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

**MEDICAL OFFICE VISITS**

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

**Section I:**

**To be completed by referring Vermont/In-Network Specialist\*and faxed to the Out–of-Network Provider for all Medicaid members, regardless member’s Accountable Care Organization (ACO) status.**

**Are visits associated with a qualified clinical trial?** Yes  No

**If yes, the** [**Medical Attestation Form**](https://dvha.vermont.gov/forms-manuals/forms/clinical-trials) **must be completed and submitted with this request.**

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

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| **Member Information** | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ | | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Gender: ☐ Female ☐ Male | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referring Provider Information** | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| *\*Provide* ***both*** *NPI and taxonomy if Medicaid Provider # is unknown.* | | | |
| Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Office Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Office Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**\*If referring provider is not an in-network specialist, explain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Letter of medical necessity from an in-network provider to support need for out-of-network services 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 the Out-of-Network Provider providing the service. Fax completed form to (802) 879-5963.**

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| **Out-of-Network Supplying Provider Information** | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| *\*Provide* ***both*** *NPI and taxonomy if Medicaid Provider # is unknown.* | | |
| Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Request: \_\_\_/\_\_\_\_/\_\_\_\_\_ | | Proposed Date of First Visit: \_\_\_/\_\_\_\_/\_\_\_\_\_ |
| Office Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Office Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| --- | --- | --- | --- |
| **Code(s) Information for Requested Office Visit Services** | | | |
| Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Procedure\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | CPT Code\*\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Procedure\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | CPT Code\*\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of Requested Visits: | | | |
| \*Procedure: complete field only if a procedure is to be completed during the office visit  \*\*Allowed CPT codes for use on this form can be found in section 2, #6 instructions below | | | |

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

**Instructions:**

Please refer to the criteria “Out-of-Network Services - office visits, elective inpatient hospital admissions and procedures, for all Medicaid members regardless of individual’s Accountable Care Organization (ACO) status” located at <https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria>

**Section I:**

1. Section I must be completed in its entirety. If you have any questions, call 802-879-5903.
2. DVHA uses the CMS definition for clinical trials. <https://www.cms.gov/medicare/coverage/clinicaltrialpolicies/downloads/finalnationalcoverage.pdf>
3. Date of request: date the form is being completed by the In-Network Provider.
4. Referring provider must be the in-network specialist. If not, please explain (for example - an in-network specialist is not available. then the referring may be the PCP).

Letter of medical necessity must be included, written by an In-Network, 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 specialist.

1. Signed by the referring specialist or PCP if no specialist is available.
2. 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 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 VT Medicaid fiscal agent, Gainwell Provider Representatives at 800-925-1706 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 (800) 925-1706.
5. Date of initial appointment if known, otherwise write “unknown”.
6. Reimbursement is limited to the following CPT codes: 99202-99215, 99381-99456, 99341-99360.
7. When completed, fax to **(802) 879-5963.**