



**STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
New Hampshire Medicaid Program**

## 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](#)
- 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.

**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.

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

**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.

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

**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.

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

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

**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.

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

**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.

**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.

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

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

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

**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).

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

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

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

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

**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.*