



**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF IMPROVEMENT AND INTEGRITY**

**Nicholas A. Toumpas
Commissioner**

**129 PLEASANT STREET – THAYER BUILDING, CONCORD, NH 03301-3857
603-271-8763 1-800-852-3345 Ext. 8763
Fax: 271-8113 TDD Access: 1-800-735-2964 www.dhhs.nh.gov**

**Tashia Blanchard
Administrator**

**HEALTH INSURANCE PREMIUM PAYMENT (HIPP)
INSTRUCTIONS FOR REIMBURSEMENT
OF CO-PAYS AND DEDUCTIBLES**

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 a doctor or medical facility that is in network 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 fill in 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 mail the items above and the form to the following address or fax to (603)271-8113:
NH Department of Health & Human Services
Medicaid – TPL
129 Pleasant Street – Thayer Bldg
Concord, NH 03301-9846

Please note:

- You can only request reimbursement for co-payments and deductible for services or drugs that are covered by NH Medicaid.
- Special Handling, Rush Shipping charges, or late fees assessed will not be paid.

Once NH Medicaid has received the form (filled out correctly) and a copy of the receipt/invoice (with the information listed above), you should receive reimbursement within 60 days.

If you have questions or need more information, please contact Denise Kitson, Program Specialist, directly at (800) 852-3345, extension 5108 or (603) 271-5108.



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**Health Insurance Premium Payment (HIPP) Program
Medicaid Third Party Liability
HIPP Co-Pay and Deductible Reimbursement Request Form**

Policyholder Name:
Policyholder Address:
Phone #

Reimbursement Information

HIPP Member Name	MID	Provider Name	Service(s)/Item(s) Purchased	Date of Service	Amount

Please return this completed form along with invoice/receipt for each above requested reimbursement.

Return to the following address:

**NH Department of Health & human Services
Medicaid - TPL
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)** Reimbursement will be made out to the policyholder and sent to the address on record for the policyholder.

Signature

Date

Please make additional copies of this form as needed and for future use