NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

MEGAN E. BALDWIN
Acting 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 (Check one):** **High Level** ☐ **Custodial** ☐

## Documentation

The following documentation must be provided with this application:

1. Completed H/C PRI and completed PASRR SCREEN for level of care requested.
2. The individual has been denied admission to all in-state SNFs within 150 miles of their residence. If placement options within 150 miles have been exhausted, providers should expand placement options in-state up to 300 miles from the member's 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. Requests from facilities for additional information will not be considered denials.

## 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: _____

**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.