

## **VERMONT MEDICAID OUT-OF-STATE PREADMISSION REQUEST FORM**

(For Admissions to Out-of-State Hospitals Excluding Border Hospitals)

**Elective Out-of-State (OOS) Inpatient Admissions** – Elective inpatient admissions to all OOS hospitals require a prior authorization from the OVHA Clinical Unit. The admitting facility must fax a completed copy of this form and clinical documentation including an explanation of why the proposed care cannot be provided in the State of Vermont, to (802) 879-5963.

The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned admission.

Date of Request: \_\_\_\_\_

### **Beneficiary / Admission Information**

Patient Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: M F (please circle)

Date of Admission: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_

Anticipated Discharge Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

### **Provider Information**

Admitting Provider Name: \_\_\_\_\_ VT Medicaid Provider #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Taxonomy #: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Contact Person Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **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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**Patient Medicaid ID #:** \_\_\_\_\_

**MANDATORY:**

*Supporting documentation (Dated and Signed) is required from the patient's specialist provider within Vermont, at a listed border facility, or from the Vermont primary care provider if there has been found to be no available specialist within Vermont or at a border facility. The documentation must provide a determination that a level of care is not available to treat his/her patient in a Vermont facility or at a designated Vermont border facility.*

Clinical Information: Please justify admission and current status.

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Please explain circumstances surrounding the admission.

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Specific Treatment Plan

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Relevant History

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Additional Information

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Admitting Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Note: This patient's medical record may be subject to an OVHA medical record review.*