

OVERRIDE REQUEST

Provider Name: _____
(please type or print)

Date: _____

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): HCFA 1500 UB 92 Medicare Crossover TAD 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 Official EDS Correspondence 8-digit batch # (if billed electronically)
Dated _____ Dated _____ 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 Requests Plus Attachments to:

**EDS
PO Box 2040
Concord, NH 03301-2040
Attn: One Year Override**