PRIOR AUTHORIZATION
NYS MEDICAL ASSISTANCE – TITLE XIX PROGRAM

OUT-OF-STATE NURSING HOME

MAIL TO:

eMedNY
PO Box 4600
Rensselaer, NY 12144-4600

NURSING HOME PROVIDER

* = *required fields*

PROVIDER NPI: *	PROVIDER NAME: *	
PROVIDER ADDRESS: *		LOCATION CD:

CLIENT

MEDICAID NUMBER: *	CLIENT NAME: *

NURSING FACILITY

ADMIT DATE: (mm/dd/yyyy)	PERIOD REQUESTED FROM: (mm/dd/yyyy)	PERIOD REQUESTED TO: (mm/dd/yyyy)

REFERRING PROVIDER

PROVIDER NPI: *	PROVIDER NAME: *

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.