STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth and Families

Form 2679
February 2017

Provider Web Billing User Account Request
Create, Change or Terminate Account

Complete the information below to request a new user logon account or to change an existing account.

USER INFORMATION

User First Name | Middle Initial | User Last Name

User Email Address | User Telephone Number

PROVIDER INFORMATION

Provider Business Name | Provider Contact Name

Street Address | City | State | Zip Code

Provider Email Address | Telephone Number

Effective Date of Requested Action | Last 4 of Social Security Number or Federal Identification Number

Provider Resource Identification Number | Provider Resource Identification Number | Provider Resource Identification Number

Provider Resource Identification Number | Provider Resource Identification Number | Provider Resource Identification Number

SERVICE(S) PROVIDED

Check as many as necessary.

- ☐ Adolescent Community Therapeutic Services
- ☐ Child Health Support
- ☐ Home Based Therapeutic
- ☐ Individual Service Option In-Home
- ☐ Therapeutic Day Treatment
- ☐ Adoptive History Report
- ☐ Clinics/Groups
- ☐ Residential Services
- ☐ Employment Related Child Care
- ☐ Preventive and Protective Child Care

ACTION REQUESTED

Designate the action by marking a circle. Select the access level by marking a square.

○ **Create New User Logon & Password**
(Use this to create a new user account. Mark one square only.)

- ☐ View Only
- ☐ View & Enter Claims
- ☐ View, Enter & Submit Claims
- ☐ Read Remittance Advice Only

○ **Change Role(s)**
(Use this to change an existing user account. Mark one square only.)

- ☐ View Only
- ☐ View & Enter Claims
- ☐ View, Enter & Submit Claims
- ☐ Read Remittance Advice Only

○ **Terminate User Account**

Provider Web Billing User Account Request

Terms and Conditions Governing the Use of the Provider Web Billing Application

1. I understand that provider billing requirements are governed by administrative rules (He-C 6339, He-C 6340, He-C 6348, He-C 6350, He-C 6914) which is incorporated herein by reference and I agree to abide by these requirements.

2. I understand and agree that as a provider, I am responsible for any and all billing invoices submitted by me or on my behalf by my authorized representative, whether user is an employee authorized as a billing representative or authorized billing representative of a management service company.

3. I understand and agree that any payments made which are based on inaccurate or fraudulent billing, whether submitted by me or by my authorized user will be recovered from me by DHHS.

4. I understand and agree that it is my responsibility to notify the Division for Children, Youth and Families by contacting Provider Relations when a user no longer requires access to the web billing application.

5. I understand that by submitting an invoice via the Provider Web Billing Application I am certifying that the invoice is true and accurate.

6. I understand and agree that information obtained via the Provider Web Billing Application is confidential and can be used solely for the purposes of administering Division for Children, Youth and Families (DCYF) Services.

7. I understand and agree that I am responsible for my authorized representative, employee, and/or any management service company's use of the Provider Web Billing Application.

8. I understand and agree that I must access my web account at least every ninety (90) days or my account will be de-activated.

Signature of User	Date
Signature of Authorized Provider	Date

This space is reserved for use by DHHS Personnel

Signature of State Authorizing Official	Date

Provider Web Billing User Account Request Instructions

PURPOSE:

The Provider Web Billing User Account Request is used to authenticate a user which enables the user to access the Department of Health and Human Services, Division for Children Youth and Families (DCYF) provider web billing application.

INSTRUCTIONS:

This form is used by providers to request one of the actions described in the Action Requested Section.

User Information Section

- Enter the user first name, middle initial, and user last name, user email address and user telephone number for whom the logon is sought.

Provider Information Section

- Enter the provider business name and contact name. Individual providers can leave the business name blank.
- Enter the provider's address.
- Enter the provider's email address and telephone number.
- Enter the provider's last four of the Social Security Number (individuals) or Federal Identification Number (agencies).
- Enter all Resource Identification numbers for the services identified.

Action Requested Section

Designate the action by marking a circle. There are three different actions that can be requested.

Select the access level by marking a square. Check the square identifying the service(s) that needs to be accessed via Provider Web Billing.

Terms and Conditions Section

By signing this form you are agreeing to the terms and conditions as specified in the Provider Agreement.

Signature Section

The person whose name was entered in the User Information Section must sign the form in the Signature of User space and enter the date of the signature. Providers working for an agency must have the user's supervisor sign in the Authorized Provider space. If the user is an employee or authorized representative of the provider, the signature of the authorized provider is required.

Approval Section

Do not write in this section. This space is reserved for the use of DHHS personnel authorized to grant user access to Provider Web Billing.

Distribution

Make a copy of this form for your records and mail the original to:

For Employment Related:
NH Department of Health and Human Services
DCYF CDB Provider Relations
129 Pleasant Street
Concord, NH 03301

For Preventive and Protective
NH Department of Health and Human Services
DCYF Provider Relations
129 Pleasant Street
Concord, NH 03301