New York State Department of Health
Medicaid Utilization Threshold Program
Threshold Override Application (TOA)

(please type or print clearly)

I. Client Information

Client ID Number

Beginning Month of Benefit Year

Name in Last Name, First Name, Middle Initial Order

Street Address

City

State

Zip

M F
Sex

Month Day Year
Birth Date

II. Provider Information

Provider Number

or

License Number

Professional Code

Name in Last Name, First Name, Middle Initial Order

Sample - Not For Submission

Correspondence Address - Line 1

Correspondence Address - Line 2

City

State

Zip

Area Code

Phone

Extension

MEDICAL ASSESSMENT:

III. Medical Data

1. Did the client receive a letter advising limits had been reached?

Y N

2. List, in order of importance, the ICD-9-CM Diagnosis Code(s) that warrant, in your judgment, an override of the Medicaid Utilization Thresholds for the remainder of the client's current benefit year.

1. 2.

3. 4.

5. 6.

3. For the service utilization threshold(s) that need to be raised, enter the amount of increase that you suggest for the remainder of the client's current benefit year.

(a) PHYSICIAN/MEDICAL CLINIC ENCOUNTERS
Provide written assessment if greater than 10

(b) PHARMACY SERVICES
(including prescription drugs, OTC's and medical/surgical supplies) - No. of items
Provide written assessment if greater than 24

(c) LABORATORY SERVICES - No. of procedures
Provide written assessment if greater than 10

(d) DENTAL CLINIC VISITS
Provide written assessment for all requests

(e) MENTAL HEALTH ENCOUNTERS
Provide written assessment if greater than 12

4. How long in months do you expect this condition to last, and the client to need additional service authorizations?

DO NOT STAPLE IN BARCODE AREA

[redacted]

MAIL TO:
CSC
CSC Federal Sector - Civil Group
PO Box 4602
Rensselaer NY 12144- 4602

I hereby certify that, in my professional judgment, the client indicated above should have his/her Medicaid utilization threshold(s) changed as indicated to ensure that proper medical treatment is available without further medical review.

Provider Signature

Date