New York State Fee-For-Service Medicaid Program

Prior Approval for Out-of-State Medical Treatment

Instructions (To be completed by the Referring Practitioner):

A. **Member Information:** Include full name, the date of birth (DOB), Medicaid Identification Number (8-digit alphanumeric), address at which the member can be reached, the county of residence, phone number and email address.

B. **Referring Practitioner:** Include the full name and National Provider Identification (NPI) number of the referring/ordering practitioner recommending out-of-state treatment. The referring practitioner must be enrolled in NYS Medicaid.

C. **Contact Person:** Include full name, title, phone and fax numbers where you can be reached, your full work mailing address (street number, street, city, state, and zip code), email address, and the hospital/agency/ facility you represent. Requests provided by the proposed out-of-state facility, rather than the referring practitioner or case manager, will not be accepted.

D. **Proposed Out-of-State Facility**: Include name of facility, NPI, full mailing address (street number, street, city, state, and zip code), Fax number, contact person and their phone number and email, anticipated dates of service, and check either inpatient or outpatient (or both if appropriate). The OOS facility or provider must be enrolled in NYS Medicaid.

E. **Documentation**:

1. Please list all NYS facilities that have been contacted about providing in-state care and explain why they cannot provide adequate inpatient admission and/or outpatient services. Provide the facility name, contact person, phone number, fax number and email address for each.

2. Please provide a narrative explaining the medical need for the member leaving New York State to receive care.

PLEASE NOTE: This form CANNOT BE ACCEPTED without this information.

F. **Attestation:** The referring/ordering practitioner must sign and date, attesting that the information provided is true and accurate.

Submission: Fax completed and signed forms to (518) 402-3253 or email to: FFSOOS@health.ny.gov.

Questions? For questions related to out of state referrals, contact the Bureau of Medical Review at 1-800-342-3005 option 4 or by email at FFSOOS@health.ny.gov

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Member Information

Full Name: _____ **DOB:** _____
Last *First* *M.I.*

Medicaid ID#: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

_____
County of Residence

Phone: _____ **Email:** _____

Referring Practitioner

Name: _____ **NPI:** _____

Contact Person

Full Name: _____ **Title:** _____

Phone: _____ **Fax:** _____

Address: _____

Email: _____ **Hospital/Agency/Facility:** _____

Proposed Out-of-State Facility

Name: _____ **NPI:** _____

Address: _____ **Fax:** _____

Contact Person: _____ **Phone:** _____

Email: _____

Anticipated Date(s) of Service: _____

Purpose of the Requested Care (Check all that apply)**:** **Inpatient** **Outpatient**

Documentation

Information that can be beneficial to our review of your request:

- A list of all NYS facilities that have been contacted about providing in-state care and explain why they cannot provide adequate inpatient admission and/or outpatient services. Provide the facility name, contact person, phone number, fax number and email address for each. Provide documentation from each facility stating why specifically they are unable to adequately serve this member.
- Primary ICD-10 Code with description
- Secondary ICD-10 Code with description
- Past medical history including any surgeries or treatments (include dates, and locations), additional diagnoses, social/living situation
- History of present illness including age of onset, progression of their disease process, current treatments and medications, impact of current condition and/or treatment on the member and their family, prognosis for their condition
- If the proposed facility is not equipped for emergency services, please confirm that there is a nearby acute care hospital that is enrolled with NYS Medicaid and can meet any unexpected medical needs of the member
- Proposed length of stay and projected discharge plan

Attestation

I certify that the information is true and accurate to the best of my knowledge, and I understand that the documentation must be kept on file and produced upon request to the Department of Health and/or its agents.

Referring/Ordering Practitioner's Signature

Signature: _____ Date: _____

Submission: Fax completed and signed forms to (518) 402-3253 or email to: FFSOOS@health.ny.gov.

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