Request to Adjust Patient Liability

Name of resident: _____ Date of birth: _____

Social Security #: _____ Medicaid ID #: _____

Name of Nursing Facility: _____

You may submit up to 3 expenses using this one form.

Amount of expense #1: _____ Date expense #1 was incurred: _____

Reason for expense #1: _____

Anticipated patient liability amount after adjustment has been applied: _____

Calendar month(s) requested to adjust patient liability: _____

Has a different request to adjust patient liability already been submitted for the month entered above?

☐ Yes ☐ No

Amount of expense #2: _____ Date expense #2 was incurred: _____

Reason for expense #2: _____

Anticipated patient liability amount after adjustment has been applied: _____

Calendar month(s) requested to adjust patient liability: _____

Has a different request to adjust patient liability already been submitted for the month entered above?

☐ Yes ☐ No

Amount of expense #3: _____ Date expense #3 was incurred: _____

Reason for expense #3: _____

Anticipated patient liability amount after adjustment has been applied: _____

Calendar month(s) requested to adjust patient liability: _____

Has a different request to adjust patient liability already been submitted for the month entered above?

☐ Yes ☐ No

You must include documents to verify all expenses. Expenses listed on this form that do not include supporting documentation, will not be used to adjust patient liability.

Hospice patients can only have patient liability adjusted for prior medical expenses. Current medical expenses cannot be used to adjust patient liability for hospice patients.

Send this Form along with all supporting documentation to:

Centralized Scanning Unit (CSU), PO Box 181, Concord, NH 03302

Or email this Form and all supporting documentation to:

centralizedscanunit@dhhs.state.nh.us