STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PROGRAM QUALITY AND INTEGRITY

BUREAU OF PROGRAM INTEGRITY - THIRD PARTY LIABILITY UNIT

Lori A. Weaver
Commissioner

Meredith J. Telus
Director

129 PLEASANT STREET, 2ND FLOOR THAYER BUILDING, CONCORD, NH 03301
603-271-8063 1-800-852-3345 Ext. 8063
Fax: 603-271-8113 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

HEALTH INSURANCE PREMIUM PAYMENT (HIPP)
CO-PAY AND DEDUCTIBLE INSTRUCTIONS FOR REIMBURSEMENT

Under the Health Insurance Premium Payment (HIPP) Program, you can be reimbursed for co-pays and deductibles in which you have paid out-of-pocket for services by an in network doctor or medical facility with your employer insurance, but not in network with NH Medicaid. This also includes any prescription drugs through a mail order pharmacy. Please follow these steps to be reimbursed by NH Medicaid.

Please complete the attached form AND provide the following:

- A receipt or invoice, which includes the date of service, doctor or medical facility's name, service provided, the person's name receiving the service, and the amount you paid or are required to pay. If the reimbursement is for mail order pharmacy, please provide the receipt or invoice that is received with the medication.

- The person receiving the prescription must be eligible for NH Medicaid and HIPP on the date of service.

Please note:

- If this is your first time submitting a Co-Pay and Deductible Reimbursement request, you must complete an Alternate W-9 form. Please print and complete the form from the HIPP web page and return it with the Reimbursement form and receipts.

- You can only request reimbursement for co-payments and deductibles for services or drugs that are covered by NH Medicaid.

- Special Handling, Rush Shipping charges, or late fees assessed will not be paid.

- All requests for reimbursement must be submitted within one year of date of service.

Once NH Medicaid has received the properly completed form and a copy of the proper receipt/invoice, you should receive reimbursement within 60 days.

If you have questions or need additional information please contact BPI Administrative Unit, Toll Free in NH only at (800) 852-3345, extension 6117, or by dialing the direct line (603) 271-6117.

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HIPP CO-PAY AND DEDUCTIBLE REIMBURSEMENT FORM

Policyholder Name:

Policyholder Address:

Phone #

Reimbursement Information

HIPP Member Name	Medicaid ID #	Provider Name	Service(s)/ltem(s) Purchased	Date of Service*	$ Amount

**** All requests for reimbursement must be submitted within 1 year from Date of Service***

Please return this completed form along with invoice/receipt for each reimbursement requested above to the following address:

NH Department of Health & Human Services
Medicaid - TPL HIPP
129 Pleasant Street — Thayer Bldg.
Concord, NH 03301

I am requesting reimbursement from the Medicaid program for HIPP Member co-payments and deductibles owed under my private insurance policy requirements. My signature below acknowledges my understanding of the following:

1) The expenses attached have not been reimbursed nor will I seek reimbursement for these expenses from any other source;
2) The expenses must qualify for reimbursement under the Medicaid program;
3) Reimbursement expense cannot be claimed as credits or deductions on my personal income tax;
4) I have retained copies of the documentation submitted with this request, as these materials will not be returned;
5) The expenses noted in this package are an obligation owed or paid by me, and the services were for an active Medicaid and HIPP member on the date of service.
6) I understand all requests for reimbursement must be submitted within 1 year from Date of Service.
7) Reimbursement will be made out to the policyholder and sent to the address on record for the policyholder.

Signature Date