



Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

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

Provide this completed form with any new prior approval requests entered into ePACES.
(Not for initial requests. Subsequent PA's only.)

Member Information

Full name: _____
Last First M.I.

Medicaid ID#: _____ DOB: _____

ICD-10 Codes: _____, _____, _____

Requesting Facility Information

Facility name: _____ NPI: _____

Facility contact person: _____ Phone: _____

Email address: _____ Fax: _____

Existing PA number: _____ Initial date of Admission: _____

Referring physician: _____ NPI: _____

Attestation

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

Yes ___ No ___

Yes ___ No ___

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