# NEW HAMPSHIRE MEDICAID
# MEDICARE CROSSOVER FORM

*New Hampshire Medicaid*
*Fee-For- Service Program*
P.O. Box 2003
Concord, NH 03302

Medicaid Provider Name: _____

Medicaid Provider Number: _____

Medicaid Member Last Name: _____

Medicaid Member First Name: _____

Medicaid Member ID Number: _____

Billed Amount: _____

Medicare Allowed Amount: _____

Medicare Deductible Amount: _____

Medicare Coinsurance Amount: _____

Medicare Provider Paid Amount: _____

From Date of Service: _____

Through Date of Service: _____

Type of Bill (if applicable): _____

Procedure Code (if applicable): _____

Medicare Paid Date: _____

****Claim form must be attached****