NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

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Executive Deputy Commissioner

New York State Fee-For-Service Medicaid Program

Request for Prior Approval
Initial Admission to an Out-of-State Skilled Nursing Facility

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

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, and the primary and secondary ICD-10 diagnosis codes.

B. **Referring Practitioner:** Include the full name and National Provider Identification (NPI) number of the referring/ordering physician recommending out-of-state skilled nursing facility placement. The referring practitioner must be enrolled in NYS Medicaid.

C. **Discharge Planner/Case Manager:** Include full name, phone number where you can be reached, email address, fax number, the hospital/agency/ facility you represent and your full work mailing address (street number, street, city, state, and zip code). Requests provided by the proposed out-of-state facility, rather than the member's case manager or discharge planner, will not be accepted.

D. **Proposed Out-of-State Skilled Nursing 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 placement date of member, and check either high level or custodial level of care. High level of care includes members with Traumatic Brain Injury or other significant medical, behavioral and/or developmental issues. The OOS facility or provider must be enrolled in NYS Medicaid.

E. **Documentation**: The documentation requested should be attached to the form when submitted.

F. **Attestation:** The discharge planner/case manager and 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

Prior Approval for Initial Admission to an Out-of-State Skilled Nursing Facility

Member Information

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

Medicaid ID#: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

_____
County of Residence

Primary ICD-10 Code: _____ **Secondary ICD-10 Code:** _____

Referring Practitioner

Name: _____ **NPI:** _____

Discharge Planner/Case Manager

Full Name: _____ **Phone:** _____

Email: _____ **Fax:** _____

Hospital/Agency/Facility: _____

Address: _____

Proposed Out-of-State Skilled Nursing Facility

Name: _____ **NPI:** _____

Address: _____ **Fax:** _____

Contact Person: _____ **Phone:** _____

Email: _____

Anticipated Placement Date: _____

Level of the Requested Care (select one): **High Level** ◯ **Custodial** ◯

Documentation

The following documentation must be provided with this application:

1. Completed H/C PRI, completed PASRR SCREEN for level of care requested, member History and Physical, recent clinical/nursing notes, and medication list.

2. The individual has been denied admission to all in-state SNFs within 300 miles of their residence before considering out-of-state placement.

3. Pediatric members (under 21 years old) must have denials from all Medicaid-enrolled pediatric facilities within NY State.

4. All denials must have been provided within the last 14 days. Referral list should include date of referral, facility name, address, phone number, person spoken with at facility, outcome of referral, and reason for denial if provided. No response from facility or request for additional information is not considered a denial.

Attestation

I certify that the information provided is true and accurate to the best of my knowledge. I attest that the member will be temporarily absent from the state and residents of the member's county customarily use medical facilities in another state.

Discharge Planner/Case Manager's Signature

Signature: _____ Date: _____

Referring/Ordering Practitioner's Signature

Signature: _____ Date: _____

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