# MEDICAID NEW HAMPSHIRE (MCDNH) PRE-ENROLLMENT INSTRUCTIONS

## WHICH FORMS SHOULD I COMPLETE?

- Billing Agent Agreement
- Letter to New Hampshire Medicaid
    - MUST contain the following:
    - Check “Billing Agent/Clearinghouses” in Section 6
        - NH Medicaid ID
        - Provider Name
        - Requested Transaction(s) 837 and/or 835
            - ERA Application required if ERA is requested

## WHERE SHOULD I SEND THE FORM(S)?

- The Billing Agent Agreement can be mailed to:

  NH Medicaid Provider Relations

  PO Box 2059

  Concord, NH 03302-2059

## WHAT IS THE TURNAROUND TIME?

- Standard processing time is approximately 7-10 business days

## HOW DO I CHECK STATUS?

- Contact NH Medicaid Provider Enrollment at (866) 291-1674 or (603) 223-4774 and ask if you have been linked to Office Ally’s Submitter ID **NH100679**
- **Upon approval, you MUST contact Office Ally at (360) 975-7000 option 1 and inform them of the approval PRIOR to submitting claims electronically. Failure to do so will result in claim rejections.**

New Hampshire Medicaid Program

## Billing Agent Agreement

All Providers that use a billing agent or clearing house must print and sign the Billing Agent Agreement. Only original signatures will be accepted. Copied or stamped signatures are not acceptable.

* Required Field

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

Office Ally - TPA NH100679

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.

| Provider Name | Provider/Authorized Representative Signature | Date Signed * |
|---|---|---|
| | | |

NH Medicaid Provider Relations
P.O. Box 2059
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