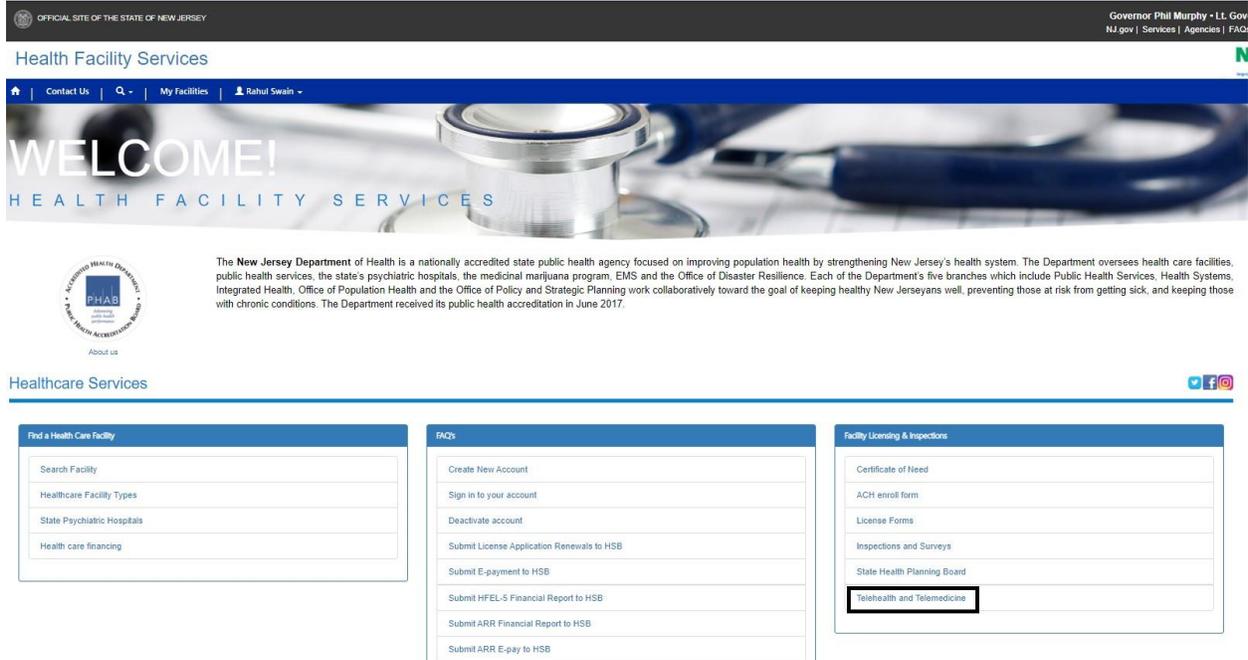
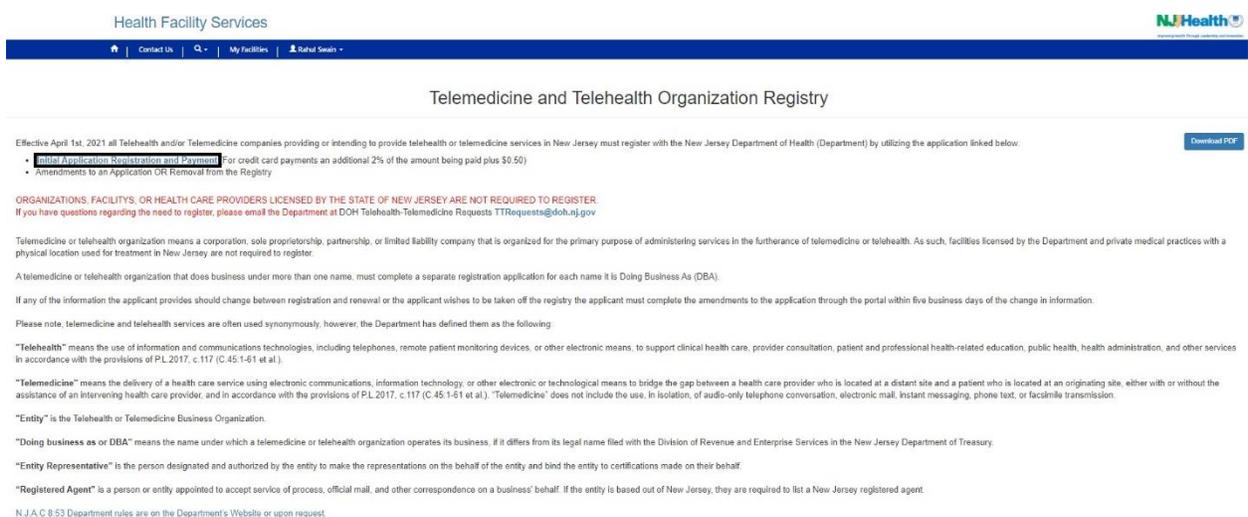


1. Entity representative can submit the Telemedicine and Telehealth applications at <https://dohlicensing.nj.gov>, by clicking on **Telehealth and Telemedicine** option under **Facility Licensing & Inspections** section.

NOTE: Please use the link: <https://dohlicensing.nj.gov/telehealthtelemedicine/> to directly access **Telehealth Registry Instructions** page.



2. On the instructions page users will have an option to initiate the Initial registration application by clicking on **Initial Application Registration and Payment** hyperlink.



Please note any field with an * is required/mandatory field to be filled.

3. Upon clicking, the user will get redirected to the CN 25 form as shown below. User will fill in all the details on the CN-25 form and click on the **Next** to move to the **Payment and Certification** page.

The screenshot shows a web form titled "Application for Registration of Telemedicine / Telehealth Organizations". At the top, there is a progress bar with four steps: "1 Telemedicine Form", "2 Payment & Certification", "3 Review & Submit", and "4 Print/Summary". The form is divided into several sections:

- Organization / Entity information:** Includes fields for EIN (Employer / Tax ID) with the value "12-2314567", Entity name with the value "Test", and a section for the main office location with fields for street address, city, state, and zip.
- Doing business as (DBA) information:** Includes a field for "Doing business as (DBA) *" with the value "Tester".
- Registered agent information:** Includes fields for "Registered agent name" (value "Tester1") and "Registered agent New Jersey street address".
- Entity representative information:** Includes fields for "First name *" (value "John"), "Middle name", "Last name *" (value "Doe"), "Representative title *" (value "Admin"), "Representative email address *" (value "abc@xyz.com"), and "Phone *" (value "(213) 456-7890").
- Registered agent email address:** Includes a field for "Registered agent email address" (value "abc@xyz.com") and a "Phone" field (value "(213) 456-7890").

At the bottom left of the form, there is a blue button labeled "Next".

NOTE: If the Entity address is not from NJ, then the registered agent address becomes mandatory and must be a NJ address.

If the Entity address is from NJ, then the Registered agent isn't mandatory. When the Registered agent details are not updated, these are the following outcomes:

- If there is no registered agent details available as part of the application, then the mailing address at the application level will be blank and also no contact record will be created for registered agent.
- If there is no registered agent details available as part of the application, then the mailing address at the facility level will also be blank.
- If there is no registered agent details available as part of the application, then the registered agent details at the company level will also be blank.

Please note any field with an * is required/mandatory field to be filled.

4. The user will have an option to make an online payment for the registration application by clicking on the Pay Now button.

2. Payment & Certification 3. Review & Submit 4. Print(Summary)

Payment & Certification

Payment

Application Fee	Application Fee Due	Application Fee Paid	Holding Fee Paid
\$1,500.00	\$1,500.00	\$0.00	\$0.00

Pay now

Certification

I, John Doe of full age, hereby certify that I am employed with Test in the capacity of Admin and am duly authorized to make the representations contained within this registration on behalf of the applicant and to bind the applicant thereto on 08-17-2021;

- That the applicant (Entity) will operate in accordance with all applicable laws, rules and regulations, both state and federal;
- That all information supplied in this registration, are true, accurate and correct to the best of my knowledge.
- I am aware that if any of the information contained in this registration is willfully false or misleading, then I may be subject to civil and/or criminal penalties.

Previous **Next**

5. User will go into the e-payments page where he/she needs to fill in the basic details and **select the type of service** if **Electronic Check Payment** or **Credit Card Payment**. Then the user needs to click on **Continue**.



STATE OF NEW JERSEY
DEPARTMENT OF HEALTH



Payer Application

Application Name: **Telemedicine and Telehealth-Initial Registration**

Individual Or Business Entity Information

* Entity Name:

* Physical Address(Trade or Home): Physical Address Line 2:

* City: * State: * Zip:

* Phone Number: Fax: * Email Address:

Responsible Party Information

* Last Name: * First Name:

Application Type Information

* License/Permit/Certificate:

New Registration

Payment Information

* Select the type of service: **Electronic Check Payment** Credit Card Payment

* Amount:

Security Message: **dfzis7by** Refresh

Not Case Sensitive

* Enter Security Message:

CONTINUE

Please note any field with an * is required/mandatory field to be filled.

If Electronic Check Payment:

6. Once you click **Continue**, the system will display a preview page. Please verify that the information displayed is correct. If correct, click on **Confirm** If the information is incorrect, click on **Edit** to make the corrections.



STATE OF NEW JERSEY
DEPARTMENT OF HEALTH



Payer Application

Application Name: **Telemedicine and Telehealth-Initial Registration**

Individual Or Business Entity Info

* Entity Name:
John Doe

* Physical Address Line 1: **25 Scotch Road, Ewing Township, NJ,** Physical Address Line 2: **25, Scotch Road,**

* City: Ewing Township	* State: NJ	* Zip: 08628
* Phone Number: 213 - 456 -7890	Fax:	* Email Address: abc@xyz.com

Responsible Party Information

* Last Name: **Doe** * First Name: **John**

Application Type Information

Application Description: **License/Permit/Certificate**

Application Type: **New Registration**

Payment Information

* Select the type of service **Electronic Check Payment**

* Amount: **\$1500.00**

Note: Please use **EDIT** button to edit the information. **Do not click on the back button.**

CONFIRMEDIT

7. Clicking **Confirm** will take you the payment information page. On this page, please answer the question and then select your account type, either **“Checking”** or **“Savings”**.

Then proceed to enter your bank information and click on **Submit** to proceed with the payment process or click on **Reset** to clear the page and start over.



Payment Information

Payer Information

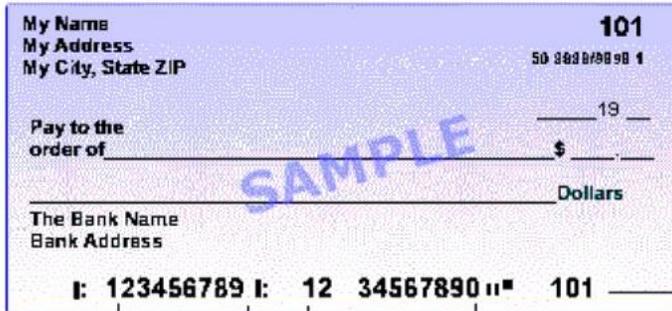
Last Name: Doe

First Name: John

Electronic Check Payment

In order to comply with new banking rules, please answer the following question:

* Will the funds for the payment come from an account outside of the United States: Yes No



Bank Routing Number (Routing number is 9 digits between the ⑆ ⑆ symbols)
Your Account Number (Account number usually to the left of ⑆⑆)

Please refer to the sample check above to identify your bank's routing number and your bank account number on an unused check from the bank account that the payment will be withdrawn.

Enter your Bank's Routing Number and Account Number as it appears on your check. The Routing Number is the 9-digit number at the bottom left of your check. The Account Number is to the right of the Routing Number. DO NOT enter any special characters in your account number. DO NOT enter the unused check number as part of the account number.

If you have any questions regarding these numbers, please contact your bank.

Electronic Check Information

*Bank Routing Number:	<input type="text" value="123456789"/>
*Bank Account Number:	<input type="text" value="1234567890"/>
*Account Type:	<input type="text" value="Checking"/>
*Amount:	<input type="text" value="\$1500.00"/>
<input type="button" value="SUBMIT"/> <input type="button" value="RESET"/>	

8. After clicking on **Submit**, you will be asked to verify the information and to agree to allow the State of New Jersey to debit the amount you see on the page.

If the information is correct, click on **Submit Echeck** to submit the payment. Once the payment is processed the system will redirect you back to **Payment and Certification** page. .



Check Confirmation

Payer Information

Last Name: Doe First Name: John

Please Verify all of the information below for accuracy. If all the information is correct, please press the "Submit ECheck" button and your payment will be debited from your account on the settlement date.

Payer Contact Information

Electronic Check Payment

E-Check Debit Information

* Bank Routing Number: 123456789
 * Bank Account Number: 1234567890
 * Account Type: Checking
 * Amount: \$1500.00

A return and/or payment is accepted and confirmed for processing on or before 11:59 PM on the due date, or legally extended due date, will be deemed timely filed and paid even though the actual Settlement Date assigned by the ACH Banking System may be after the due date or legally extended due date. If the due date falls on a weekend or a legal holiday, the due date is legally extended to the following business day.

Important EFT Filer Information: You have designed a bank account that differs from the bank account information currently on file with the New Jersey Division of Revenue EFT Unit. This information must be updated using an account revision request form and submitted to the EFT Unit for future EFT payments to be credited to your account. Any questions about updating your EFT banking information, call the EFT Unit @(609) 292-9292

* I authorize the State of New Jersey to debit the bank account listed above for the amount of \$1500.00? Yes No

[SUBMIT ECHECK](#)

If Credit Card Payment:

NOTE: There is a service charge/convenience fee for facilities that choose the credit card payment option.

Customer credit card information is not retained by State of New Jersey (Department of Health).

10. Once you click **Continue**, the system will display a preview page. Please verify that the information displayed is correct. If correct, click on **Confirm** If the information is incorrect, click on **Edit** to make the corrections.



Payer Application

Application Name: **Telemedicine and Telehealth-Initial Registration**

Individual Or Business Entity Info

* Entity Name:
John Doe

* Physical Address Line 1:
25 Scotch Road, Ewing Township, NJ,

Physical Address Line 2:
25, Scotch Road,

* City:
Ewing Township

* State:
NJ

* Zip:
08628

* Phone Number:
213 - 456 -7890

Fax:

* Email Address:
abc@xyz.com

Responsible Party Information

* Last Name:
Doe

* First Name:
John

Application Type Information

Application Description: **License/Permit/Certificate**

Application Type: **New Registration**

Payment Information

* Select the type of service **Electronic Check Payment**

* Amount: **\$1500.00**

Note: Please use EDIT button to edit the information. Do not click on the back button.



11. Please verify the details on the screen. If everything looks good, click on **I Agree to the Terms** to proceed with the payment process.

Payment Information

Payer Information

Last Name: Doe

First Name: John

Credit Card Payment

Credit Card Disclaimer

Should you decide to proceed with this transaction, please note that New Jersey Information Division of NICUSA, Inc. (NICUSA-NJ), an electronic government partner with the State, will process your payment through an upgraded and secure payment gateway. NICUSA-NJ will remit to the State of New Jersey all payments and amounts owed to the State.

The online charge processed through NICUSA-NJ includes funds in excess of payments owed. NICUSA-NJ uses the excess funds solely to develop, run, maintain, enhance and expand the State's electronic service offerings. NICUSA-NJ does not share any excess funds with the State of New Jersey.

Contact Information

* Telephone Phone: 213-456-7890

* Email Address: abc@xyz.com

Payment Information

* Amount: \$1500.00

[I Agree to The Terms](#)

12. After agreeing to the credit card disclaimer, you will be directed to the Payment Management Services page. The page should be auto filled with your Billing Information. If it is not, then please fill out the requested information.

NOTE: There is a service charge/convenience fee for facilities that choose the credit card payment option. Customer credit card information is not retained by State of New Jersey (Department of Health).

Transaction Summary

Description	Amount
Health and Senior Services Test Service	\$1,500.00
Pay now with New Jersey Government Services	\$1,534.00

Customer Billing Information

Name *

Company Name

Billing Address *

Billing Address 2

Billing City *

Country *

State *

ZIP/Postal Code *

Phone Number *
or

Fax Number
or

Email Address *
Please enter your email address.

Please note any field with an * is required/mandatory field to be filled.

13. Once the customer billing information is filled/updated please scroll down the page to add the credit card information. Click on **Continue** to move forward with the payment or you can click **Cancel Payment** to cancel the payment process.

Credit Card Information

Credit Card Type *
[Visa ▼]

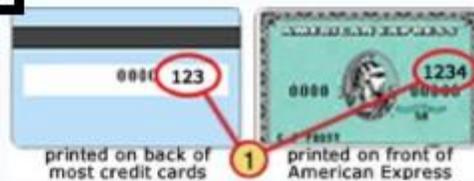
Credit Card Number *
[1234567812341111]

Expiration Date *
[02 - February ▼] [2026 ▼]

Name on Credit Card *
exactly as it appears on the card
[John Doe]

Verification Code *
[123]

Continue **Cancel Payment**



14. After clicking on **Continue**, you will be guided to a preview/verification page. Please make sure all information shown on screen is correct.

If anything is not accurate, you can click on **Edit** to update the information and then click on **Make Payment** to process the payment or you can click **Cancel Payment** to cancel payment procedure.

Once the payment is processed the system will redirect you back to **Payment and Certification** page.

15. Here the entity representative name, title and entity name will be pre-populated from the CN -25 form. The user will have an option to check the box to certify the information. Please click on **Next** to go to **Review & Submit** section.

2 Payment & Certification 3 Review & Submit 4 Print(Summary)

Payment & Certification

Payment

Application Fee	Application Fee Due	Application Fee Paid	Holding Fee Paid
\$1,500.00	\$1,500.00	\$0.00	\$1500.00

[Pay now](#)

Certification

I, John Doe of full age, hereby certify that I am employed with Test in the capacity of Admin and am duly authorized to make the representations contained within this registration on behalf of the applicant and to bind the applicant thereto on 08-17-2021;

1. That the applicant (Entity) will operate in accordance with all applicable laws, rules and regulations, both state and federal;
2. That all information supplied in this registration, are true, accurate and correct to the best of my knowledge.
3. I am aware that if any of the information contained in this registration is willfully false or misleading, then I may be subject to civil and/or criminal penalties.

[Previous](#) [Next](#)

16. In the **Review & Submit** section, the user can review the information and submit the application. When clicked on **Submit**, the portal will allow the user to print a summary of what she/he has submitted.

NOTE: Once submission is done on, an email notification is sent to the user.

3 Review & Submit 4 Print(Summary)

Application for Registration of Telemedicine / Telehealth Organizations

Organization / Entity information			Doing business as (DBA) information		
Entity name Test			Doing business as(DBA) Tester		
EIN (Employer / Tax ID) 12-1234567			Registered agent name Tester1		
Street address 25, Scotch Road,	Suite/Floor		Street address 25, Scotch Road,	Suite/Floor	
City Ewing Township	State NJ		City Ewing Township	State NJ	
Zip 08628			Zip 08628		
Entity representative information			Registered agent information		
First name John	Middle name	Last name Doe	Registered agent email address	Phone	
Representative title Admin					
Representative email address abc@xyz.com					
Phone (213) 456-7890					

Payment & Certification

Payment

Application Fee	Application Fee Due	Application Fee Paid	Holding Fee Paid
\$1,500.00	\$0.00	\$0.00	\$1,500.00

Certification

I, John Doe of full age, hereby certify that I am employed with Test in the capacity of Admin and am duly authorized to make the representations contained within this registration on behalf of the applicant and to bind the applicant thereto on 06-17-2021;

- That the applicant (Entity) will operate in accordance with all applicable laws, rules and regulations, both state and federal;
- That all information supplied in this registration, are true, accurate and correct to the best of my knowledge.
- I am aware that if any of the information contained in this registration is willfully false or misleading, then I may be subject to civil and/or criminal penalties.

17. Below is the **Print Summary**.

4. Print(Summary)

Tracking Number
RLTH7318-16783

Organization / Entity information

Entity name	EIN (Employer / Tax ID)	Street Address
Test	12-1234567	25, Scotch Road,
Suite/Floor	City	State
	Ewing Township	NJ
Zip		
08828		

Doing business as (DBA) information

Doing business as(DBA)
Tester

Entity representative information

First name	Middle name	Last name
John		Doe
Representative title	Representative email address	Phone
Admin	abc@xyz.com	(213) 456-7890

Registered agent information

Registered agent name	Street Address	Suite/Floor
Tester1	25, Scotch Road,	
City	State	Zip
Ewing Township	NJ	08828
Registered agent email address	Phone	

Payment

Application Fee	Application Fee Due	Application Fee Paid	Holding Fee Paid
\$1,500.00	\$0.00	\$0.00	\$1,500.00

Certification

I, John Doe of full age, hereby certify that I am employed with Test in the capacity of Admin and am duly authorized to make the representations contained within this registration on behalf of the applicant and to bind the applicant thereto on 08-17-2021;

- That the applicant (Entity) will operate in accordance with all applicable laws, rules and regulations, both state and federal;
- That all information supplied in this registration, are true, accurate and correct to the best of my knowledge.
- I am aware that if any of the information contained in this registration is willfully false or misleading, then I may be subject to civil and/or criminal penalties.

18. Once the entity representative submits the application, they will receive an invitation on the email address they mentioned on the CN 25 form to sign up by **redeeming** the invitation code.

[Sign in](#) [Redeem invitation](#)

Sign up with an invitation code

* Invitation code

I have an existing account

[Redeem Invitation](#)

19. Click on **Sign In**.

Health Facility Services



20. Upon clicking, you will be directed to the **Sign-In** page. Here, please fill in your username and password and click on **Sign In**, you will be directed to your account.

[Sign in](#) [Redeem invitation](#)

Facility User Login

* User name

* Password

Remember me?

[Sign in](#) [Forgot your Username/Password?](#)