PROVIDER NEGATIVE BALANCE REQUEST FORM

PROVIDER INFORMATION (please print all information)

All fields in the boxes with a * below are required information. See below for ** and *** information.

Provider Tax ID*:	Billing and Rendering (If applicable) Provider name*:
Date(s) of Service**:	Claim number(s)**:

How would you like to receive the Negative Balance Report?

☐ Fax ________________________

☐ Postal Mail Address ________________________________
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DIRECTIONS: Please **fax** the Provider Negative Balance Request form to NH Healthy Families' Provider Service Department, ATTN; PROVIDER SERVICES at 1-877-502-7255 or mail completed form to:

NH Healthy Families – Provider Services
2 Executive Park Drive
Bedford, NH 03110

Important Notice: NH Healthy Families will make reasonable efforts to resolve this request within 15 calendar days of receipt. **Incomplete forms will not be accepted and will not be returned.**

** You can request a Negative Balance Report based on either the claim number(s) or the date(s) of service. The claim number is preferred.
*** You may request more than one claim/date of service

Questions about how to fill out this form, please call Provider Services Department
Monday – Friday, 8AM-6PM 1-844-265-1278

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