



## NH Medicaid Provider Payment Agreement for the MMIS Transition

<b>Provider Name:</b>		<b>Provider ID (Hewlett Packard):</b>	
<b>Practice/Group Name:</b>		<b>Provider ID (Xerox) (if available):</b>	
<b>Contact Person:</b>		<b>Provider Type:</b>	
<b>Phone:</b>		<b>E-mail (if available):</b>	
<b>Name of Billing Agent or Trading Partner (if applicable):</b>			
DEADLINE for transition and/or contingency payment: <b>Monday, February 25, 2013.</b>			
DEADLINE for contingency payment only: <b>Monday, April 1, 2013.</b>			
Please sign and either scan and e-mail to: nhproviderrelations@xerox.com, or fax to: 1-866-446-3318			
This is an agreement between the NH Medicaid provider (named above) and the Department of Health and Human Services for weekly payments occurring for the period of time when the MMIS will not accept claims or distribute payments.			
I, _____ (Provider Name) of _____ (Practice/ Group Name):			
<p>(1) Attest that there are no outstanding investigations against me or my practice by either the State of NH or Federal officials.</p> <p>(2) Will continue to abide the State of NH and Federal requirements as states in my Provider Enrollment Agreement.</p> <p>(3) Elect to receive with the following justification of need:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Transition payment – a pre-payments made at the beginning of the blackout period occurring from March 8, 2013 through April 1, 2013</p> <p style="margin-left: 20px;"><input type="checkbox"/> Contingency payments – weekly pre-payments made in the event of an extended blackout period starting after April 1, 2013 and concluding once the Health Enterprise is operational.</p> <p style="margin-left: 20px;"><input type="checkbox"/> Both transition payments and contingency payments</p> <p>(4) Attest to the need for financial support in accordance with my selection (3) above and that the following justification of need is true: _____</p> <p>(5) Understand:</p> <p style="margin-left: 20px;">The payments accepted in accordance with this agreement are for services to be rendered during the blackout period and will be discontinued once the MMIS is fully operational.</p> <p style="margin-left: 20px;">The amount of the each payment is a weekly average payment determined by the Department.</p> <p style="margin-left: 20px;">The payment will be recouped by the Department as follows:</p> <p style="margin-left: 20px;">For transition payments only –over a 4 week period beginning with the first financial cycle in April 2013.</p> <p style="margin-left: 20px;">For contingency payments alone or in addition to transition payments – Over a period of time that is at least four weeks in length and proportion to the total blackout period.</p> <p>(6) Have either:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Submitted my NH Medicaid Provider re-enrollment application with Xerox; or</p> <p style="margin-left: 20px;"><input type="checkbox"/> Re-enrolled as a NH Medicaid provider with Xerox.</p> <p>(7) Waive my right to appeal the amount, duration, and recoupment method of the payments accepted under this agreement.</p> <p>(8) Agree to continue to abide by the State and Federal requirements as stated in my Provider Enrollment Agreement.</p> <p>(9) Attest that the information provided in this agreement is true and accurate.</p>			
The Department of Health and Human Services is not responsible for the completeness of this form. Providers submitting incomplete forms are not eligible for this payment.			
<b>Name of Authorized Person (Please print):</b>		<b>Date :</b>	
<b>Signature of Authorized Person (Named above):</b>		<b>Date:</b>	