

**State of Vermont** *Agency of Human Services*

**Department of Vermont Health Access**

280 State Drive, NOB 1 South [Phone] 802-879-5903

Waterbury, VT 05671-1010 [Fax] 802-879-5963

**www.dvha.vermont.gov**

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**VERMONT ELECTIVE OUT-OF-STATE/OUT-OF-NETWORK**

**MEDICAL OFFICE VISITS**

**Instructions for completing the form can be found on page 2.**

**Section I:**

**To be completed by referring Vermont/In-Network Provider and faxed to the Out–of-Network Provider.**

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

**Beneficiary Information**

Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: / / Gender: M  F

**Referring Provider Vermont/In-Network**

Referring Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VT. Medicaid Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Letter of medical necessity from an In-Network Provider Specialist or Primary Care Provider as appropriate, is required**

**A second opinion may be requested after treatment options with an in-network facility have been exhausted, there has been an unsatisfactory clinical course and a second opinion from another in-network specialist is not possible.**

**Telemedicine services should be considered when appropriate. Telemedicine is a covered service under Vermont Medicaid and is reimbursable when it is clinically appropriate and within the provider’s licensed scope of practice. Vermont Medicaid has an established telemedicine Place of Service (POS) code 02 (Telehealth) for use by practitioners providing telehealth services from off site.**

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**Section II:**

**To be completed by Out-of-Network Provider providing the service. Fax completed form to (802) 879-5963.**

**Out-of-Network Supplying Provider Information**

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

Supplying Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VT. Medicaid Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplying Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Supplying Provider have an Affiliation **and** Admitting Privileges to an In-Network Facility?  Yes  No

Office Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Initial Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Visits Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Code(s) Requested**

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_ Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_ Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please note: Only office visit(s) are being approved. Do not proceed with any outpatient procedures or tests until you have first determined and documented that the service cannot be performed by an in-network provider.**

**Instructions:**

**Section I:**

1. Section I must be completed in its entirety. If you have any questions, call 802-879-5903.
2. Date of request: date the form is being completed by the In-Network Provider.
3. Referring provider can be the Primary Care Provider (PCP) *or* the In-Network Specialist.
4. Letter of medical necessity must be included, ***written by an In-Network Specialist or Primary Care Provider****,* must include the following supporting documentation:
   1. Medical necessity for an Out-of-Network provider’s service **AND**
   2. A determination that the level of care requested is not available to treat the beneficiary by an In-Network Provider.
5. Signed by the referring provider.
6. When completed, forward form to Out-of-Network Supplying Provider with this instruction page.

**Section II:**

1. Section II must be completed in its entirety. If you have any questions, call 802-879-5903.
2. Date of request: date the form is being completed by the Out-of-Network Supplying Provider.
3. Provider numbers: Supplying provider and their VT Medicaid Provider number must match. These should be documented by providing number of the provider, hospital or facility that will be billing for the visits. The providers must be an active and participating Vermont Medicaid provider. If you do not know your Vermont Medicaid number, you can call Provider Relations at 802- 878-7871 or visit http://www.vtmedicaid.com/#/provEnrollResources. *Note: Many out of state providers are not active/participating Vermont Medicaid providers and will bill through their affiliated hospital or facility.*
4. Does the Supplying Provider have an Affiliation **and** Admitting Privileges to an In-Network Facility? If a provider is affiliated with **AND** has admitting privileges to an In-Network facility **AND** has been approved by DVHA, no prior authorization is required. If you are unsure, please call (802) 879-5903.
5. Date of initial appointment if known, otherwise write “unknown”.
6. Reimbursement is limited to the following CPT codes: 99201-99215, 99381-99456, 99341-99360.
7. When completed, fax to **(802) 879-5963.**