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:

- must be legible,
- must have the exact FDOS as initial claim billed,
- must have like or corrected charges as initial claim billed.

5. If the claim was submitted previously, attach a copy of the Remittance Advice (please check all items that you have attached):

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

AN OVERRIDE REQUEST CAN NOT BE CONSIDERED FOR A PREVIOUSLY SUBMITTED CLAIM WITHOUT A COPY OF THE REMITTANCE ADVICE ATTACHED

- The RA must show the initial billing was less than 12 months from FDOS
- The attached claim corrects the previous reason(s) for denial
- All pertinent information must be circled on all RAs to pinpoint the facts and support the request: i.e., FDOS, RA dates, MID #s, Provider #s, Denial Codes

6. 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 six (6) months of the retroactive eligibility determination.

Please indicate type of NH Medicaid Recipient eligibility:

☐ Regular NH Medicaid Eligibility ☐ Special Eligibility ☐ Nursing Facility

Send Completed Override Request Plus Attachments to:
NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003
Attn: One Year Override