



New York State Fee-For-Service Medicaid Program Request for Enhanced Rate for Out-of-State Medical Treatment

Instructions (To be completed by the Referring Practitioner):

- A. **Member Information:** Include full name, the date of birth (DOB), Medicaid Identification Number (8-digit alphanumeric), address at which the member can be reached, the county of residence, phone number and email address.
- B. **Referring Practitioner:** Include the full name and National Provider Identification (NPI) number of the referring/ordering practitioner recommending out-of-state treatment. The referring practitioner must be enrolled in NYS (New York State) Medicaid.
- C. **Contact Person:** Include full name, title, phone and fax numbers where you can be reached, your full work mailing address (street number, street, city, state, and zip code), email address, and the hospital/agency/ facility you represent. Requests must be submitted by the provider/case manager.
- D. **Proposed Out-of-State Facility:** Include name of facility, NPI, full mailing address (street number, street, city, state, and zip code), Fax number, contact person and their phone number and email, anticipated dates of service, and check either inpatient or outpatient (or both if appropriate). The OOS facility or provider must be enrolled in NYS Medicaid.
- E. **Required Documentation:**
 - 1. Submit a list of all referrals sent to NYS facilities about providing in-state care and explain why they cannot provide adequate inpatient admission and/or outpatient services. Provide the facility name, contact person, phone number, fax number and email address for each.
 - 2. Please provide a narrative explaining the medical need for the member leaving New York State to receive care.

PLEASE NOTE: This form CANNOT BE ACCEPTED without this information.

- F. **Attestation:** The New York State referring/ordering practitioner must sign and date, attesting that the information provided is true and accurate.

Submission: Fax completed and signed forms to (518) 402-3253 or email to: FFSOOS@health.ny.gov.

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

New York State Fee-For-Service Medicaid Program
Request for Enhanced Rate for Out-of-State Medical Treatment

Member Information

Full Name: _____ DOB: _____
Last First M.I.

Medicaid ID: _____

Medicare ID: _____

Other Insurance: _____

Address: _____
Street Address Apartment/Unit #

City State Zip Code

County of Residence

Referring Practitioner

Name: _____ NPI: _____

Contact Person

Full Name: _____ Title: _____

Phone: _____ Fax: _____

Address: _____

Email: _____ Hospital/Agency/Facility: _____

Proposed Out-of-State Facility

Name: _____ NPI: _____

_____ Fax: _____

Contact Person: _____ Phone: _____

Email: _____

Date(s) of Service: _____

Purpose of the Requested Care (Check all that apply): Inpatient Outpatient

Documentation

Required information that must be submitted with this request:

- A list of all referrals submitted to NYS facilities/provider(s) about providing in-state care. Referral list must include ALL the following: NYS facility name, contact person, phone number, fax number and email address for each, and the reason why each facility indicated they are unable to adequately service the member.
- Primary and secondary ICD-10 codes with description of each.
- Letter of Medical Necessity signed and dated by the referring NYS provider addressing the reasons this member cannot obtain the necessary services within NYS.
- Past medical history including any surgeries or treatments (include dates, and locations), additional diagnoses, social/living situation.
- History of present illness including age of onset, progression of their disease process, current treatments and medications, impact of current condition and/or treatment on the member and their family, prognosis for their condition.
- If the proposed facility is not equipped for emergency services, please confirm that there is a nearby acute care hospital that is enrolled with NYS Medicaid and can meet any unexpected medical needs of the member.
- Proposed length of stay and projected discharge plan.

Please note: All covered laboratory and radiological services will be paid at standard NYS Medicaid rates.

Attestation

I certify that the information is true and accurate to the best of my knowledge, and I understand that the documentation must be kept on file and produced upon request to the Department of Health and/or its agents.

Referring/Ordering Practitioner's Signature

Signature: _____ Date: _____

Submission: Fax completed and signed forms to (518) 402-3253 or email to: FFSOOS@health.ny.gov.

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

For office use only:

Reviewer:

Rate Code: