OVERRIDE REQUEST

Provider Name: _____ Date: _____
(please type or print)

Provider Number: _____

Recipient Name:	Identification Number:	Amount of Claim:

INSTRUCTIONS:

1. Complete this form for each claim for which an override is being requested.

2. Enter the NH Medicaid provider name, number, and date of request in the spaces at the top of this form.

3. Enter the NH Medicaid recipient's name, identification number, and the amount of the claim in the boxes provided at the top of this form.

4. Attach ONE CLEAN claim to this completed form for each request (please check type of claim being submitted):
☐ CMS ☐ 1500 ☐ UB 04 ☐ Medicare Crossover ☐ Dental

In order to be accepted, the claim shall:

- Be legible;
- Have the exact first date of service (FDOS) as initial claim billed; and
- Have the same information, or the corrected charges, as initial claim billed.

5. If the claim was submitted previously, attach a copy of the Remittance Advice (RA)
(please check all applicable attachments):

☐ NH Medicaid RA Dated _____ ☐ Official Fiscal Agent Correspondence Dated _____ ☐ 8-digit batch # (if billed electronically) In this format: _____C_____ Dated _____

AN OVERRIDE REQUEST CANNOT BE CONSIDERED FOR A PREVIOUSLY SUBMITTED CLAIM WITHOUT A COPY OF THE RA ATTACHED

6. The following shall be required:

- The RA shows that the initial billing was less than 12 months from FDOS;
- The attached claim corrects the previous reason(s) for denial; and
- All pertinent information is circled on all RAs to pinpoint the facts and support the request: i.e., FDOS, RA dates, Medicaid identification numbers, Provider numbers, Denial Codes.

7. If the claim was **not** previously denied, but is over 12 months old, approval will be considered ONLY if (a) there was a delay in determining the NH Medicaid recipient's eligibility; (b) the claim is for a covered service provided during the retroactive eligibility period; and (c) the claim is submitted within 6 months of the retroactive eligibility determination; or the claim could not be processed due to a department or MCO system issue or error.

Please indicate type of NH Medicaid Recipient eligibility:

☐ Regular NH Medicaid Eligibility ☐ Special Eligibility ☐ Nursing Facility

Send completed Override Request with attachments to:
NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003
Attn: One Year Override