



**SERVICE AUTHORIZATION (SA) REQUIREMENTS FOR  
NH MEDICAID MEDICAL SERVICES  
FOR STRAIGHT FEE-FOR-SERVICE (FFS) MEDICAID ONLY**

**PLEASE SEE PROVIDER SPECIFIC INSTRUCTIONS AT THE END OF THIS DOCUMENT.**

**For timely Service Authorization Request approvals, BEFORE** submitting a Service Authorization Request the following are required.

**VERIFY ELIGIBILITY:** It is the responsibility of the provider to verify a Member's eligibility *and* other insurance information for each date of service, prior to requesting authorization or rendering each service. Three ways to verify eligibility: call the number on the back of the Medicaid ID card, contact the Fiscal Agent at 1-866-291-1674, or look directly in the MMIS system.

**If** the Member is enrolled in Fee-for-Service, proceed to the next section.

**If** the Member is enrolled as a Qualified Medicare Beneficiary (QMB), NH Medicaid pays the premiums, deductibles and copays. We do not give SAs (Service Authorizations) for QMB.

**If** the Member is enrolled in a Managed Care Organizations (MCO) they do not have Fee-for-Service Medicaid as secondary insurance. Contact the MCO directly for SA requirements and use their Standard Authorization form.

**VERIFY IF THE SERVICE REQUIRES AN SA:** The list of codes is located at <https://nhmmis.nh.gov>. Click on documentation, then documents and forms, and find the most current fee schedules. For example: 2023 Fee Schedule - Covered Procedures Report with SA Requirements as of 04-01-2023 . If there is an N in the column labeled SA, you do not need an SA from this department. If the code is not on the list, contact the Fiscal Agent at 1-866-291-1674.

**USE THE PROPER FORM; THE SPECIFIC SA FORM FOR YOUR SERVICE:** Go to <https://nhmmis.nh.gov>, click on documentation, documents and forms, service authorizations for FFS, and scroll until you find the proper SA forms for the service you are providing. Or visit <https://www.dhhs.nh.gov/ombp/medicaid/service-auth.htm>. Print this document, in full size, and fill in the information about the request.

**SA REQUESTS MUST INCLUDE THE FOLLOWING DOCUMENTATION**

- Clinical records that provide the medical justification for the service(s) or equipment being requested.
- SIGNED, Physicians order. If Private Duty Nursing, a doctor signed 485 is sufficient.
- SIGNED, Letter of Medical Necessity.
- If Durable Medical Equipment (DME), check to see if it requires a Form 272M or the Form 272EQ. Both are mobility evaluations to be completed by a Physical Therapist.
- If Durable Medical Equipment (DME) the acquisition cost and MSRP on a manufacturer's quote form or a paid invoice.



If information is missing or invalid, you will receive a form requesting more information. We will keep the original Service Authorization Request for 30 days. If we have not heard back from you, we will delete or shred the file.

Once the SA is medically approved, an email or fax will be sent to the contact name on the SA form. The request is then sent to the Fiscal Agent to create the SA. The Fiscal Agent has up to three business days to create and mail the SA to the performing provider. Call the Fiscal Agent at 1-866-291-1674 to obtain the status after three business days.

**Please visit the following sites that document SA Requirements in more detail.**

1. **Administrative rules** governing the NH Medicaid FFS program are located at the following website. [http://gencourt.state.nh.us/rules/state\\_agencies/he-w500.html](http://gencourt.state.nh.us/rules/state_agencies/he-w500.html).
2. **The General Billing Manual – Volume I** has in depth information on provider requirements. This manual applies to every enrolled provider who submits to the NH Medicaid program. A complete copy of this manual can be obtained at <https://nhmmis.nh.gov>. Click on provider, click on billing manual.
3. **The Provider Specific Billing Manual – Volume II** has in depth provider specific requirements. This manual is specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*. A complete copy of this manual can be obtained at <https://nhmmis.nh.gov>. Click on provider, click on provider manual.

### **INSTRUCTIONS FOR FILLING OUT A SERVICE AUTHORIZATION REQUEST FORM:**

Please note that before this form is filled out, **it is your responsibility to verify eligibility** of the recipient for the Fee-for-Service (FFS) program. This can be done by calling the number on the back of the recipient's Medicaid card, calling Fiscal Agent at 866-291-1674, looking directly in the MMIS system, or using the software your office has to access the information.

This fully electronic form is made to tab through. Open the .pdf form and click on the icon "Fill & Sign." Place your cursor in the box after "Recipient Name," fill in the information, and tab to the next fill-in spot. Save your document when done and send it and all required documents in an encrypted email to [ServiceAuthorizationFFS@dhhs.nh.gov](mailto:ServiceAuthorizationFFS@dhhs.nh.gov)

The first two sections are the Recipient Information and Provider Information which should be filled out accordingly. The ordering physician and the rendering facility will have two different Medicaid ID numbers. If there is an alternate insurance, NH Medicaid is the payer of last resort. Providers are expected to follow all third party payors requirements for payment and all third party obligations shall be exhausted before billing Medicaid, in accordance with 42 CFR 433.139. To ensure your claim to NH Medicaid is not rejected, you will be required to submit third party payment information or a proper denial from the third party with your NH Medicaid claim. An approved service authorization is not a guarantee of payment.



The next section is the information on the requested service. Each form has its own information needed. Please follow the section titles to fill in this part of the form. Fill in a description of the service, the Procedure Code, the appropriate Modifier, quantity/hours/units, and the start and end date of these services.

The section following is the legal information with references to the Medicaid rule, for your convenience. Note that you are **required to attest, by signature**, that you have done each of the things listed in this section.

## INSTRUCTIONS TO SUBMIT A SERVICE AUTHORIZATION REQUEST

Request a secured email link, by emailing [ServiceAuthorizationFFS@dhhs.nh.gov](mailto:ServiceAuthorizationFFS@dhhs.nh.gov). In the subject line write Requesting Approval for: then choose DME, Incontinence, Therapy etc. You will receive a secured email thread. Alternatively you can use your own process for securing Protected Health Information in documents sent by email. Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Return all documentation and the Service Authorization Request form to [ServiceAuthorizationFFS@dhhs.nh.gov](mailto:ServiceAuthorizationFFS@dhhs.nh.gov) or fax to: 603-314-8101.

**Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Email all documentation, and the SA form, in an encrypted/secured email to [ServiceAuthorizationFFS@dhhs.nh.gov](mailto:ServiceAuthorizationFFS@dhhs.nh.gov) or fax all documentation, and the SA form, to 603-314-8101.**

If the information sent is incomplete, you will receive a request for more information. This is not a denial. Send in the information as above for the request to be reconsidered. It is not necessary to send in the complete request, just send back the requested information.

If all information is complete and criteria is met, you will receive a confirmation from the state with the approval information. Once the Request for Service Authorization has been approved by the State it is sent to the Fiscal Agent to create the authorization. The Fiscal Agent has three business days to create and mail the authorization to the performing provider. If you have questions, please call the Fiscal Agent at 1-866-291-1674.

## PROVIDER SPECIFIC PROVIDER INSTRUCTIONS BY PROVIDER TYPE:

**Durable Medical Equipment** The section on page 2, is the equipment you are requesting. Fill in a description of the DMEs, the Procedure Code and an RR modifier if it is a rental, the number of units, the acquisition cost **per unit** and the manufacturer's suggested retail, from your vendor's quote form or a paid invoice. **(We cannot process without the cost information.)** Add monthly rental charge **per unit** if applicable, and the start and end date of service. **\*\*Note that proof of your costs must be**



attached on the vendor quote form with the vendor letterhead. This is not your quote, it is the vendor's rate to you.

**Incontinence Products** The first section for services is for **NEW** incontinence products. Fill in the Description, the CPT Code and modifier, the number of units **per month**, and the start and end date of service.

The second section is used if you need to change an existing SA. NOTE: if you need different dates of service, you will need to make out the top section on a new form.

- Write in the current SA number and reason for the change.
- Enter the description of the products
- Fill in the CPT Code and Modifier in From and To if changing code.
- Enter the number of units per month.
- Enter start and end date of the change.

**Physical Therapy, Occupational Therapy, and Speech Therapy** In the section for the service you are requesting, **each discipline (PT, OT, and ST) must have its own SA, FORM 272EPOS**. Fill in a description of the treatment, the Procedure Code, how often therapy will take place, the total number of units in excess of the 80 units allowed without service authorization, and the start and end date of these extra units.

**Private Duty Nursing** Service Authorization requests are approved for a range of codes. This means you will enter the correct modifier (no modifier for days, U1 modifier for nights and weekends, and U4 modifier for intensive/ventilator care if the vent is used more than 12 hours a day) and the number of nursing hours requested per week. You will be able to use those hours, with that modifier for either RN or LPN. Each modifier will need its own separate line on the form.

The first section for services is for **NEW** private duty nursing hours. Fill in the modifier, the number of hours/units **per week**, the days of the week and hours of the day, and the start and end date of service.

The second section is used if you need to change an existing SA. NOTE: if you need different dates of service, you will need to make out the top section on a new form.

- Write in the current SA number and reason for the change.
- Check the box for add (if you need more hours during these dates of service,) change (if you need to change time of day, modifier) or transfer (if you are giving units you cannot fill to another agency) Enter the number of hours/units to be changed.
- Fill in the CPT Code Modifier where the units are coming from.
- Enter the new CPT Code or Agency and modifier where the units are going to.
- Enter start and end date of the change.

The second page of the request is additional information and school information needed to process your request, please fill it in completely.