



New York State Fee-For-Service Medicaid Program
Renewal Request for Out-of-State Skilled Nursing Facility

Member Information

Full name: Last First M.I.

Medicaid ID#: DOB: Date of this request:

Home Address: Street Address Apt./Unit # City State Zip Code
County ICD-10 Codes:

Requesting Facility Information

Facility name: NPI:

Facility Address: Street Address City State Zip Code

Facility contact person: Phone:

Email address: Fax:

Existing PA number: Initial date of Admission:

Date of Service Requested: From: To:

Referring Physician: NPI:

Attestation

- I attest that it is medically necessary for this member to continued to reside at this facility. Yes ___ No ___
I attest that the resident, guardian, or legal representative is not pursuing repatriation to NYS at this time. Yes ___ No ___
I am requesting authorization for a new prior approval valid for 365 days. Yes ___ No ___

Signature: Date: