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: <u>https://dohlicensing.nj.gov/telehealthtelemedicine/</u> to directly access **Telehealth Registry Instructions** page.

I OFFICIAL SITE OF THE STATE OF NEW JERSEY		Governor Phil Murphy - LL Gov NJ.gov Services Agencies FAQ:
Health Facility Services		N
Contact Us Q. Wy facilities I Rahul Swale -	ationally accredited state public health agency focused on improving population health h ospitals, the medicinal marijuana program, EMS and the Office of Disaster Resilience. E and the Office of Policy and Strategic Planning work collaboratively toward the goal of kee of its public health accreditation in June 2017.	y strengthening New Jersey's health system. The Department oversees health care facilities, ach of the Department's five branches which include Public Health Services, Health Systems, ping healthy New Jerseyans well, preventing those at risk from getting sick, and keeping those
Accut us Healthcare Services		
Find a Health Care Facility	FAQs	Facility Licensing & Inspections
Search Facility	Create New Account	Certificate of Need
Healthcare Facility Types	Sign in to your account	ACH enroll form
State Psychiatric Hospitals	Deactivate account	License Forms
Health care financing	Submit License Application Renewals to HSB	Inspections and Surveys
	Submit E-payment to HSB	State Health Planning Board
	Submit HFEL-5 Financial Report to HSB	Telehealth and Telemedicine
	Submit ARR Financial Report to HSB	
	Submit ARR E-pay to HSB	

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.

Health Facility Services	alth®
🕈 Cardatth, Q+ My/redilles Åt.Detu Seale -	
Telemedicine and Telehealth Organization Registry	
Effective April 1st, 2021 all Telehealth and/or Telemedicine companies providing or intending to provide telehealth or telemedicine services in New Jersey must register with the New Jersey Department of Health (Department) by utilizing the application linked below. Immedia Application Readstration and Payment For credit card payments an additional 2% of the amount being paid plus \$0.50) Amendments to an Application CR Removal from the Registry	wnload PDF
ORGANIZATIONS, FACILITYS, OR HEALTH CARE PROVIDERS LICENSED BY THE STATE OF NEW JERSEY ARE NOT REQUIRED TO REGISTER. If you have questions regarding the need to register, please email the Department at DOH Tolehealth-Telemedicine Requests TTRoquests@doh.nj.gov	
Telemedicine or telehealth organization means a corporation, sole proprietorship, partnership, or limited liability company that is organized for the primary purpose of administering services in the furtherance of telemedicine or telehealth. As such, facilities licensed by the Department and private medical practices v physical location used for treatment in New Jensey are not required to register.	with a
A telemodicine or telehealth organization that does business under more than one name, must complete a separate registration spplication for each name it is Doing Business As (DEA).	
If any of the information the applicant provides should change between registration and renewal or the applicant visities to be taken off the registry the applicant must complete the amendments to the applicant provides should change between registration and renewal or the applicant visities to be taken of the registry the applicant must complete the amendments to the applicant provides should change between registration and renewal or the applicant visities to be taken of the registry the applicant must complete the amendments to the applicant provides should change between registration and renewal or the applicant visities to be taken of the registry the applicant must complete the amendments to the applicant provides should change between registration and renewal or the applicant visities to be taken of the registry the applicant must complete the amendments to the applicant visities to applic	
Please note, leteredicine and telehealth services are often used synonymously, however, the Department has defined them as the following	
"Telebealth" means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other in accordance with the provisions of PL 2017, c. 117 (C.45:1-61 et al.).	services
"Telemedicine" means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without assistance of an intervening health care provider, and in accordance with the provisions of PL 2017, c117 (C 45.1-E1 et al.). Telemedicine' does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.	t the
"Entity" is the Telehnedicine Business Organization.	
"Doing business as or DBA" means the name under which a telemedicine or telehealth organization operates its business, if it differs from its legal name filed with the Division of Revenue and Enterprise Services in the New Jensey Department of Treasury	
"Entity Representative" is the perion designated and authorized by the entity to make the representations on the behalf of the entity to certifications made on their behalf.	
"Registered Agent" is a person or entity appointed to accept service of process, official mail, and other correspondence on a business' behalf. If the entity is based out of New Jersey, they are required to list a New Jersey registered agent.	
NJAC 8:53 Department rules are on the Department's Website or upon request.	

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.

Organization / Entity information		Doing business as (DBA) information					
EIN (Employer / Tax ID) *		Doing business as(DBA) *					
12-2314567				Tester	Tester		
Entity name *				Registered agent information			
Test		Registered agent name	Registered agent name				
Enter street address for the applicant entity main office location.		Tester1					
Enter a location		Registered agent New Jersey street address					
Address not found ?		Enter a location					
Street address *		Suite/Floor		Address not found ?			
25, Scotch Road,				Street address	Suite/Floor		
City *		State *		25, Scotch Road,			
Ewing Township	NJ		City	State			
Zip *				Ewing Township	NJ		
08628				Zip			
				06628			
ity representative information				Registered agent email address			
First name *	Middle name		Last name *	abc@xyz.com			
John			Doe		Dhana		
Representative title *				212) 452 7200			
Admin				(213) 430-7030			
Representative email address *							
abc@xyz.com							
Phone *							
(213) 456-7890							

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.

Payment			
Application Fee	Application Fee Due	Application Fee Paid	Holding Fee Pa
\$1,500.00	\$1,500.00	\$0.00	\$0.00
Certification			
 I, John Doe of full age, hereby certify that I am That the applicant (Entity) will operate in ac That all information supplied in this registra I am aware that if any of the information core 	employed with Test in the capacity of Admin and am duly authorized to make the cordance with all applicable laws, rules and regulations, both state and federal; tion, are true, accurate and correct to the best of my knowledge. tained in this registration is wilffully false or misleading, then I may be subject to the state of the state of	representations contained within this registration on behalf of the applicant an civil and/or criminal penalties.	d to bind the applicant thereto on 08-17-2021

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 to click on **Continue.**

STATE OF NEW J	ersey ent of Health		Nu Health New Jersey Department of Health
Payer Application			
Application Name: Telemedic	ine and Telehealth-Initial Re	gistration	
Individual Or Business Enti	ty information		
 Entity Name: John Doe 			
* Physical Address(Trade or Ho	me):	Physical Address Line 2:	
25 Scotch Road, Ewing Township	o, NĴ,	25, Scotch Road,	
♦ City: Ewing Township	★ State: NEW JERSEY ✓	★Zip: 08628	
* Phone Number: 213 - 456 - 7890	Fax:	★Email Address: abc@xyz.com	
Responsible Party Information	tion		
*Last Name: Doe		*First Name: John	
Application Type Informati	on		
* License/Permit/Certificate	~		
New Registration			
Payment Information			
* Select the type of service	O Electronic Check Paymer	Credit Card Payment	
* Amount: 1500.00			
Security Message:	dfzjs7by ot Case Sensitive	esh	
 Enter Security Message 	: dfzjs7by		
		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	of Hea	LTH		NJHeatth New Jersey Department of Health
Payer Application				
Application Name: Telemedicine and	d Telehealth-Ir	itial Registration		
Individual Or Business Entity Info)			
Entity Name: John Doe Physical Address Line 1:			Physical Address Line 2+	
25 Scotch Road, Ewing Township	, NJ,		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/Per	mit/Certificate			
Application Type: New Registration				
Payment Information				
* Select the type of service Electr	ronic Check Pay	vment		
*Amount: \$1500.00				
Note: Please use EDIT button to edit	the information.	Do not click on the back but	ton.	
		CONFIRM		

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.

STATE OF NEW JERSEY DEPARTMENT OF I	Health	NJHeatth New Jerrey Department of Health
Payment Information		
Payer Information		
Last Name: Doe	First Name: John	
Electronic Check Payment In order to comply with new banking rules, p * Will the funds for the payment come from a	please answer the following question: In account outside of the United States: O Yes O No	
My Name My Address My City, State ZIP	101 50 38338/98 98 1	
Pay to the order of		
The Bank Name Bank Address	Dollars	
I: 123456789 I	: 12 34567890 101	
(Routing number is 9 dig the 1 symbols)	jits between (Account number usually to the left of II*)	
Please refer to the sample check above to iden the b	ntify your bank's routing number and your bank account number on an unused ch vank account that the payment will be withdrawn.	eck from
Enter your Bank's Routing Number and Accou bottom left of your check. The Account Num account number. DO N	int Number as it appears on your check. The Routing Number is the 9-digit number nber is to the right of the Routing Number. DO NOT enter any special characters in IOT enter the unused check number as part of the account number.	er at the n your
If you have any o	uestions regarding these numbers, please contact your bank.	

Electronic Check Information

Bank Routing Number:	123456789		
Bank Account Number:	1234567890		
Account Type:	Checking 🗸		
Amount:	\$1500.00		
		SUBMIT	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.



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.

STATE OF NEW JERSEY DEPARTMENT OF HEALTH



Payer Application

Application Name: Telemedicine and	l Telehealth-I	nitial Registr	ation
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 Add abc@xyz	ress: .com
Responsible Party Information			
* Last Name: Doe			* First Name: John
Application Type Information			
Application Description: License/Perr	mit/Certificate		
Application Type: New Registration			
Payment Information			
* Select the type of service Electr	onic Check Pa	yment	
*Amount: \$1500.00			
Note: Please use EDIT button to edit	the information.	Do not click	on the back button.
		CONFIRM	EDIT

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.

STATE OF N DEPAR	New Jersey TMENT OF HEALTH	NUHeatth New Jersey Department of Health
Payment Informa	tion	
Payer Information		
Last Name: Doe	First Name: John	
Credit Card Paymer	it	
	Credit Card Disclaimer	
Should you decide to p electronic government NJ will remit to the Sta The online charge proo to develop, run, maint with the State of New	roceed with this transaction, please note that New Jersey Information Division of NICUSA, Inc. (NICUSA-NJ), an partner with the State, will process your payment through an upgraded and secure payment gateway. NICUSA- te of New Jersey all payments and amounts owed to the State. essed through NICUSA-NJ includes funds in excess of payments owed. NICUSA-NJ uses the excess funds solely sin, enhance and expand the State's electronic service offerings. NICUSA-NJ does not share any excess funds lersey.	
Contact Informatio	n	
*Telephone Phone:	213-456-7890	
*Email Address:	abc@xyz.com	
Payment Informati	on	
*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 wi	th New Jersey Government Services \$1,534.00

Doe, John	
Company Name	
John Doe	
Billing Address *	
25 Scotch Road, Ewing Township, NJ,	
Billing Address 2	
25, Scotch Road,	
Billing City *	
Ewing Township	
Country *	
United States	~
State * New Jersey	
ZIP/Postal Code *	
08628	
Phone Number *	
213-456-7890	
Fax number ####################################	
Hax Number ########### or ########################	

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	1
Credit Card Type *	
Visa 🗸	
Credit Card Number *	
1234567812341111	
Expiration Date *	
02 - February 💙 2026 💙	
Name on Credit Card * exactly as it appears on the card	
Com Doo	
Verification Code * (1)	
123 \$	
17	THE REAL PROPERTY AND INCOME.
	000 123
	0000 10 00000
	printed on back of a printed on front of
	most credit cards
Continue Cancel Payment	9
	2

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.

<u>indit a octanoadan</u>			
Payment			
Application Fee	Application Fee Due	Application Fee Paid	Holding Fee Pai
\$1,500.00	\$1,500.00	\$0.00	\$1500.00
 I, John Doe of full age, hereby certify that I am e That the applicant (Entity) will operate in according to the second sec	ployed with lest in the capacity of Admin and am duly authorized to make the re dance with all applicable laws, rules and regulations, both state and federal; n, are true, accurate and correct to the best of my knowledge.	presentations contained within this registration on behalt of the applicant an	d to bind the applicant thereto on 08-17-2021;

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(Summ	nary)					
Application for Registration of Tele	medicine / Telehealth Organizations					
Organization / Entity information			Doing business as (DBA) information			
Entity name			Doing business as(DBA)	Doing business as(DBA)		
Test			Tester	Tester		
EIN (Employer / Tax ID)	EIN (Employer / Tax ID)					
12-1234567			Registered agent name			
			Tester1			
Street address	Suite/Floor					
25, Scotch Road,			Street address	Suite/Floor		
City	State		25, Scotch Road,			
Ewing Townshin	NJ		City	State		
cours to month			Ewing Township	NI		
Zip			Lining containp	10		
08628			Zip			
			08628			
Entity representative information	1 <mark>.</mark>		Registered agent email address	Registered agent email address		
First name	Middle name	Last name				
John		Doe				
Representative title			Phone			
Admin						
Representative email address						
abc@xyz.com						
Dhana						
(212) 455 7900						
(213) 400-7080						

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 Text 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 referral; 2. That all informations supplied in this registration are true, accurate and or 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.				
3. I am aware that if any of the information (

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

27				
Tracking Number				
RI-TH7318-18783				
Organization / Entity information				
Entity name	EIN (Er	nployer / Tax ID)	Street Address	
Test	12-123	587	25, Scotch Road,	
Suite/Floor	City		State	
	Ewing	ownship	NJ	
Zip				
08628				
Doing business as (DBA) information				
Doing business as(DBA)				
Tester				
Entity representative information				
First name	Middle	name	Last name	
John			Doe	
Representative title	Repres	entative email address	Phone	
Admin	abc@x	z.com	(213) 458-7890	
Registered agent information				
Registered agent name	Street	lddress	Suite/Floor	
Tester1	25. Sec	ich Road,		
City	State		Zip	
Ewing Township	NJ		08828	
Registered agent email address	Phone			
Payment				
Application Fee	Application Fee Due	Application Fee Paid	Holding	y Fee Paid
\$1,500.00	\$0.00	\$0.00	\$1,500.0	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 t	e representations contained within this registration on behalf of the application	nt and to bind the applicant thereto on 08-17-2021;	

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 wi	h an invitation code	
	* Invitation code	
		□ I have an existing account
		Redeem Invitation

19. Click on Sign In.



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

◆) Sign in	Redeem invitation			
Facility Use	r Login			
	Г	* User name		
		* Password		
			Remember me?	

Forgot your Username/Password?