PRIOR AUTHORIZATION
NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM

HIGH/SPECIAL LEVEL OF CARE
DETERMINATION OF MEDICAL ELIGIBILITY

1. PROVIDER NUMBER	2. PROVIDER NAME	3. MEDICAL RECORD NUMBER	6. CLIENT MEDICAID NUMBER	7. CLIENT NAME
	4. PROVIDER ADDRESS	5. LOC CODE		

8. NURSING FACILITY ADMIT DATE	9. PERIOD REQUESTED FROM	10. PERIOD REQUESTED TO
M M D D C C Y Y	M M D D C C Y Y	M M D D C C Y Y

PA REVIEW OFFICE CODE

↑
← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

DO NOT STAPLE IN BARCODE AREA

Please note that this approval does not guarantee payment. Payment depends on the person's Medicaid eligibility at the time the service is rendered and requires that the service provider be enrolled as a New York State Medicaid provider. All Medicare and other third party insurance must be applied and documentation required by the New York State Health Department must be provided.

11. LOCAL MEDICAL DIRECTOR'S OR DESIGNEE'S SIGNATURE	12. DATE
	M M D D C C Y Y

Explanatory Notes

Provider Number	The nursing facility's Medicaid provider identification number issued to the provider by the Department of Social Services upon the provider's enrollment in the New York State Medicaid Program. Completion mandatory.
Provider Name	The name that the nursing facility admitting the Medicaid recipient uses to identify itself to the New York State Medicaid Program. Completion mandatory.
Medical Record Number	The medical record number the nursing facility has assigned to the patient.
Location Code	Location where the nursing facility wishes to receive any correspondence related to this determination.
Client Medicaid Number	The recipient's New York State Medicaid identification number. Completion mandatory.
Client's Name	The last name, first name and middle initial of the New York State Medicaid recipient being admitted to the nursing facility.
Nursing Facility Admission Date	If the Medicaid recipient is already in the nursing facility, the date of admission or the date of transfer to the current level of care.
Period Requested	The start and end dates of the approval period requested for the Medicaid recipient. Completion mandatory.