



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 a claim 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.

The New Hampshire Department of Health and Human Services will automatically assign the effective date of enrollment unless a specific date is requested. In order for a specific enrollment date to be considered, a valid claim for Title XIX covered services must be attached to the application.

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:

Electronic Data Systems
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 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) and the “NH Medicaid Electronic Billing - Provider Agreement” form.
- Sign and date the “Electronic Claims Submission Registration” form if not currently enrolled to submit electronic claims.
- 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.

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: Individual Group (Check both boxes if applying both as an individual provider and within a group.)

APPLICATION FOR (check one): Initial Enrollment Enrollment of Additional Location(s) Change of Ownership

Recertification Change of Information Other _____

Tax ID Change – Please provider previous NH Title XIX ID # _____

TO BE COMPLETED BY EDS

PROVIDER ID NUMBER: _____

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.

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 Remittance Advices (RA’s) 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.**

AGENCY NAME: _____

ATTN: BUILDING, SUITE # (if applicable): _____

NUMBER & STREET ADDRESS: _____

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 **can not 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 3 - MEDICAL SPECIALTIES

FOR PROVIDERS OF PHYSICIAN SERVICES ONLY: Please write the number(s) that correspond to the area(s) in which you specialize next to the specialty type:

1 = Primary		2 = Secondary		3 = Additional specialty	
___ 001 General Practice	___ 018 Ophthalmology	___ 034 Urology	___ 073 Day Habilitation Centers		
___ 002 General Surgery	___ 019 Dentists	___ 047 Chiropractic	___ 075 Medical Service Clinic		
___ 003 Allergy	___ 020 Orthopedic Surgery	___ 048 Podiatry-Surgical Chiropody	___ 078 Nurse - Group		
___ 004 Otology, Laryngology, Rhinology	___ 021 Pathologic Anatomy, Clinical Pathology	___ 049 Pediatrics	___ 079 Adult Medical Day Care		
___ 005 Anesthesiology	___ 022 Pathology	___ 061 Oral Surgery	___ 080 Advanced Registered Nurse Practitioner (ARNP)		
___ 006 Cardiovascular Disease	___ 023 Peripheral Vascular Diseases or Surgery	___ 062 Endodontics	___ 081 Respite Care		
___ 007 Dermatology	___ 024 Plastic Surgery	___ 063 Pedodontics	___ 082 Home Health Agency		
___ 008 Family Practice	___ 025 Physical Medicine and Rehabilitation	___ 064 Orthodontics	___ 083 Home & Community Based Care, Developmentally Disabled (HCBC-DD)		
___ 010 Gastroenterology	___ 026 Psychiatry-Psychology	___ 065 Periodontics	___ 084 Home and Community Based Care, Elderly and Chronically Ill (HCBC-ECI)		
___ 011 Internal Medicine	___ 027 Psychiatry-Neurology	___ 066 Prosthodontics	___ 085 Interpreter Services		
___ 012 Manipulative Therapy	___ 028 Proctology	___ 067 Oral Pathology	___ 087 Hearing Aid Services		
___ 013 Neurology	___ 029 Pulmonary Diseases	___ 068 Public Health	___ 088 Optometrist/Optician		
___ 014 Neurological Surgery	___ 030 Radiology	___ 069 Mental Health	___ 089 Ambulatory Surgery		
___ 015 Family Planning	___ 031 Roentgenology, Radiology	___ 070 Clinic or Other Group Practice	___ 096 1-99 Bed Count		
___ 016 Ob-Gynecology	___ 032 Radiation Therapy	___ 071 CHAP	___ 097 100-249 Bed Count		
___ 017 Otology, Laryngology, Rhinology, Ophthalmology	___ 033 Thoracic Surgery	___ 072 Child Health	___ 098 250 and More Bed Count		
			___ 099 Other – please explain: _____ _____		

Please provide a brief description of the services you will be providing to the Title XIX population. If you are an interpreter of any language, please indicate which language(s). A Provider Enrollment Specialist will contact you if we have any further questions.

SECTION 4 - OWNERSHIP INFORMATION

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

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

• 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.

1. 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) _____

2. 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: _____

3. 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 Internal Revenue Services (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. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to NH Title XIX recipients are not greater than charges for services to non-NH Title XIX individuals, the New Hampshire Department of Health and Human Services, hereinafter referred to as the Department, or its authorized representatives will be used to make such determinations.

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

FOR NH DEPARTMENT OF HEALTH AND HUMAN SERVICES USE ONLY

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

_____ 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

_____, City, State, and Zip Code agrees to participate in the New Hampshire Medicaid and/or
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. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to NH Title XIX recipients are not greater than charges for services to non-NH Title XIX individuals, the New Hampshire Department of Health and Human Services, hereinafter referred to as the Department, or its authorized representatives will be used to make such determinations.

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.

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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.

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FOR PROVIDERS OF SERVICES USE ONLY

FOR NH DEPARTMENT OF HEALTH AND HUMAN SERVICES USE ONLY

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

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

