

- Medicare denied claims – subject to a timely filing deadline of 2 years from the date of service. Submit a paper HFS 2360, HFS 1443, HFS 2209, HFS 2210, or HFS 2211 with the EOMB attached showing the HIPAA compliant denial reason/remark codes. Attach Form HFS1624, Override Request form, stating the reason for the override. For institutional claims, submit a paper UB-04 with the EOMB attached showing the HIPAA compliant denial reason/remark codes. Attach Form HFS1624A, UB-04 Override Request form, stating the reason for the override.
- New provider enrollment, provider re-enrollment, addition of a new specialty/sub-specialty, or addition of an alternate payee – **applies only to those claims that could not be billed until the enrollment, re-enrollment, addition of a new specialty/sub-specialty, or payee addition was complete.** The 180 day period shall begin with the date the enrollment, re-enrollment, or update was recorded on the provider file. Attach form HFS 1624, Override Request (NIPS providers) or HFS 1624A, UB-04 Override Request (institutional providers), stating the reason for the request to a paper claim form. Upon receipt of claims with an override request, HFS staff will verify that the claim(s) could not have been billed without the change to the provider file. Requests for override due to a provider file change must be requested within 180 days of a claim rejecting due to the discrepancy.
- Retroactive Participant eligibility – 180 days from the Department’s system update viewed on MEDI when verifying eligibility. Please ensure eligibility verification is for the date of service and not current date or date range. Attach a HFS 1624, Override Request Form (NIPS providers) or HFS 1624A, UB-04 Override Request Form (institutional providers), stating the reason for the override to a paper claim form.
- Replacement or Void/Rebill of an entire claim or single service line (NIPS only claims) – The Department will accept electronic transactions submitted through MEDI or via 837I or 837P files to void or replace a pending payable or paid claim (includes claims paid at \$0). The transaction must be submitted within 12 months from an original paid voucher date.

Note: The functionality of allowing replacement claims and claims to be re-billed following a void is for the purpose of correcting errors on previously submitted and paid claims (e.g., incorrect provider number, incorrect date of service, incorrect procedure code, etc.) and not for the purpose of billing additional services.

- Replacement claims – To replace a single service line (NIPS only) or entire claim, enter Claim Frequency “7”. Detailed instructions on how to replace a claim electronically can be found in the [Chapter 300](#), 837P and 837I Companion Guides. This method is preferred as it requires no manual override.

- Void & Re-bill – This process involves two steps. The void portion may be completed electronically or on paper. Please refer only to step #1 below for a void with no re-bill.
 1. To electronically void a single service line (NIPS only) or an entire claim, enter Claim Frequency “8”. Detailed instructions on how to void a claim electronically can be found in the Chapter 300, 837P and 837I Companion Guides. A paper void may be completed by submitting a NIPS Adjustment Form HFS 2292 or Hospital Adjustment Form 2249. Instructions on how to complete the forms are located in the [Handbook Supplement](#).
 2. Following completion of the void, a new original claim must be submitted within 90 days of the void DCN and may require manual override. If manual override is required, attach form [HFS 1624, Override Request Form](#) for NIPS claims, or the [HFS 1624A, Institutional Override Request](#) for institutional claims, stating the reason for override.

Note: For void or replacement claims the following data elements must match the original claim:

- Document Control Number - The 17-digit DCN from the original paid claim is required. Using the 12-digit DCN from the paper remit
 - Add ‘201’ to the beginning of that 12-digit DCN
 - Add **either** the 2-digit section number to void or replace a single service line (NIPS only), **or** ‘00’ to void or replace an entire claim, to the end of the 15-digit number
 - Provider NPI, or for atypical providers the HFS Provider Number
 - Recipient Identification Number
- TPL – Claims must be submitted to the Department within 180 days after the final adjudication by the primary payer. Claims may be submitted electronically or on paper and must have TPL fields completed. Timely submission will be calculated systematically based on the TPL adjudication date. For this reason, no override request is necessary.
- In the case of long term care facilities, once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.