Attachment D2
PSHA Medicaid Billing Guidance

Updated January 2026

This attachment provides information on the Medicaid Portal such as checking Participant Medicaid information and eligibility, the mechanics of Medicaid billing, how to review previous claims, and how to update passwords. It includes a link to a video of setting up claim submissions, and a sample paper submission form.

MEDICAID PORTAL

The Medicaid Portal accessed here: Vermont Medicaid Portal.

The portal provides access to a variety of forms, manuals, and guidance, under the "Information" tab.

Once logged in under the "Transactions" tab, billing specialists can check Medicaid eligibility and information through their personal Medicaid Portal.

Here you can verify the spelling of names, check to see if Medicaid is active, and if a person falls under eligible Aide Categories.

CLAIM SUBMISSION

Contracted Providers can submit claims on paper or electronically:

- **Paper Claims:** Complete and submit the CMS 1500 Form for Medicaid Billing.
- **Electronic claims:** This billing mechanism offers faster processing and payment. Contracted Providers can apply for a Transaction Services Account for electronic claims submission capabilities. The application and required forms can be found at http://www.vtmedicaid.com/#/hipaaTools.

Claims for Pre-Tenancy Support Services and Tenancy Sustaining Services can be submitted once per month for each Participant with an active Prior Authorization, provided that minimum service delivery requirements are met. Community Transition Assistance claims may be submitted as needed when approved and up to the identified caps. These funds will be reimbursed to the Contracted Provider.

While monthly billing is recommended, Medicaid requires that all billing be completed

within 180 days of the date of service per their Timely Filing rule. More information on Timely Filing deadlines can be found on the https://www.vtmedicaid.com/assets/resources/TimelyFilingFAQ.pdf and in section 3.3 of the GeneralBillingFormsManual.pdf.

Information Needed for Claim Submission

Contracted Providers need the following information for claim submission:

- **Provider Type:** T47 (FAMILY SUPPORTIVE HOUSING)
- **Specialty:** S55-Permanent Supportive Housing
- **Taxonomy:** 171M00000X- Case Manager/Care Coordinator
- **Diagnosis Code**: The diagnosis code describes the Participant's condition and the reason for services. All providers should use the following code for their PSHA services:

Z59.9 Problems related to housing and economic circumstances, unspecified

(Z codes may be subject to change)

- **Procedure Code**: The procedure code (also known as the CPT Code) identifies the service or good provided to the Participant for which the claim is being submitted.

Contracted Providers should utilize the following procedure codes and modifiers:

  - Pre-Tenancy Support Services – **H0044 U1**

    (H0044 is the code, U1 is the modifier)

  - Tenancy Sustaining Services – **H0044 U2**
  - Community Transition Assistance
    - Security Deposit – **H0043 U4**
    - Move-in Support – **H0043 U1**
    - Essential Utilities – **H0043 U2**
    - Pest Eradication – **H0043 U3**

Adjust procedure code modifiers for the month following a Participant's move into housing.

- **Place of Service Code** –The place of service code identifies the location of service. Use the following POS code: **99 –** Other Place of Service

- **Claim Amount** – Identifies the dollar amount of the reimbursement:

- **Pre-Tenancy Support and Tenancy Sustaining Services** - $667.00 PMPM
- **Community Transition Assistance** – The actual dollar amount spent or to be spent, not exceeding caps.

- **Medicaid Member ID Number** – The Medicaid ID, provided upon referral, number identifies the Participant who received the service or good for which the claim is being submitted.

Service Name	CPT Code/Modifier	Unit of Service/ Payment	Rate or Cap
Pre-Tenancy Support Services	H0044 UI	PMPM	$667.00
Tenancy Sustaining Services	H0044 U2	PMPM	$667.00
Housing Move-In Support *(household furnishing, moving expenses, etc.)*	H0043 UI	Cost-based reimbursement up to a lifetime cap	Up to $1,000
Essential Utility Set-Up	H0043 U2	Cost-based reimbursement up to a lifetime cap	$500 for utility deposits $500 for re-instatement of utilities payment $500 for utility arrears
Pest Eradication	H0043 U3	Cost-based reimbursement up to an annual cap	$3,000 per year
Security Deposit	H0043 U4	Cost-based reimbursement up to a cap	Up to $2,000 **Two-time only per Participant**

Here is the link to the **PES claim submission** training:
https://attendee.gotowebinar.com/recording/5654111423770135297

The video walks through creating lists to help the biller auto fill fields later.

Provider: Connect with the PSHA Provider Representative to ensure the agency is

using accurate information in this field as this will vary between agencies, depending on NPI status.

Client: A binary gender selection is required on this slide, sorry! The good news is that the gender chosen does not have any bearing on claims processing so if an entered gender disagrees with what the client identified when applying to Medicaid, that's fine. An address for the participant is required. It is **not** critical that this is the same address they used when applying for Medicaid so an agency could use their own address if a participant is unhoused, then switch it when permanent housing is attained.

Names need to be spelled correctly, though middle initials are not required, and Medicaid ID numbers must be accurate.

Please check the VT Medicaid portal to ensure member eligibility and the correct spelling of their name.

Diagnosis: When billing electronically, use ICD 10 and code Z599 (without a decimal point). The video walks you through the fields needed to bill.

The video shows what to do on each tab. Here is some of the information, reiterated:

SRVI tab

Select "Group" under billing provider type.

When billing for the H0044 codes, use the last day of the month. So, 6/30/2025-6/30/2025. For H0043 codes, use the date the items were paid for.

CPT / procedure codes - that is the H0044 and H0043. Use of modifiers is required. UI, U2, U3, and U4

Units - always use 1

Billed Amount - Use $667.00 for H0044 and the actual amount for H0043s

SRV2 tab

Connect with your Medicaid Provider Representative to ensure you are using the correct information under Rendering Provider as this will vary between agencies depending on NPI status.

A sample completed **CMS 1500 form** can be found at the end of this document.

Paper claims can be mailed to Gainwell at:
Gainwell Technologies
PO Box 888
Williston, VT 05495-088
Or emailed to your Provider Representative, joe.mcginnis@gainwelltechnologies.com.

REVIEW PREVIOUS CLAIMS

Billers can review the status of previous claims by looking at their Remittance Advice (RA). RAs will show if claims are paid out and when, or if they have been denied and why. Here is link to a video training on how to read RAs: https://mmislearningcenter.myabsorb.com/#/login.

You can also read more about RAs in the general Medicaid Provider Manual in section 3.9 on page 15: https://www.vtmedicaid.com/assets/manuals/GeneralProviderManual.pdf.

AID CATEGORIES

Medicaid PSHA services are only able to be billed for individuals actively enrolled in the Medicaid State Plan which encapsulates Medicaid Managed Care and Traditional Medicaid. Individuals qualify under different Aid Categories. Up to date Aid Category listings can be found here, AidCategoryListing.pdf. As Aid Categories can be changed due to changes in income and resources, particularly after Medicaid renewal, Provider Agencies can verify participants have active enrollment in eligible Aid Categories through their vtmedicaid.com portal. Examples of Aid Categories that do not qualify include VPharm which assists those with Medicare part D coverage to pay for prescriptions or Qualified Medicare Beneficiaries where Medicaid pays for Medicare costs.

CHANGE PASSWORDS

Your VT Medicaid password will need to change every 60 days. And, you must change it in two different places. You may discover the need to change a password because

your PES submission fails and your Communication Log provides and error code of 203 (password expired) or 202 (Web and PES passwords do not match). Detailed instructions for changing passwords can be found here: PESSubmissionFailureResolutionInstructions.pdf.

SAMPLE SUBMISSION

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brando, Marlin, G

3. PATIENT'S BIRTH DATE (MM DD YY) SEX: MM DD YY M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES | NO X

b. AUTO ACCIDENT? YES | NO X | PLACE (State)

c. OTHER ACCIDENT? YES | NO X

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX: M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X — If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A Z59.9 B C D

E F G H

I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

You need to enter cents, even if 00

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1	03 30 27	03 30 27	99		H0044 U1		A	667 00	1		NPI Provider ID #
2	03 21 27	03 21 27	99		H0043 U4		A	1965 00	1		NPI NPI # Provider ID #
3											NPI NPI #
4											
5											
6											

If you do not have an NPI, enter Provider ID in shaded block. If you DO have an NPI, skip the Provider ID & enter NPI in the non-shaded block.

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ 2632 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

Agency Name
Agency Address

a. NPI b. Provider ID

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

VERMONT

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 803795

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brando, Marlin, G

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) (

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | X NO

a. INSURED'S DATE OF BIRTH MM DD YY | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES X

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? X

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. Designated

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

If yes, complete items 9, 9a, and 9c.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1			H0044	U1	A	$667.00	1		NPI	provider ID # if no NPI (or) NPI #
2	05 25 25 05 25 25	99	H0043	U4	A	$1965.00	1		NPI	provider ID # OR NPI # if you have one
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ $2632.00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Office of Economic Opportunity
280 State Dr
Waterbury VT, 05676

(use your information)

(or)

a. NPI # b. provider ID #

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Molly Shriver-Blake

2025-08-12 19:47:10

This is where you will put the service code and modifier as outlined in the provider manual. H0044- U1 Pre-tenancy services

H0044- U2 Tenancy sustaining services H0043- U1 Move in support

H0043- U2 Essential

Molly Shriver-Blake

2025-08-12 19:47:30

If you do not have an NPI, put your Medicaid provider ID in the shaded section. If you do have an NPI, put that number in the non shaded field.

Molly Shriver-Blake

2025-08-12 19:47:47

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cents must come after the dotted line.

Molly Shriver-Blake

2025-08-12 19:48:16

Use 99 for place of service indicating "other"