

**VERMONT MEDICAID ADMISSION NOTIFICATION FORM  
FOR OUT-OF-STATE HOSPITALS  
URGENT AND EMERGENT ADMISSIONS**  
(For Admissions to Out-of-State Hospitals Excluding Border Hospitals)

Prior authorization is not needed for out-of-state (OOS) urgent or emergent inpatient admissions. Notification of the admissions and clinical documentation must be faxed to the DVHA Clinical Unit by the next business day for concurrent review. Concurrent review will begin at the time of notification and throughout the course of the inpatient hospital stay. Notification of discharge is required.

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**Beneficiary Information**

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Medicaid ID Number: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: M F  
(please circle)  
Date of Admission: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_  
Anticipated Discharge Date: \_\_\_\_\_

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**Provider Information**

Admitting Provider Name: \_\_\_\_\_ VT Medicaid Provider #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Taxonomy #: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Contact Person Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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**Facility Information**

Facility Name: \_\_\_\_\_ VT Medicaid Provider #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Taxonomy #: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Contact Person Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_ Procedure: \_\_\_\_\_ CPT Code: \_\_\_\_\_  
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