New York State Department of Health
Medicaid Utilization Threshold Program
Threshold Override Application (TOA)

(please type or print clearly)

I. Member Information

Member ID Number

Beginning Month of Benefit Year

Name in Last Name, First Name, Middle Initial Order

Street Address

City

State

Zip

M F
Sex

Month Day Year
Birth Date

II. Provider Information

Provider Number or License Number Professional Code

Name in Last Name, First Name, Middle Initial Order

Correspondence Address - Line 1

Correspondence Address - Line 2

City

State

Zip

Area Code Phone - Extension

DESCRIBE MEDICAL CONDITION supporting TOA:

III. Medical Data

1. Did the member receive a letter advising limits had been reached? Y N

2. List, in order of importance, the ICD Diagnosis Code(s) that warrant, in your judgment, an override of the Medicaid Utilization Thresholds for the remainder of the member's current benefit year.

1. 2.
3. 4.
5. 6.

3. For the service utilization threshold(s) that need to be raised, enter the amount of increase that you suggest for the remainder of the member's current benefit year.

(a) PHYSICIAN/MEDICAL CLINIC ENCOUNTERS
Provide written documentation for all requests

(b) PHARMACY SERVICES
(including prescription drugs, OTC's and medical/surgical supplies) - No. of items
Provide written documentation for all requests

(c) LABORATORY SERVICES - No. of procedures
Provide written documentation for all requests

(d) DENTAL CLINIC VISITS
Provide written documentation for all requests

(e) MENTAL HEALTH ENCOUNTERS
Provide written documentation for all requests

4. How long in months do you expect this condition to last, and the member to need additional service authorizations?

DO NOT STAPLE IN BARCODE AREA

MAIL TO:
eMedNY Federal Sector - Civil Group
PO Box 4602
Rensselaer, NY 12144-4602

I hereby certify that, in my professional judgment, the member indicated above should have his/her Medicaid utilization threshold(s) changed as indicated to ensure that proper medical treatment is available without further medical review.

Requesting Provider Signature Date

Print Name

New York State Department of Health
Medicaid Utilization Threshold Program
Threshold Override Application (TOA) Instructions

NOTE: Only original Threshold Override Application forms will be accepted

SECTION I – MEMBER INFORMATION

1. **Member ID Number** – Enter the 8-character Member ID number of the Member. The first 2 characters are alpha, the next 5 are numeric and the last 1 is alpha.
2. **Beginning Month of Benefit Year** – Enter the beginning month of the Member's benefit year. This information is returned to the Provider as the Anniversary Month in the MEVS response and is also given in Warning and At Limit letters sent to the Member.
3. **Last Name/First Name/Middle Initial** – Enter the Member's last name, first name and middle initial (in that order).
4. **Street Address/City/State/Zip Code** – Enter the Member's street address. This is the address the system uses to generate a response letter.
5. **City** – Enter the Member's city.
6. **State** – Enter the Member's state.
7. **Zip Code** – Enter the Member's zip code.
8. **Sex** – Place an X over M for male or over F for female to indicate the Member's sex.
9. **Birth Date** – Enter the Member's date of birth in month/day/full year (MM/DD/YYYY) format.

SECTION II – PROVIDER INFORMATION

1. **NPI Provider ID** – Enter the 10-digit National Provider Identification (NPI) number.
2. **License Number** – Providers can enter their License Number in this field. (You must complete the Profession Code when entering a License number in this field). If a NY State License Number is used, it must be preceded by 2 zeros (or 0F for Nurse Practitioner/Midwife). If an out of state License Number is used, it must be preceded by a valid 2-character alpha state code.
3. **Profession Code** – If a License number is entered, the 3-digit profession code must be entered. The profession code identifies the profession assigned to the license number. Profession codes are 3 digits – **do not enter "MD" in this field or the TOA form will be rejected.**

   - Profession Codes can be found at **www.eMedNY.org**

   choose the **NYHIPAADESK** option from the menu
   click on Crosswalks
   click on NYS Medicaid License and Profession Code Table
4. **Last Name/First Name/Middle Initial** – Enter the Provider's last name, first name and middle initial (in that order).
5. **Correspondence Address/City/State/Zip Code** – Enter the Provider's full correspondence address. This is the address the system uses to generate a response letter.
6. **Area Code/Phone/Extension** – Enter the Provider's telephone number with the area code and any applicable extension.

TOA WILL NOT BE ACCEPTED WITHOUT A DESCRIPTION OF THE MEDICAL CONDITION THAT SUPPORTS THE NEED FOR ADDITIONAL SERVICES.

SECTION III – MEDICAL DATA

1. **Did Member receive letter?** – Place an X over Y for Yes or over N for No to indicate if the Member received an At Limits letter. If unknown, leave blank.
2. **Diagnosis Codes** – This field is used to indicate diagnosis codes that describe the Member's condition. You must enter at least one diagnosis code, and can enter up to 6 codes if necessary. ICD Diagnosis codes are used to describe a medical condition. ICD Diagnosis codes can be found in the ICD Diagnosis book of diagnosis codes. The ICD Diagnosis code set used should comply with the current CMS HIPAA Guidelines.

In lieu of diagnosis codes, the Dental codes (listed below) must be used for all TOAs submitted to request an increase in Dental Clinic visits. The Dental codes describe the type of treatment required and are as follows:

DIAGNOSTIC	D0100
PREVENTIVE	D1000
RESTORATIVE	D2000
ENDODONTICS	D3000
PERIODONTICS	D4000
PROSTHODONTICS (REMOVABLE)	D5000
PROSTHODONTICS (FIXED)	D6000
ORAL AND MAXILLO-FACIAL SURGERY	D7000
ORTHODONTICS	D8000
ADJUNCTIVE GENERAL SERVICES	D9000

3. **Amount of Increase** – Enter the number of additional services being requested for the Member in the appropriate category. Provide the required written medical documentation. Only 2-digit entries are accepted. To request an exemption in a particular category, enter 99.
4. **Duration of Need** – Enter the number of months the Member will require the increased number of services. If the need is life long, enter 99.

SIGNATURE - The TOA form must have an original signature and date. Rubber stamps, photocopies and carbon-copied signatures will not be accepted. Please print name under signature to assist with any follow-up contact.