**VERMONT MEDICAID OUT-OF-NETWORK PREADMISSION REQUEST FORM**

(For admissions to out-of-network hospitals excluding [out-of-state in-network hospitals](https://dvha.vermont.gov/providers/provider-network-info/green-mountain-care-network))

**Elective Out-of-Network (OON) Inpatient Admissions –** Elective inpatient admissions to all OON hospitals require a prior authorization from the DVHA Clinical Unit regardless of the member’s Accountable Care Organization (ACO) status. The admitting facility must fax a completed copy of this form and clinical documentation to (802) 879-5963, including an explanation of why the proposed care cannot be provided in an in-network facility.

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

**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/Admission Information** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Admission: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Anticipated Discharge Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Gender: [ ]  Female [ ]  Male |  |

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

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

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| **ICD-10 Diagnosis and CPT codes are required to process the request** |
| Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***MANDATORY:***

Supporting documentation (dated and signed) is required from the patient’s in-network specialist provider\*. The documentation must provide a determination that a level of care is not available to treat the patient in a Vermont facility or at a designated In-Network facility.

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

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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MEDICAL RECORDS MAY BE SUBJECT TO A DVHA MEDICAL RECORD RETROSPECTIVE REVIEW.