NON-PARTICIPATING PROVIDER ACTIVATION FORM

You must submit this completed form and a copy of your W-9 via fax to **866-779-5948** or via e-mail to **NHProvider.Enrollment@wellsense.org**. If you do not , this will cause a delay in the processing of your claims.

Date of Request _____ **Referral/Auth. #** _____

Requested By _____ **Department:** _____

Member Name _____ **Member ID #:** _____

Member Plan _____

Are you in process of contracting? ☐ Yes ☐ No

Provider Information

Please complete all applicable fields below. Fields highlighed in yellow are required. Failure to provide this information will result in delays and/or the inability to process your request.

Entity ☐ Practitioner ☐ Facility ☐ Group

Provider Name _____

Provider NPI # _____

Provider Title (i.e. MD, DMO, PA) _____

Group Name (if applicable) _____

Provider's SSN _____ **License #** _____

Provider's DOB _____ **Specialty** _____

NH Medicaid ID _____ **Gender** _____

Email Address _____ *Your e-mail address is required to receive notification so that you may submit claims.*

Primary Practice

Physical address where members will be receiving their service, P.O. Box is not accepted.

Address Line 1 _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Office Contact _____ **Office Phone** _____

Office Fax _____

Billing Information

Billing Name _____

Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Billing Contact _____ **Phone** _____

TAX ID _____ **Fax** _____

Please Attach Copy of W-9 Form

Comments (Include here)

Providers may not bill or balance-bill New Hampshire Medicaid members for any covered service. In addition, non-contracted providers treating members of Well Sense Health Plan must obtain prior-authorization before delivering services to Plan members. You may contact the Prior-Authorization team by phone at 877-957-1300 and choosing option#3. Failure to obtain prior authorization may result in a denial of your claim.