



Dear Provider Applicant:

Attached is the application for enrollment as a New Hampshire Title XIX (Medicaid and Healthy Kids-Gold) Program provider you requested. As this application was designed to collect enrollment information from all provider types, to decrease production costs and improve efficiency, not all information requested may apply to your provider type.

**If you are an out of state provider (outside of New Hampshire), please be certain to include either an original red and white claim form for services rendered to a recipient of Title XIX (New Hampshire Medicaid or Healthy Kids-Gold), or a detailed explanation as to why you wish to enroll as a New Hampshire Title XIX provider. All out of state Inpatient Hospital Admissions require a Prior Authorization. Please refer to “Hospital Form – In-Patient Hospitalization - Out of State Prior Authorization Request Form (272H).”**

The New Hampshire Department of Health and Human Services will automatically assign the effective date of enrollment unless a specific date is requested.

**NOTE:** If a temporary provider is going to continue on as a permanent provider, a new Provider Enrollment application is required. Locum Tenens are temporary providers.

Please hold this Provider Enrollment application until any pending State licensure activity has been completed. The application will be returned to you if all State survey or certification activities are not complete.

Please return the completed and signed application package to:

HP Enterprise Services  
Attention: Provider Enrollment  
PO Box 2040  
Concord, NH 03302-2040  
(603) 224-1747 or 1-800-423-8303 (NH and VT only)

**DID YOU REMEMBER TO:**

- Include a copy of your current professional license; if applicable (you must be licensed in the state in which you are providing services).
- Include a copy of your NPI number and Taxonomy from the Enumerator.
- Include a copy of your CLIA certificate for hospitals and independent laboratory services.
- Include an application for each individual provider, within your group, who is not already enrolled in the New Hampshire Title XIX program, if you are applying as a group.
- Sign and date both copies of the “Provider Enrollment Agreement” form (goldenrod).
- Include a “Trading Partner Agreement” and “NH Title XIX EDI Registration” form to be assigned a Trading Partner number to allow you to download your PDF Remittance Advice. Please indicate if you will be using this Trading Partner number to submit claims electronically (check the appropriate boxes). If you already have a Trading Partner number, please indicate the number on the NH Title XIX EDI Registration form.
- Review the entire application to ensure all sections that apply to your provider type have been completed.
- If a DME (Durable Medical Equipment) provider, please submit a catalog of the services you can provide, or a cover letter describing the services you can provide.
- Include a copy of CP575 or 147c Notice, if required. If tax exempt, please send a copy of your IRS exemption.

Failure to complete an applicable section may result in the return of the application and delay in enrollment.

If you need assistance or have questions, please contact the Provider Enrollment Specialist by using the above-noted address or telephone number.

## NEW HAMPSHIRE TITLE XIX (MEDICAID) PROGRAM PROVIDER ENROLLMENT APPLICATION

This application must be completed if you wish to become enrolled as a NH Title XIX (NH Medicaid and Healthy Kids Gold) Provider. This application may be used for both individual and group provider enrollments. If you need to enroll as both an individual provider and as a provider within a group, please be certain to check both the individual and group boxes as follow:

TO BE COMPLETED BY THE PROVIDER	
APPLICATION DATE: _____	REQUESTED EFFECTIVE DATE: _____
ENROLLING AS: <input type="checkbox"/> Individual <input type="checkbox"/> Group (Check both boxes if applying both as an individual provider and within a group.)	
APPLICATION FOR (check one):	
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Enrollment of Additional Location(s)
<input type="checkbox"/> Recertification	<input type="checkbox"/> Change of Information
<input type="checkbox"/> Tax ID Change – Please provide previous NH Title XIX PIN _____	<input type="checkbox"/> Change of Ownership
	<input type="checkbox"/> Other _____

TO BE COMPLETED BY HP ENTERPRISE SERVICES	PROVIDER ID NUMBER: _____
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### SECTION 1 - ADDRESS INFORMATION

**Please type, or clearly print, the following information:**

**A. PERSON COMPLETING THIS APPLICATION:**

NAME: \_\_\_\_\_ CONTACT PHONE #: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

TITLE: \_\_\_\_\_ CONTACT FAX #: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

**B. PROVIDER NAME AND STREET ADDRESS:** If an individual, the provider’s name and physical location is required. If a group or facility, the DBA name along with the physical location is required. The name in this field is used when submitting claims as the billing provider.

NAME OF APPLICANT: \_\_\_\_\_

ATTN: BUILDING, SUITE #: \_\_\_\_\_  
(Physical Practice Location)

NUMBER & STREET ADDRESS: \_\_\_\_\_

PO BOX (In addition to above-noted street address, if applicable): \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ PHONE NUMBER: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

**C. GROUP/FACILITY:** This name must match the FEIN. This address is also the “pay to” address, and is where provider payments will be mailed when different from the above physical address.

NAME OF GROUP/FACILITY: \_\_\_\_\_

ATTN: BUILDING, SUITE # (if applicable): \_\_\_\_\_

NUMBER & STREET ADDRESS (or PO Box): \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ PHONE NUMBER: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

**D. BILLING AGENT NAME & ADDRESS:** Only when applicable, however, **THIS INFORMATION IS MANDATORY IF A BILLING AGENCY IS SUBMITTING CLAIMS TO NH TITLE XIX FOR PROCESSING OR VERIFYING CLAIMS OR ELIGIBILITY INFORMATION ON THE PROVIDER’S BEHALF.**

AGENCY NAME: \_\_\_\_\_

ATTN: BUILDING, SUITE # (if applicable): \_\_\_\_\_

NUMBER & STREET ADDRESS (or PO Box): \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ PHONE NUMBER: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

**E. ADDITIONAL SERVICE LOCATION NAME & ADDRESS:** Check here  if deleting this practice location.

How many practice locations does this applicant utilize? \_\_\_\_\_ Please make a copy of this Section (D) and complete it for each additional practice location.

“Doing Business As” name for this location: \_\_\_\_\_

Medicare Identification Number for this location (if applicable): \_\_\_\_\_

Business Street Address Line 1: \_\_\_\_\_

Business Street Address Line 2: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code + 4: \_\_\_\_\_

Telephone #: \_\_\_\_\_ FAX #: \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Is this location a/an:  off site clinic?  distinct part unit?  multi-campus site?  branch?  
 location that files a consolidated cost report?  provider based facility?  designated receiving facility  
 or none of these?

Date applicant began practicing at this location (MM/DD/YYYY): \_\_\_\_\_

Date applicant ceased practicing at this location, if applicable (MM/DD/YYYY): \_\_\_\_\_

Check whether the applicant owns or leases this practice location:  Owns  Leases

**F. MEDICARE/MEDICAID PROGRAM INFORMATION:**

Does applicant now have, or has applicant ever had, a Medicare or Medicaid Provider number in this or any other state?  Yes  No If “Yes” supply all current and prior information requested below, as applicable.

**Current:**

Carrier Name \_\_\_\_\_

Intermediary Name \_\_\_\_\_

Medicaid Number/State \_\_\_\_\_

Medicare Number/State \_\_\_\_\_

**Prior:**

Carrier Name \_\_\_\_\_

Intermediary Name \_\_\_\_\_

Medicaid Number/State \_\_\_\_\_

Medicare Number/State \_\_\_\_\_

**SECTION 2 - PROVIDER DATA**

- **SOCIAL SECURITY NUMBER:** A Social Security number is required for federal tax purposes for all providers.

Social Security Number #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- **LICENSE:** The following information must correspond to the current license issued by the state in which the provider/facility practices, and is required if the provider type has a licensing requirement. Please ensure that copies of licenses are attached that cover all dates of enrollment requested.

License #: \_\_\_\_\_ State: \_\_\_\_\_ Effective Date: \_\_\_\_\_ End Date: \_\_\_\_\_

- **DRUG ENFORCEMENT AGENCY (DEA) NUMBER:**

DEA #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ End Date: \_\_\_\_\_

If you do not have a DEA number, please explain: \_\_\_\_\_

\_\_\_\_\_

A Provider Enrollment Specialist may contact you to obtain additional information.

- **GROUP CROSS REFERENCE NUMBERS:** If you are an individual provider enrolling within an active group, please complete this section and provide the NH Title XIX number(s) for all groups in which you wish to enroll:

Group #: \_\_\_\_\_ FEIN: \_\_\_\_\_ Begin Date: \_\_\_\_\_

Group #: \_\_\_\_\_ FEIN: \_\_\_\_\_ Begin Date: \_\_\_\_\_

- **FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):** If a group or facility is enrolling, if you are an individual providers enrolling within an active NH Title XIX group, or if you are an individual provider who wants to have claims processed under your tax ID#, a FEIN (Federal Employer Identification Number - Tax ID#) is required. The FEIN must match the name in Section 1-C. Please enter the FEIN effective and end date.

FEIN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Effective Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Individual providers enrolling within an active NH Title XIX group should skip to Section 3. All other enrolling providers must provide the following information:

- **GROUP AFFILIATION/CROSS REFERENCE NUMBERS:** Please complete the following **only** if you are **enrolling as a group practice:**

Please provide NH Title XIX provider numbers for all providers enrolling within your group. If the provider does not have a NH Title XIX provider ID number, a Provider Application Enrollment form must be completed for the individual provider. **Note:** The following provider types **cannot enroll as a group:** Audiologists, Certified Clinical Social Workers, Chiropractors, Occupational Therapists, Opticians, Optometrists, Podiatrists, Physical Therapists, Psychologists, Speech Therapists, and Interpreters.

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

- **NATIONAL ASSOCIATION OF BOARDS OF PHARMACY (NABP) NUMBER:** \_\_\_\_\_

- **CLIA** (Clinical Laboratory Improvement Amendments) certificate: A current CLIA certificate (HCFA-116) is required when a hospital, independent laboratory, or physician office which performs non-waivered laboratory services under CLIA is enrolling. Please include photocopies of all CLIA certificates that cover all dates of enrollment requested.

CLIA # (10 digits): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Effective Date: \_\_\_\_\_ End Date: \_\_\_\_\_

- **OWNERSHIP TYPE:** (circle one)

A - Public-Federal, State, or Municipal

D - Corporation

B - Charitable, Non-Profit Making or Religious Organization

E - Partnership

C - Sole Proprietor

F - Other (please specify): \_\_\_\_\_

- **PRIVATE PRACTICE:** (circle one) **YES** **NO**

- **NON-PROFIT ORGANIZATION:** (circle one) **YES** **NO**

- **TAX EXEMPT STATUS:** Please attach a copy of your IRS issued exemption, if applicable.

- **FISCAL YEAR END:** \_\_\_\_\_

- **MEDICARE PARTICIPATION:** If you have an active Medicare provider number and want your Medicare claims to cross over to the NH Title XIX program, please provide the following information:

Medicare Part **A** and/or **B** (circle one or both as applicable)

Medicare Provider ID#: \_\_\_\_\_ Begin Date: \_\_\_\_\_



**SECTION 4 - OWNERSHIP INFORMATION**

**All applicants must submit a copy of the document received from the IRS which provided their tax ID number, for example: Form CP 575 or 147C Notice. Copy of W-9 is not acceptable.**

**Please complete the following information for each person with an ownership or control interest of 5% or more in the business entity desiring to enroll. If more than one person, please copy and complete the following information for each person.**

How many owners have 5 percent or more ownership interest in this entity? \_\_\_\_\_  
(maximum of 20)

Please complete the following for each owner who has 5% or more ownership interest in this entity.

- Identifying information:

Owner Name: \_\_\_\_\_  
First Middle Last Jr/Sr/MD/DO/etc.

Other Name: \_\_\_\_\_  
First Middle Last Jr/Sr/MD/DO/etc.

Date of Birth: \_\_\_\_\_ State of Birth: \_\_\_\_\_ County of Birth: \_\_\_\_\_  
(MM/DD/YYYY)

Legal Business Name: \_\_\_\_\_

“Doing Business As” (DBA) Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employer Identification Number: \_\_\_\_\_

Medicare Identification Number (if applicable): \_\_\_\_\_

Are any of the persons with an ownership or controlling interest in the provider’s company related to one another as spouse, parent, child or sibling? If so, please list their names and relationship to you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_

- Does this owner **now have**, or has this owner ever had, a Medicare or Medicaid provider number in this or any other state?  Yes  No If “Yes,” supply all current and prior information as requested below, as applicable.

Current Carrier Name: \_\_\_\_\_

Prior Carrier Name: \_\_\_\_\_

Current Fiscal Intermediary Name: \_\_\_\_\_

Prior Fiscal Intermediary Name: \_\_\_\_\_

Current Medicaid #/State: \_\_\_\_\_ Prior Medicaid #/State: \_\_\_\_\_

- Has this owner ever **managed or directed other organizations** that have billed, or are currently billing, Medicare or Medicaid for services?  Yes  No If “Yes,” how many? \_\_\_\_\_

**Please copy and then complete the following information for each organization this owner managed or directed in the last 10 years. If this list of organizations is incomplete, please check here indicating that some information for the last 10 years is missing.**

Organization’s Legal Business Name: \_\_\_\_\_

Date Associated (MM/DD/YYYY): From \_\_\_\_\_ To \_\_\_\_\_

Employer Identification #: \_\_\_\_\_ Medicare Identification #: \_\_\_\_\_

Current Medicaid #/State: \_\_\_\_\_ Prior Medicaid #/State: \_\_\_\_\_

Current Carrier Name: \_\_\_\_\_

Prior Carrier Name: \_\_\_\_\_

Current Fiscal Intermediary Name: \_\_\_\_\_

Prior Fiscal Intermediary Name: \_\_\_\_\_

- Has this owner ever **had ownership in** other organizations that have billed, or are currently billing, Medicare or Medicaid for services?  Yes  No If "Yes," how many? \_\_\_\_\_

**Please copy and then complete this information for each organization this owner has had ownership in during the last 10 years. If this list of organizations is incomplete, please check here indicating that some information related to the last 10 years is missing.**

Organization's Legal Business Name: \_\_\_\_\_

Date Associated (MM/DD/YYYY): From \_\_\_\_\_ To \_\_\_\_\_

Employer Identification #: \_\_\_\_\_ Medicare Identification #: \_\_\_\_\_

Current Medicaid #/State: \_\_\_\_\_ Prior Medicaid #/State: \_\_\_\_\_

Current Carrier Name: \_\_\_\_\_

Prior Carrier Name: \_\_\_\_\_

Current Fiscal Intermediary Name: \_\_\_\_\_

Prior Fiscal Intermediary Name: \_\_\_\_\_

- Please identify the name and address of any owner of the business entity desiring to enroll who has a direct or indirect ownership of 5% or more of a subcontractor to the business entity desiring to enroll.

Name: \_\_\_\_\_

Attn: Building, Suite #: \_\_\_\_\_

Number & Street Address: \_\_\_\_\_

PO Box (In addition to above-noted street address, if applicable): \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone Number: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

Do any of the persons with an ownership interest or control interest in the provider's company have ownership of 5% or more in a subcontractor to the provider's company? If so, is/are such person(s) related to the owners of the subcontractor company as spouse, parent, child or sibling? If so, please list their names and relationship to you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THE FOLLOWING QUESTIONS MUST BE ANSWERED COMPLETELY IN ORDER TO ENROLL IN THE NH MEDICAID AND HEALTHY KIDS-GOLD (NH TITLE XIX) PROGRAM.**

Failure to provide any of the following information will cause your application to be returned, unprocessed, to you for completion.

- Has the applicant, agent, or managing employee of the enrolling provider ever been convicted, assessed, or excluded from a Medicare/Medicaid program due to fraud, obstruction of an investigation, or a controlled substance violation?

Yes     No    If "Yes," please furnish the following information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(First, Middle, Last, Jr./Sr./etc.)

Program excluded from (check all that apply):     Medicare     Medicaid \_\_\_\_\_  
(name of state)

- Check if the applicant has ever had any of the following adverse legal actions imposed by Medicare, Medicaid (in any state), any licensing board in any state, or any other federal agency or program. **Next to each box checked, write the date the adverse legal action was imposed. Check all that apply, or the "none of these" box. Attach a copy** of all adverse legal action notifications, including notification of pending actions.

- Administrative sanction(s), including Board discipline: \_\_\_\_\_  
 Program exclusion(s) - by the Office of Inspector General \_\_\_\_\_  
by any other state? \_\_\_\_\_

Please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Suspension of payment(s) \_\_\_\_\_     Assessment(s) \_\_\_\_\_  
 Civil monetary penalty(s) \_\_\_\_\_     Program debarment(s) \_\_\_\_\_

- Health Care Related:  
 Criminal fine(s) \_\_\_\_\_     Pending criminal judgment(s) \_\_\_\_\_  
 Restitution orders(s) \_\_\_\_\_     Pending civil judgment(s) \_\_\_\_\_  
 Judgment(s) pending under the False Claims Act: \_\_\_\_\_

- None of these:**

- Does the applicant have any outstanding criminal fines?     Yes     No  
Restitution orders?     Yes     No

- Has the applicant, agent, or managing employee of the enrolling provider ever been convicted of any criminal offense related to the person's involvement in any program under Title XVIII – Medicare, Title XIX – Medicaid, Title XX - Block Grants for Social Services, or any other health care services or programs?  
 Yes     No

- Does the applicant, under any name or business identity, have any outstanding overpayments with Medicare, Medicaid, or any other federal program?     Yes     No

If "Yes," under what federal program?  
\_\_\_\_\_

If "Yes," under what name?  
\_\_\_\_\_

**SECTION 5 - SIGNATURE**

**CERTIFICATION**

For the purpose of establishing eligibility to receive direct payment for services rendered to recipients of the New Hampshire (NH) Title XIX Program, I certify that the information furnished in this application is true, accurate, and complete to the best of my knowledge. I understand that it is my responsibility to notify NH Medicaid's Fiscal Agent of any changes to the information on this application, including but not limited to: name, address, group affiliation, or change in ownership.

\_\_\_\_\_  
Type or print name of individual provider enrolling, or if a group, the owner/administrator's name.

\_\_\_\_\_  
Signature (Required)

\_\_\_\_\_  
Date (Required)

\_\_\_\_\_  
Title

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

**Note:** The above-noted name and signature must be the same as the name and signature placed on the NH Medicaid Program Provider Enrollment Agreement.

**SECTION 6 – BILLING AGENT AGREEMENT**

Will a billing agent be submitting all or part of your claims? (circle one)      **YES**      **NO**

If **YES** is circled, please be certain the billing agent's address and phone number have been entered correctly in Section 1-C.

\_\_\_\_\_  
Billing Agent's Name (Please print or type)

I authorize the above-stated billing agent to submit claims and to follow up with New Hampshire (NH) Medicaid and/or the NH Medicaid Fiscal Agent on my behalf. I understand that all payments will be made to me, Remittance Advises (RA's) will be sent directly to the accounting address I have listed, and that this agreement does not exempt me from the responsibility for claims filed on my behalf or from established claim filing policy. I further understand that the billing agent must be held to the same requirements of confidentiality and access to records that I am, as reflected in my agreement with NH Medicaid. I will immediately notify NH Medicaid's Fiscal Agent of any change to this authorization and will supply updated lists of authorized names and signatures as changes occur.

\_\_\_\_\_  
Provider Name (Please print or type)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEW HAMPSHIRE MEDICAID PROGRAM PROVIDER ENROLLMENT AGREEMENT

This is to certify that \_\_\_\_\_ of \_\_\_\_\_
Name of Provider Street Address

\_\_\_\_\_ agrees to participate in the New Hampshire Medicaid and/or
City, State, and Zip Code

Healthy Kids-Gold Program, hereinafter referred to as the NH Title XIX Program.

I agree that my fees or charges for services or items delivered to NH Title XIX recipients will not exceed my fees or charges for similar services or items delivered to non-NH Title XIX individuals.

I agree that in any case or cases where it becomes necessary for State or Federal representatives to ascertain the appropriateness and necessity of care or services, the Department or its authorized representatives such as, the New Hampshire Foundation for Medical Care (PRO), or any other entity designated by the Department will determine the appropriateness and necessity of care or services.

I agree to keep such records as are necessary to fully disclose the extent of the care or services provided to individuals under the NH Title XIX Program and to furnish the Department with such information regarding any payment claimed, as may be requested.

I agree that as a condition of NH Title XIX Program participation, I will disclose, within 35 days of the date on a request by the Secretary or the Department, ownership information including full and complete information about the ownership of any subcontractor or wholly-owned supplier with whom I have had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request, ownership information and any significant business transactions between myself and any wholly owned supplier, or between myself and any contractor, during the 5-year period ending on the date of the request.

I agree to maintain current required permits, licenses, certifications, or other documentation as required by applicable State and Federal laws which allows me to continue in my practice.

I agree to disclose to the Department the name of any owners officers, directors, agents, and managing employees of my business who have been convicted of fraud against any programs under Titles XVIII, XIX, or XX of the Social Security Act.

I acknowledge that I may be suspended or terminated from participation in the NH Title XIX Program if convicted of a criminal offense under the Medicare or Title XIX Program, or if the Department has administratively determined that fraud exists. In addition, I acknowledge and agree that this agreement may be terminated by either party without cause with a sixty (60) day written notice to the other party.

I agree not to sell my accounts receivable for NH Title XIX Program patients to bill collection agencies or similar entities.

I agree to abide by all rules, regulations, billing manuals, and bulletins promulgated by the Department pertaining to the provision of care or services under NH Title XIX and the claiming of payments for those services.

I agree to accept payments made by NH Title XIX as payments in full for the services or items I may provide, and to retain records supporting each bill for a period of not less than six years.

I agree to provide services or items without discrimination as required by Title VI of the Civil Rights Act of 1964, and without discrimination on the basis of handicap as required by Section 504 of the Rehabilitation Act of 1973 as amended.

I agree that the US Department of Health and Human Services, its authorized representatives, those of the New Hampshire Department of Health and Human Services, and the Medicaid Fraud Control Unit of the New Hampshire Attorney General's Office will have access to the same records and information as does the New Hampshire Department of Health and Human Services.

I acknowledge that enrollment is not transferable and terminates upon date of sale of practice or transfer of ownership.

This agreement becomes effective on the date of enrollment, as entered by the authorized agent of the Department, when the signature of the authorized agent of the Department is affixed.

FOR PROVIDERS OF SERVICES USE ONLY

Signature Authorized Provider/Owner/Administrator Date
Title of Authorized Provider/Owner/Administrator

FOR NH DEPARTMENT OF HEALTH AND HUMAN SERVICES USE ONLY

Authorized Department Signature Date
Title of NH Title XIX Agent
Effective Date of Enrollment



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEW HAMPSHIRE MEDICAID PROGRAM PROVIDER ENROLLMENT AGREEMENT

This is to certify that \_\_\_\_\_ of \_\_\_\_\_
Name of Provider Street Address

\_\_\_\_\_ agrees to participate in the New Hampshire Medicaid and/or
City, State, and Zip Code

Healthy Kids-Gold Program, hereinafter referred to as the NH Title XIX Program.

I agree that my fees or charges for services or items delivered to NH Title XIX recipients will not exceed my fees or charges for similar services or items delivered to non-NH Title XIX individuals.

I agree that in any case or cases where it becomes necessary for State or Federal representatives to ascertain the appropriateness and necessity of care or services, the Department or its authorized representatives such as, the New Hampshire Foundation for Medical Care (PRO), or any other entity designated by the Department will determine the appropriateness and necessity of care or services.

I agree to keep such records as are necessary to fully disclose the extent of the care or services provided to individuals under the NH Title XIX Program and to furnish the Department with such information regarding any payment claimed, as may be requested.

I agree that as a condition of NH Title XIX Program participation, I will disclose, within 35 days of the date on a request by the Secretary or the Department, ownership information including full and complete information about the ownership of any subcontractor or wholly-owned supplier with whom I have had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request, ownership information and any significant business transactions between myself and any wholly owned supplier, or between myself and any contractor, during the 5-year period ending on the date of the request.

I agree to maintain current required permits, licenses, certifications, or other documentation as required by applicable State and Federal laws which allows me to continue in my practice.

I agree to disclose to the Department the name of any owners officers, directors, agents, and managing employees of my business who have been convicted of fraud against any programs under Titles XVIII, XIX, or XX of the Social Security Act.

I acknowledge that I may be suspended or terminated from participation in the NH Title XIX Program if convicted of a criminal offense under the Medicare or Title XIX Program, or if the Department has administratively determined that fraud exists. In addition, I acknowledge and agree that this agreement may be terminated by either party without cause with a sixty (60) day written notice to the other party.

I agree not to sell my accounts receivable for NH Title XIX Program patients to bill collection agencies or similar entities.

I agree to abide by all rules, regulations, billing manuals, and bulletins promulgated by the Department pertaining to the provision of care or services under NH Title XIX and the claiming of payments for those services.

I agree to accept payments made by NH Title XIX as payments in full for the services or items I may provide, and to retain records supporting each bill for a period of not less than six years.

I agree to provide services or items without discrimination as required by Title VI of the Civil Rights Act of 1964, and without discrimination on the basis of handicap as required by Section 504 of the Rehabilitation Act of 1973 as amended.

I agree that the US Department of Health and Human Services, its authorized representatives, those of the New Hampshire Department of Health and Human Services, and the Medicaid Fraud Control Unit of the New Hampshire Attorney General's Office will have access to the same records and information as does the New Hampshire Department of Health and Human Services.

I acknowledge that enrollment is not transferable and terminates upon date of sale of practice or transfer of ownership.

This agreement becomes effective on the date of enrollment, as entered by the authorized agent of the Department, when the signature of the authorized agent of the Department is affixed.

FOR PROVIDERS OF SERVICES USE ONLY

Signature Authorized Provider/Owner/Administrator Date
Title of Authorized Provider/Owner/Administrator

FOR NH DEPARTMENT OF HEALTH AND HUMAN SERVICES USE ONLY

Authorized Department Signature Date
Title of NH Title XIX Agent
Effective Date of Enrollment



**HP Enterprise Services  
PO Box 2040  
Concord, NH 03302-2040  
Attn: Provider Enrollment**

First Class  
U.S. Postage  
PAID  
Permit #1425  
Concord, NH