The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

# Home Health Coverage Determination Form

*(Attach EOB from primary insurer to this form.)*

Provider Name _____
Provider Address _____
Branch Address _____
Contact Name _____
Contact Phone/Fax No. _____
MassHealth Provider No. _____
NPI _____

**Send to: MassHealth**
**Home Health Claims**
**The Schraffts Center**
**529 Main Street, 3rd Floor**
**Charlestown, MA 02129**
**Fax: 617-886-8133**

Date _____

Member Name _____ Member ID _____

Diagnosis _____

Dates of Service _____ to _____

**Services Provided (Check all that apply.)**

- ☐ Skilled Nursing
- ☐ Continuous Skilled Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech/Language Pathology
- ☐ Home Health Aide

**Qualifying/Triggering Event (Check one.)**

- ☐ New admission to a home health agency (HHA)
- ☐ A readmission to an HHA after a discharge from an inpatient hospital or skilled facility stay; resulting in a change of skilled services in the plan of care
- ☐ Cessation of commercial insurance coverage or a change of insurance (attach a completed TPLI form)
- ☐ Exhaustion of annual commercial insurance coverage or other periodic benefit(s)
- ☐ Reinstatement of insurance benefits
- ☐ Change in the patient's medical condition resulting in a change of skilled services in the plan of care

Please provide a brief description of the change in the box below.

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| |

**Is this a personal injury protection (PIP) case?** ☐ yes ☐ no

**Are you covending?** ☐ yes ☐ no

If yes, name of covendor. _____

## Purpose of Home Health Coverage Determination (HHCD) Form

The MassHealth HHCD Form is used by home health agencies to show compliance with MassHealth's third-party liability (TPL) regulations (130 CMR 450.316 and 450.317). For members with commercial insurance in addition to MassHealth, providers must submit claims to the commercial insurer for a coverage determination before submitting the claim to MassHealth. Coverage determinations and explanations of benefits (EOBs) must be obtained whenever a member has a qualifying event. The HHCD Form must accompany the coverage determination and/or EOB to MassHealth within 10 days of the provider's receipt of the EOB. Home health providers must continue to submit paper coverage determinations for all qualifying events whether billing electronically or on paper.

## Instructions for Completing the HHCD Form

**Provider Information**
Fill in your provider name, branch address, and contact's phone and fax numbers.

**MassHealth Provider No.**
Fill in your MassHealth provider number.

**NPI**
Fill in your national provider identifier (NPI) number.

**Date**
Fill in the date you are sending the form and accompanying EOB to MassHealth.

**Member Name**
Fill in the member's name.

**Member ID**
Fill in the member's ID number.

**Diagnosis**
Fill in the diagnosis/diagnoses; ICD codes are not necessary.

**Dates of Service**
Fill in the dates you want MassHealth to start and end payment. If there is no end date, enter a start date and indicate "ongoing."

**Services Provided:**
Check off all services the agency is providing to the member.

**Qualifying/Triggering Event**
Check off the reason the provider obtained the initial EOB or new EOB. If you are notifying us of a change in insurance, please complete both the HHCD Form and the TPLI form and send both with the EOB. Both forms are available on the MassHealth website at www.mass.gov/masshealth by clicking on the link for MassHealth Provider Forms in the lower right corner of the page.

**Description of Change**
Indicate why the primary insurance company was billed.