Office Ally

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
Concord, NH 03302-2059

New Hampshire Title XIX Medicaid Program

ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT APPLICATION

Providers who receive Electronic Remittance Advice from the NH Department of Health and Human Services' (The Department) Title XIX Program must agree to the following terms and conditions:

1. **ERA Information.** Provider will complete ERA information on this form and send in the ERA Signature Page through mail.
2. **CCD+ Format**. Provider will contact its financial institution/bank to arrange for the delivery of the information from the CCD+ EFT that is necessary for successful re-association of the EFT payment with the ERA remittance advice. The information that the bank must return is as follows:

CORE-required Minimum CCD+ Re-association Data Elements		**Corresponding v5010 X12 835 Data Elements**	
CCD+ Record #	**Field #**	Field Name	Data Element Segment Position, Number & Name
5	9	Effective Entry Date	BPR16-373 Date (EFT Effective Date)
6	6	Amount	BPR02-782 Monetary Amount (Total Actual Provider Payment Amount)
7	3	Payment Related Information	TRN Re-association Trace Number Segment

   TRN segment consists of Check or EFT trace number/Payer Identifier/optional supplemental code. These pieces of information will match what is received in the ERA (835) transaction for easy re-association. Providers must contact their financial institution to arrange for the delivery of the minimum required fields for re-association. The banks will not automatically supply this detail and it is required that the provider work out how this information will be obtained (email, e-statement, electronically, etc.).
3. **Late/Missing ERA**. In case of a late or missing ERA, the Provider will contact the Provider Relations call center at 866-291-1674. Late or missing is defined as a maximum elapsed time of four (4) business days following the receipt of EFT.
4. **Change/Cancel Enrollment**. If any changes are required to ERA enrollment information, the Provider will contact the Provider Relations call center at 866-291-1674.
5. **TIN/FEIN.** Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) field in the ERA section is equivalent to Social Security Number (SSN) for Individual Providers and Federal Employer Identification # (FEIN) for Group Providers.

1. Provider Information:

*Provider Name

Doing Business As Name (DBA)

Provider Address:

*Street

*City

*State/Province

*Zip Code/Postal Code

2. Provider Identifier Information:

*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI)

Provider License Number

License Issuer

Provider Type

Provider Taxonomy Code

3. Provider Contact Information:

*Provider Contact Name

Title

*Telephone Number

Telephone Number Extension

Email Address

Fax Number

4. Electronic Remittance Advice Information:

* Preference for Aggregation of Remittance Data

☒ Provider Tax Identification Number (TIN)

5. Submission Information:

Reason for Submission

☒ New Enrollment

Authorized Signature

Written Signature of Person Submitting Enrollment