☐ Yes ☐ No

Is this location TDD/TTY equipped? * ☐ Yes ☐ No

If Yes, list the TDD/TTY phone number *

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

If Yes, list the after-hours phone number *

If you are a Pharmacy or provide Pharmacy Services, please complete this area

Do you have drive-thru accessibility? ☐ Yes ☐ No

Do you provide delivery service? ☐ Yes ☐ No

Bed Data

If this application is for a Hospital, Nursing Facility or other Institutional Facility, please complete the following information regarding beds located at this service location facility.

Total Number of Facility Beds

Total Number of Acute Beds

Total Number of Psychiatric Beds *(Hospitals Only)*

Total Number of Rehabilitation Beds (*Hospitals Only)*

Total Number of NH Title XIX Beds *(Certified Beds Only)*

Total Number of Dually Certified Beds

Total Number of Swing Beds

Clinical Laboratory Improvement Amendments (CLIA) Certificate *(10 digits)*

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.

CLIA Number	Effective Date	Expiration Date

Mailing Address *(The location to which printed materials will be sent)*

Is this mailing address the same as the Service Location Address? *

- ☐ Yes. If Yes, skip to Mailing Location Contact Person.
- ☐ No. If No, please provide Mailing Address information.

P.O. Box/Street*

Building/Suite Number *

City, State, and Zip *

County *

Telephone *(Include area code)*

Fax *(include area code)*

Mailing Address Contact Person

Contact Name *(Last Name, First Name, MI)*

Telephone *(Include area code)*

Fax *(Include area code)*

E-mail Address

Position

Electronic Funds Transfer (EFT) Payments

Do you wish to participate in Electronic Funds Transfer payments (EFT)? *

☐ Yes. If Yes, please complete the Electronic Funds Transfer (EFT) Enrollment Application and EFT Agreement form and submit them with this application.

☐ No. If No, checks will be mailed to the billing address indicated below.

Billing Address *(The location to which mailed payments will be sent)*

Is this billing address the same as the Service Location Address? *

☐ Yes. If Yes, skip to Billing Location Contact Person. ☐ No. If No, please provide Billing Address.

Is this billing address the same as the mailing address? *

☐ Yes. If Yes, skip to Billing Location Contact Person. ☐ No. If No, please provide Billing Address.

P.O. Box/Street *

Building/Suite Number

City, State, and Zip *

County *

Billing Address Contact Person

Contact Name *(Last Name, First Name, MI)*

Telephone (*Include area code*)

Fax (*Include area code*)

E-mail Address

Position

Third Party Billing

Does a third party billing agent submit your claims? * ☐ Yes ☐ No

If Yes, The Billing Agent Agreement in **Section 8** must be completed and signed.

If Yes, does this Billing Agent have authority to make inquiries on your behalf? ☐ Yes ☐ No

Remittance Advice *(Requested delivery media for Remittance Advice (RA))* *

☐ Both ☐ Electronic (835) ☐ Web Provider Message Center (*Downloadable to paper*)

If you select "Both" Or Electronic (835), please complete the Electronic Remittance Advice (ERA) Enrollment Application and submit it with this application.

Providers are able to download and print paper RAs from the secure Provider Message Center on the NH MMIS Health Enterprise system. Enrolling Providers must complete and submit the Register for Web Access form along with this application to obtain a password and user ID for secure access to the NH MMIS Health Enterprise system.

PROVIDER AFFILIATIONS

Section 5

Instructions:
List all active NH Title XIX Individual Providers, and related information, who perform services on behalf of the Group at the location identified in Section 4. This information will be cross referenced to affiliations identified by Individual Providers to ensure consistency. Additional copies of this page may be made if necessary.

Information Regarding Affiliations and Claims Processing:
In order for Group Providers to receive payment for services performed by individual practitioners on behalf of the Group, performing providers must be enrolled in the NH Title XIX program as Individual Providers and affiliated with the Group Providers in the NH Medicaid Management Information System (MMIS).

Group applicants are responsible for identifying in this section, all Individual Providers who perform services on behalf of the group practice at the location identified in Section 4.

The performing practitioners must enroll separately as NH Title XIX Individual Providers, likewise identifying the Group Providers with which they are affiliated. Individual Providers and Group Providers will be affiliated in the system for claims processing purposes.

When the Group Provider submits a valid claim for services performed by an affiliated Individual Provider, payment will be made to the Group.

If the Group Provider has not identified an affiliated Individual Provider, claims submitted by the Group Provider for services performed by the individual practitioner will be denied.

Name of Individual Provider	NH Title XIX Individual Provider Number	Effective Date of Affiliation

ELECTRONIC TRANSACTION SUBMISSIONS

Section 6

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

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

Electronic Transaction Submissions
Indicate which of the following methods will be used to submit electronic claims-related transactions.

☐ NH MMIS Health Enterprise system

☐ Vendor Software

Vendor Software Name *

Software Name * | Version Number *

Protocol *

☐ Billing Agent/Clearinghouse

Billing Agent/Clearinghouse Name

Contact Name | Contact Phone Number (*include area code*)

Street Address | Street Address 2

City, State, and Zip

Electronic Transactions

For Software Vendor and Billing Agent/Clearinghouses, please check transactions authorized to submit and/or receive on behalf of applicant.

Submit	**Receive**
☐ 837I Institutional Claim	☐ 997 Functional Acknowledgement
☐ 837P Professional Claim	☐ 835 Remittance Advice
☐ 837D Dental Claim	☐ 271 Eligibility Response
☐ 270 Eligibility Request	☐ 277 Claim Inquiry Response
☐ 276 Claims Inquiry Request	☐ 278 Service Authorization Response
☐ 278 Service Authorization	☐ 824 Error Response
☐ All of the Above	☐ All of the Above

OWNERSHIP & EXCLUSION/SANCTION INFORMATION

Section 7

Ownership Information

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

(Make an additional copy of this section for each additional owner.)

If the owner is an individual, complete this area.

Last Name | First Name | MI | Title

Doing Business As (DBA) Name | Effective Date of Ownership

Date of Birth | State or Country of Birth

SSN *(9 digits)* | NH Title XIX Number *(if applicable)*

If the owner is a group or other business entity, complete this area.

Business Name | Doing Business As (DBA) Name

FEIN | Effective Date of Ownership | NH Title XIX Number *(if applicable)*

2. Are any of the persons with an ownership or controlling interest in the provider's company related to one another as spouse, parent, child, sibling or household member? * ☐ Yes ☐ No

If yes, provide information about the family or household member(s) below.

Family or Household Member

Last Name | First Name | MI | Relationship

Last Name | First Name | MI | Relationship

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

(Make additional copies of this section for each additional managing/directing employee.)

Last Name | First Name | MI | Title

Date of Birth | SSN *(9 digits)* | State or Country of Birth

4. Has this managing/directing employee ever had a Title XIX number in this or any other state? *

☐ Yes ☐ No

If yes, please enter the information below for each organization you managed or directed in the last 10 years (make additional copies if necessary.)

Business Name | Effective Date | End Date

SSN/FEIN | Current Title XIX Number/State | | Prior Title XIX Number/State |

5. Do any of the members of the immediate family (*spouse, parent, child, sibling, or household member*) of the named owner have ownership of 5% or greater in a subcontractor to your business or practice?(*A subcontractor is an individual, agency, or organization to which an applicant/provider has contracted or delegated some of its management functions or responsibilities for providing medical care to its patients.)*

☐ Yes ☐ No

(Make an additional copy of this section for each additional owner)

Last Name: | First Name: | MI: | Relationship:

Subcontractor Name:

Street Address: | Building/Suite #:

City, State, and Zip: | County:

Exclusion/Sanction Information (If applicable, supporting documentation as requested below must be submitted as part of the application.)

1. Are any of the named owners related to owners of the subcontractor as spouse, parent, child, sibling, or household member? * ☐ Yes ☐ No

If yes, provide information about the family or household member(s) below.

Family or Household Member | **Relationship**

Last Name | First Name | MI

Last Name | First Name | MI

2. Is the applicant group chain-affiliated? * ☐ Yes ☐ No

If yes, provide information about the corporation below.

Business Name | FEIN

Street Address | City, State, and Zip

Phone Number *(include area code)*

3. Is the applicant group operated by a management company, or leased in whole or in part by another organization? * ☐ Yes ☐ No

4. Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5% or more in the group that have been convicted of a criminal offense related to the involvement of such individuals or organizations in any of the programs established by Titles XVIII-Medicare, XIX-Medicaid, or XX-Social Services Block Grants? * ☐ Yes ☐ No

5. Are there any directors, officers, agents, or managing employees of the group that have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX? * ☐ Yes ☐ No

6. Has any family or household member, or any person who has ownership or controlling interest in the group, ever been convicted, assessed, or excluded from the Title XIX Program or any other federal program due to fraud, obstruction of an investigation, or a controlled substance violation? * ☐ Yes ☐ No

If yes, please provide the following information about the excluded individual(s) *(make additional copies if necessary)*.

Excluded Individual			Relationship
Last Name	First Name	MI	
Last Name	First Name	MI	

7. Do you under any name or business identity, have any outstanding overpayments with the Title XIX or any other federal program? * ☐ Yes ☐ No

If yes, please provide the following information on the overpayment(s) *(make additional copies if necessary)*.

Federal Program Name	Name Under Which Overpayment Exists

8. Has any person who has ownership or controlling interest in the group, ever been convicted of a felony under Federal or State law? * ☐ Yes ☐ No

If yes, please include appropriate documentation pertaining to the situation with your application.

9. Please indicate for each item below whether or not the applicant has ever had any of the following adverse legal actions imposed or pending by Title XIX or any other federal agency or program. Check the appropriate box and indicate the date when the adverse legal action was imposed. *

Important: Please attach any copies of adverse legal action notification(s).

Administrative Sanction * ☐ Yes ☐ No	Date of Occurrence
Professional Board Disciplinary Action * ☐ Yes ☐ No	Date of Occurrence
Program Exclusion * ☐ Yes ☐ No	Date of Occurrence
Suspension of Payment * ☐ Yes ☐ No	Date of Occurrence
Civil Monetary Penalty * ☐ Yes ☐ No	Date of Occurrence
Assessment * ☐ Yes ☐ No	Date of Occurrence
Program Debarment * ☐ Yes ☐ No	Date of Occurrence
Criminal Fine * ☐ Yes ☐ No	Date of Occurrence
Restitution Order * ☐ Yes ☐ No	Date of Occurrence
Pending Civil Judgment * ☐ Yes ☐ No	Date of Occurrence
Pending Criminal Judgment * ☐ Yes ☐ No	Date of Occurrence
Judgment Pending under False Claims Act * ☐ Yes ☐ No	Date of Occurrence

BILLING AGENT AGREEMENT

Section 8

If you utilize a Billing Agent or Clearinghouse please verify that you checked 'Yes' in the Third Party Billing segment of Section 4 and correctly completed the Billing Agent/Clearinghouse segment in Section 6, then complete the information below.

Billing Agent/Clearinghouse

I authorize the entity identified above to submit claims and/or other electronic transactions on my behalf as specified in Section 6 of this application. This authorization includes conducting any necessary follow-up with the NH Title XIX fiscal agent relative to submitted transactions. I understand that all payments will be made to me; Remittance Advices (RAs) will be delivered via the delivery media I selected in Section 4; and this agreement does not exempt me from the responsibility for claims filed on my behalf in accordance with established NH Title XIX billing policies. I further understand that the billing agent is held accountable to the same requirements of confidentiality and access to records that I am, as reflected in my agreement with the NH Title XIX Program. I will immediately notify the NH Title XIX fiscal agent of any change to this authorization.

Group Provider Applicant Name	Applicant Signature *	Date Signed *

APPLICATION SIGNATURE

Section 9

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

2. I authorize the NH DHHS Title XIX fiscal agent to verify the information contained herein. I agree to notify the NH DHHS Title XIX fiscal agent of any changes to information in this form within 30 days of the effective date of the change. I understand a change in my ownership status as an Individual or Group Provider may require a new application.

3. I am not currently subject to sanction under the NH Title XIX Program or debarred, suspended or excluded under any other federal agency or program, or otherwise prohibited from providing services for the NH Title XIX Program or other federal healthcare programs beneficiaries.

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

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

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

7. I certify that I am the individual practitioner who is applying for the NH Title XIX Provider number.
Additional Copies of this page may be made if necessary.

Signature of Officer, CEO, or General Partner of Group Provider *	Title	Date Signed

Ownership Information (Signature required for each Individual Owner)

Print Name	Signature	Date
Print Name	Signature	Date
Print Name	Signature	Date
Print Name	Signature	Date

Managing/Directing Employees (Signature required for each Managing/Directing Employee)

Print Name	Signature	Date
Print Name	Signature	Date
Print Name	Signature	Date
Print Name	Signature	Date

Authorized Representative (Signature required for each Authorized Representative)

Print Name	Signature	Date

Pharmacist-in-Charge (Signature required for each Pharmacist-in-Charge)

Print Name	Signature	Date

ELECTRONIC FUNDS TRANSFER (EFT) AGREEMENT

Providers who receive payment of claims via Electronic Funds Transfer from the NH Department of Health and Human Services' (he Department) Title XIX Program must agree to the following terms and conditions:

1. **Legal Compliance**. Provider shall abide by all Federal and State laws governing the NH Title XIX Program.
2. **EFT Information**. Provider will complete EFT information on this form and submit a bank letter or voided check from the account to which funds will be transferred.
3. **Non-provider Payee**. Designation of a payee other than the Provider shall not relieve the provider of any liability for acceptance of medical assistance payments under the NH Title XIX Program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future NH Title XIX payments (accounts receivable) due to Provider after agreeing to sell, transfer, or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be based solely upon the delivery by the provider of appropriate medical assistance under the NH Title XIX Program, and shall not include any cost of processing or be based on the percentage of amounts paid or upon collection of the payments.
4. **Acceptance of Funds**. Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the NH Title XIX Program. Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. Provider understands that payment will be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.
5. **Notice of Changes**. Provider will notify the Department in writing at least ten (10) days in advance of any changes in Payee, Payee's name or address, or bank account name or number (supported by a bank letter or voided check on the new account.
6. **Alternate Payment Methods**. For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the Department may substitute payment by check for EFT until the cause requiring the substitution has been satisfied as determined by the Department. Payment by check will be made to the billing address for payments on record with the Department.
7. **Incorporated Document**. This EFT Agreement is incorporated into the NH Title XIX Provider Participation Agreement and shall not modify or eliminate any provision of the NH Title XIX Provider Participation Agreement (including applicable Policies and Procedures manuals of the Department), except as specifically provided herein.
8. **Expiration or Termination of EFT**. Violation of these terms may cause termination of the EFT and/or the NH Title XIX Provider Participation Agreement by the Department. Expiration or termination of the NH Title XIX Provider Participation Agreement for any reason will terminate EFT automatically. The Department will give written notice of termination to the Provider.

Payee Name

Signature of Provider or Authorized Representative of Provider | Date signed

A bank letter or voided check must be submitted along with this agreement as a component of the authorization.

NH Medicaid Provider Relations
P.O. box 2059
Concord, NH 03302