New York State Medicaid Program

Print Form

Prior Authorization for Initial Admission in an Out of State Skilled Nursing Facility

(see reverse for instructions)

A. Beneficiary:

Name: _____ Medicaid CIN: _____

County/District of Residence: _____ Primary Diagnosis: _____ Secondary Diagnosis: _____

Address: _____

B. Referring Practitioner:

Name: _____ NPI: _____

C. Discharge Planner/Case Manager:

Name: _____ License #: _____

Phone # _____ Hospital/Agency: _____

Address: _____

D. Proposed Nursing Facility:

Name: _____ NPI: _____

Address: _____

Contact Person: _____ Phone #: _____

Anticipated Placement Date: _____ ☐ N/S Custodial ☐ High/Special

E. Documentation:

The following documentation is on file. (Please indicate yes or no.):

Yes	No	
☐	☐	Completed SCREEN form and/or completed PASRR Evaluation Report for level of care requested.
☐	☐	Beneficiary has been denied admission to all in-state facility placements for requested level of care within 50-75 miles from his/her residence.
☐	☐	Beneficiary will be temporarily absent from the state and residents of beneficiary's county/district customarily obtain care at proposed facility.

F. Attestation:

The information above is true and accurate and I/we understand that the documentation must be kept on file and produced upon request to the Department of Health and/or its agents.

_____ _____

Discharge Planner/Case Manager Signature **Date**

_____ _____

Attending /Ordering Practitioner's Signature **Date**

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Prior Authorization:

Prior authorization for initial admission in an **Out of State Skilled Nursing Facility** ensures that New York State Medicaid beneficiaries are provided every opportunity to remain in and receive health care services from providers within the borders of New York. Payment will not be made to facilities unless admission has been authorized by the New York State Department of Health, Office of Health Insurance Programs.

NOTE: Prior Authorization is not required for short term rehabilitation or when Medicare is the primary payer.

Instructions: (should be completed by the Discharge Planner/Case Manager)

A. Beneficiary Information
Include full name, Medicaid Client Identification Number (8 digit alphanumeric), the county/local social services district of residence, address at which the beneficiary can be reached, primary and secondary diagnosis codes.

B. Referring Practitioner
Include the full name and National Provider Identification number of the referring/attending/ordering physician recommending skilled nursing facility placement.

C. Discharge Planner/Case Manager
Include full name, license number, phone number where you can be reached, the hospital or agency you represent and your full work mailing address (street number, street, city, state and zip code).

D. Proposed Nursing Facility
Include name of facility, National Provider Identification number, contact person and their phone number, full mailing address (street number, street, city, state, and zip code) anticipated placement date of beneficiary, and check either non-specialized/custodial or high/special level of care. High/special level of care includes beneficiaries with Traumatic Brain Injury or other significant medical, behavioral and/or developmental issues.

E. Documentation
Answer YES or NO to the three questions. This documentation may be requested and must be provided upon request.

F. Attestation
The physician and discharge planner must sign and date attesting that the information provided is true and accurate.

Submission:

Fax completed and signed form to **(518)402-3253.**

Questions? Call **1(800)342-3005, option 1.** For callers outside of New York State please call **(518) 474-3575, option 1.**