NEW YORK STATE | Department of Health

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:** _____

Home Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

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:** _____

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: _____