Supportive Housing

Provider Manual
Volume II

December 2024

New
Hampshire
Medicaid

Table of Contents

Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication

1.0 NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes, which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and the Provider Specific Billing Manuals – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The General Billing Manual – Volume I Appendices Section encompasses a range of supplemental materials such as Contact Information, Common Acronyms, and general information.

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

These manuals are ***not*** designed for use by NH Medicaid members (hereinafter referred to as members).

1.2 Provider Accountability

Participating providers must know the content of both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

1.3 Document Disclaimer/Policy Interpretation

It is the Department's intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

1.4 Notifications & Updates

Providers are notified of NH Medicaid program changes and any other changes applicable to participating providers through several types of media including provider bulletins, provider notices, memos, letters, website updates, newsletters and/or updated pages to the General Billing Manual – Volume I, and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

1.6 Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2.0 Provider Participation & Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

Approved Supportive Housing providers shall be authorized to provide Medicaid Funded Supportive Housing services pursuant to the approved 1915(i) HCBS Benefit. Enrollment under additional provider types neither qualifies for nor precludes from becoming a Supportive Housing provider. Being approved to provide Medicaid Program funded Supportive Housing services alone entitles providers to provide only those services described in the 1915(i) HCBS Supportive Housing benefit.

2.1 Staff Qualifications for Supportive Housing Programs and Providers

Individuals providing Housing Stabilization – Transition and Housing Stabilization - Sustaining services must have:

- Knowledge of local housing resources
- Completed housing stabilization service training approved by DHHS as outlined in the Administrative Rules
- Completed mandated reporter training which includes training on Adult Protection law.
- Must pass a criminal background check

Housing Navigators employed by the Regional Access Points (RAP) must demonstrate the following:

Education

- Bachelor's degree from a recognized college or university with major study in social work, sociology, psychology, counseling, nursing or a related field; or
- A high school diploma or equivalency; and
    - Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who has lived experience in the homeless services system; and
    - Meets the training requirements for housing navigator.

Experience

- Two years of professional experience providing direct service to individuals, youth, or families experiencing homelessness in social work, psychology, human services, counseling, mental health or equivalent.

License/Certification

- Valid State driver's license and/or access to transportation with liability coverage as required by state laws for travel throughout the State of NH.

Upon hire, housing navigator must complete the required trainings within one year of hire date, including, but no limited to:

- Orientation
- Regional Access Point Training
- Case Conferencing training
- Coordinated Entry System training

Servicing Case Managers must demonstrate the following:

Education

- Bachelor's degree from a recognized college or university with major study in social work, sociology, psychology, counseling, nursing or a related field; or
- A high school diploma or equivalency; and
    - Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who has lived experience in the homeless services system; and
    - Meets the training requirements for case management.

Experience

- Two years of professional experience providing direct service to individuals, youth, or families experiencing homelessness in social work, psychology, human services, counseling, mental health or equivalent.

License/Certification

- Valid State driver's license and/or access to transportation with liability coverage as required by state laws for travel throughout the State of NH.

3.0 Covered Services & Requirements

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization ***prior to*** service delivery in order to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit these requests can be found in this Provider Specific Billing Manual - Volume II.

Under the approved 1915(i) State Plan Home and Community Based Services (HCBS), New Hampshire provides Supportive Housing benefits. Services recommended by a licensed or certified practitioner of the healing arts shall be provided in accordance with NH Administrative Rules and state and federal laws. It is the provider's responsibility to be familiar with the 1915(i) State Plan HCBS and all state and federal regulations. All information is subject to change as state or federal regulations impacting NH Medicaid are revised or implemented.

3.1 Covered Services

Housing Stabilization Service-Transition
Procedure Code: H2021 V1

Community supports that assist members to plan for, find, and move to homes of their own in the community including:

- Supporting the member in applying for benefits to afford their housing
- Identifying services and benefits that will support the member with housing instability
- Assisting the member with the housing search and application process
- Assisting the member with tenant screening and housing assessments
- Helping a member understand and develop a budget
- Helping members understand and negotiate a lease
- Helping the member meet and build a relationship with a prospective landlord
- Identifying resources to cover moving expenses
- Helping the member arrange deposits
- Ensuring the new living arrangement is safe and ready for move-in
- Remote support when required to ensure their housing transition
- Helping a member organize their move

Transition services **do not** cover:

- Deposits
- Food
- Furnishings

- Rent
- Utilities
- Room and board
- Moving expenses

Housing Stabilization Service – Sustaining
Procedure Code: H2021 V2

Community supports that assist a member to maintain living in their own home in the community including:

- Developing, updating and modifying the housing support and crisis plan on a regular basis. A regular basis means, at the time of any change in housing status and at a minimum on an annual basis.
- Prevention and early identification of behaviors that may jeopardize continued housing
- Education and training on roles, rights, and responsibilities of the tenant and property manager
- Coaching to develop and maintain key relationship with property managers and neighbors
- Advocacy with community resources to prevent eviction when housing is at risk
- Assistance with the housing recertification processes
- Continuing training on being a good tenant, lease compliance, and household management
- Supporting the member to apply for benefits to retain housing
- Supporting the member to understand and maintain income and benefits to retain housing
- Supporting the building of natural housing supports and resources in the community
- Remote support when required to help the member retain their housing

Sustaining services **do not** include:

- Deposits
- Food
- Furnishings
- Rent
- Utilities
- Room and board
- Moving expenses

Housing Consultation Services/Plan of Care Creation
Procedure Code: Housing Consultation/Plan of Care Creation: T2024

Housing Consultation: Annual planning services that are person-centered and assist the member with the creation of the person-centered plan. This annual service is separate from Housing Stabilization services, though persons providing Housing Stabilization services will work based on the person-centered plan. Members may also receive referral to other needed services based on the person-centered plan. The consultant monitors and updates the plan annually or more frequently if the member requests a plan change or experiences a change in circumstance. This service shall be separate and distinct from all other services and shall not duplicate other services or assistance available to the participant. Housing consultation services may only be billed after approval of the plan by DHHS. System edits will be in place to prevent the payment of targeted case management services in the same month in which housing consultation services are billed.

Targeted Case Management
Procedure Code: T1017

Targeted Case Management: Under the 1915(i) Supportive Housing HCBS benefit, Case Managers will meet with members to develop the Person-Centered Plan of Care. This plan of care will address any need relevant to supporting the member's goals of obtaining and sustaining their housing. During the service authorization process, a service review will show if the member is already receiving TCM. If that is the case, the member will meet with their current Case Manager to collaboratively develop the Person-Centered Plan of Care. If the member is not receiving TCM from another system, the RAP will work with the member to create the Plan of Care, and an enrolled provider will be identified to provide ongoing TCM.

3.2 Service Limits

Housing Stabilization Services, Transition and Sustaining

Annual Limits

- Transition services are limited to 150 hours annually.
- Sustaining services are limited to 150 hours annually.

Remote support

- Remote support means a real-time, two-way communication between the provider and the participant. The provision of services using remote support must meet the intermittent or unscheduled needs for support for when a participant needs it to live and work in the most integrated setting, supplementing in-person service delivery. Remote support is limited to check-ins and consultations within the scope of housing stabilization services. Remote support may be utilized when it is chosen by the participant and approved in the service plan as a method of service delivery.

- Remote support shall be limited to one hour per month for all housing stabilization services in a calendar month. Requests for additional time will be reviewed by DHHS. See Section 5 Service Authorizations, for more information.

- Providers may not:
    - Bill direct support delivered remotely when the exchange between the service and participant and the provider is social in nature;
    - Bill direct support delivered remotely when real-time, two-way communication does not occur;
    - Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports.

General

- Transition Services (pre-tenancy support) and Sustaining Services (post-tenancy support) may not be provided concurrently.

- Transition Services may only be provided to support a transition to a lower level of care.

- If a member is transitioning from a medical facility to the community, supportive housing services are not billable earlier than 180 days prior to the transition.

3.3 Member Eligibility for Services

Members enrolled in this 1915(i) benefit program shall be:

- Eligible for Medicaid
- 18 years of age and older; and
- Have a documented disability or disabling condition, as defined below:
    - Disability means the term as defined at 42 U.S.C. 416(i), except that the required minimum duration of the impairment shall be 48 months.
    - Disabling condition means an injury, substance use disorder, mental health condition, or illness, as diagnosed by a qualified health professional, that is expected to cause an extended or long-term incapacitation but does not meet the definition of disability stated above.
- Requires assistance with achieving and maintaining housing as a result of a disability or disabling condition, as indicated by a need for assistance with at least one of the following:
    - Mobility;
    - Decision-making;
    - Maintaining healthy social relationships;
    - Assistance with at least one basic need such as self-care, money management, bathing, changing clothes, toileting, getting food or preparing meals: or
    - Managing challenging behaviors: and
- Experiencing housing instability as evidenced by one of the following risk factors:
    - Is chronically homeless – a member is considered chronically homeless if they are living in a place not meant for human habitation or a shelter, have been continuously homeless for at least one (1) year or on at least four (4) separate occasions in the last three (3) years;
    - Is at risk of chronic homelessness – a member is considered at risk of chronic homelessness if they are living in a place not meant for human habitation or a shelter, have been continuously homeless for less than one (1) year and less that four (4) separate occasions in the last three (3) years, lack sufficient resources and support networks to assist them in obtaining permanent housing; or
    - Has a history of chronic homelessness – a member is considered to have a history of chronic homelessness if they are currently housed, previously met the chronically homeless criteria, and is at risk of returning to homelessness without this 1915(i) benefit.

Eligibility will be determined by the Bureau of Homeless Services (BHS) utilizing applicant information gathered during the Coordinated Entry process by the Regional Access Point (RAP). The member experiencing homelessness or housing instability will reach out to the Regional Access Point directly or via 211. The Regional Access Point will conduct the Coordinated Entry assessment. If the member appears to meet criteria for 1915(i) Supportive Housing Services, the participating RAP will work with the member to complete the application and gather documentation to verify housing and disability status. The RAP will email the completed application and attachments to the Bureau of Homeless Services (BHS). After reviewing documentation, verifying active Medicaid benefits, and completing a service review to determine if the member is receiving Targeted Case Management, BHS will send a Notice of Decision to the member and inform the RAP that the member is eligible to receive services.

The RAP will then work to identify providers of Targeted Case Management and the Transition and Sustaining Supportive Housing services. If the service review identifies that the member currently receives Targeted Case Management (TCM), the Regional Access Point will communicate with the TCM provider and direct the member to follow up with the TCM provider to develop their housing Plan of Care. If the member is not receiving TCM, the Regional Access Point will develop the Plan of Care and identify an enrolled Supportive Housing provider for ongoing TCM. The respective providers of each service component must complete a service authorization request (form BHS 101) and submit it to BHS for approval. The providers of the benefit must resubmit service authorization paperwork annually to demonstrate continued medical necessity.

Housing Stabilization Services are provided to members living in their own home where the member controls the services they receive and who provides them.

An eligible household means individuals living together who meet Medicaid eligibility when needs, income, and/or resources are combined together, in addition to meeting the needs-based HCBS eligibility criteria. Household composition is determined by the adult members of the group living together that intends to apply for benefits.

Housing Stabilization Services are individualized, provided in the community or the member's own home, and allow full access to the broader community according to individual needs and preferences.

Service eligibility reevaluations are conducted at least every twelve months.

Process for Performing Service Eligibility Evaluation/Reevaluation

- NH DHHS will evaluate eligibility and re-determination and perform the independent evaluation of needs-based criteria. In order to determine eligibility of the needs-based State Plan HCBS eligibility criteria, NH DHHS staff will review the following information:
    - Completed Coordinated Entry Housing Assessment tool (completed by Regional Access Point)
    - Completed Housing Status Documentation:
        - Homeless-self certification signed by applicant and Regional Access Point
        - At-Risk of Homelessness - documentation of income, documentation of housing situation that would lead to homelessness without support
    - Completed Disability Documentation:
        - Disability Verification Form which includes written diagnosis in addition to one of the following
            - Written verification of the disability from a licensed professional;
            - Written verification from the Social Security Administration; or
            - The receipt of a disability check
- During re-determination of eligibility, the updated annualPlan of Care (covered under T2024) will be reviewed, in addition to the following supporting documentation:
    - Homeless- self certification signed by applicant and Regional Access Point
    - At-Risk of Homelessness - documentation of income, documentation of housing situation that would lead to homelessness without support
    - A letter from the 1915(i) supportive housing servicing provider with justification for ongoing services by demonstrating the household lacks sufficient resources and support networks necessary to retain housing without waivered services.

4.0 Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the "Non-Covered Services" section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, prior to delivery of the service, that it is non-covered by NH Medicaid, and that should the member still choose to receive the service, then the member will be responsible for payment. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

5.0 Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization for a specific item or service.

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The SA form should be submitted to the Department via the following email address: SupportiveHousingBenefit@dhhs.nh.gov

A Supportive Housing provider may make a written request to the Department to authorize additional service hours if the benefits annual limits outlined in the 1915(i) are met.

A request for additional service authorization shall include a specific reference to the pertinent section of the 1915(i), a full description of why the additional services are necessary, and a full explanation of alternative provisions or procedures proposed by the Supportive Housing provider. No provision or procedure prescribed by statute shall be waived.

A request for additional service authorization shall be granted after the Department determines that the alternative proposed by the Supportive Housing provider meets the objective, or intent of the rule, and:

- Does not negatively impact the health or safety of members; or
- Does not affect the quality of Supportive Housing provider services.

Upon receiving an approval of a service authorization request, the Supportive Housing provider's subsequent compliance with the alternative provisions, or procedures approved in the service authorization, shall be considered compliance within the limits of which the service authorization was sought.

Service Authorizations shall be granted in writing for a specific duration not to exceed one year, except as in those service authorizations which relate to fire safety or other issues relative to member health, safety or welfare that require periodic reassessment.

A Supportive Housing provider may request a renewal of a service authorization from the Department. Such a request shall be made prior to the expiration of a current service authorization.

6.0 Documentation

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer. See the "Record Keeping" section of the General Billing Manual – Volume I for more detailed documentation requirements.

The Supportive Housing provider shall maintain clinical information, and documentation of services, as required by federal regulation. This clinical record shall include:

- The signature of the service provider;
- The service provider's credentials;
- The legible name of the service provider, including a typed name, name stamp, or printed name within proximity of the credentials and signature of the service provider;
- The date of service; and
- The date of documentation.

All documentation in the clinical record of a Supportive Housing service shall comply with the following requirements:

- The specific services rendered;
- The date and actual time the services were rendered;
- Who rendered the services;
- The setting in which the services were rendered;
- The amount of time it took to deliver the services;
- The relationship of the services to the treatment regimen described in the Plan of Care (PoC) PoC; and
- Updates describing the patient's progress

7.0 Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations, CMS transmittals, provider manuals, fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services, or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume I.

8.0 Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" Section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9.0 Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for exclusions as outlined in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume 1.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10.0 Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

11.0 Claims

All providers participating in NH Medicaid must submit claims in accordance with NH Medicaid guidelines. NH Medicaid claim completion requirements may be different than those for other payers, previous NH fiscal agents, or fiscal agents in other states.

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor state staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

11.1 Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue and procedure codes. One procedure or revenue code must be provided for each charge billed.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

11.3 Service Authorizations (SAs)

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, NH Medicaid does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

11.4 Claim Completion Requirements for Therapies

Supportive Housing Providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P.

Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.

2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted areas show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
7. DO use only black or blue ink on ALL claims or adjustment that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name or signature on file.

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

For additional guidance on how to complete a CMS1500 claim form please refer to the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

12.0 Terminology

Coordinated Entry - A centralized and coordinated process that is designed to assist program applicants through intake, assessment, and the provision of referrals for housing services. Coordinated Entry works by establishing a common process to understand the situation of all individuals, youth, and families who request assistance through the housing/homeless system.

Regional Access Point (RAP) – The housing system's point of entry to the Coordinated Entry system. The majority of RAPs have a physical location and a main housing staff member to assist NH citizens in finding and connecting with housing services.