



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

New York State Fee-For-Service Medicaid Program Renewal Request for Out-of-State Skilled Nursing Facility

Member Information

Full name: _____
Last First M.I.

Medicaid ID#: _____ DOB: _____ Date of this request: _____

Medicare/Other primary insurance: _____ ID number: _____ Effective Dates: _____

Home Address: _____
Street Address Apartment/Unit #

City State Zip Code

County ICD-10 Codes: _____, _____, _____

Requesting Facility Information

Facility name: _____ NPI: _____

Facility Address: _____
Street Address

City State Zip Code

Facility contact person: _____ Phone: _____

Email address: _____ Fax: _____

Existing PA number: _____ Initial date of Admission: _____

Referring physician: _____ NPI: _____

Dates of Service Requested: _____ Comment: _____

Attestation

- I attest that it is medically necessary for this member to continued to reside at this facility. Yes___ No___
- I attest that the resident, guardian, or legal representative is not pursuing repatriation to NYS at this time. Yes___ No___
- I am requesting authorization for a new prior approval valid for 365 days. Yes___ No___

Signature: _____ Date: _____

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