NEW YORK STATE OF OPPORTUNITY. 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*

_____ ICD-10 Codes: _____, _____, _____
County

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