



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF VERMONT HEALTH ACCESS

**State of Vermont**  
**Department of Vermont Health Access**  
280 State Drive, NOB 1 South  
Waterbury, VT 05671-1010

Agency of Human Services  
[Phone] 802-879-5903  
[Fax] 802-879-5963  
[www.dvha.vermont.gov](http://www.dvha.vermont.gov)

**ELECTIVE OUT-OF-NETWORK MEDICAL OFFICE VISITS**

**This form should be completed for requests for out-of-network (OON) office visits.** Please refer to the Vermont Medicaid [Provider Network Info](#) page for [in- and out-of-network definitions](#) and [Prior Authorization Requirements for Out-of-State Providers](#).

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

**Section I:** To be completed by the referring Vermont Medicaid in-network provider and faxed to the out-of-network provider for all Medicaid members, regardless of the member's Accountable Care Organization (ACO) status.

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

If yes, the Qualified Clinical Trial [Medical Attestation Form](#) must be completed and submitted with this request.

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

Member Information			
Name: _____	Date of Birth: ___ / ___ / ___	Medicaid ID #: _____	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male

In-Network Referring Provider Information	
Name: _____	Medicaid Provider #: _____
Provider NPI: _____	Provider Taxonomy: _____
<b>*Provide both NPI and taxonomy if Medicaid Provider # is unknown.</b>	
Phone #: _____	Fax #: _____
Office Contact Person Name: _____	Office Contact Phone #: _____

Diagnosis and description of services being requested:

In-Network Referring Provider Attestation:

- Check this box if the referring provider attests to the following:
- There is medical necessity for an out-of-network provider's service **AND**
  - The level of care requested is not available in a timely fashion to treat the member by an in-network specialist OR
  - A second opinion cannot be provided by another in-network specialist. (See Considerations section below.)



**Section II:**

**To be completed by the out-of-network provider providing the service.**

Out-of-Network Supplying Provider Information	
Name: _____	Medicaid Provider #: _____
Provider NPI: _____	Provider Taxonomy: _____
<b>*Provide both NPI and taxonomy if Medicaid Provider # is unknown.</b>	
Phone #: _____	Fax #: _____
Date of Request: ____ / ____ / ____	Proposed Date of First Visit: ____ / ____ / ____
Office Contact Person Name: _____	Office Contact Phone #: _____

Code(s) Information for Requested Office Visit Services			
Diagnosis: _____	ICD-10 Diagnosis Code: _____	Procedure*: _____	CPT Code**: _____
Diagnosis: _____	ICD-10 Diagnosis Code: _____	Procedure*: _____	CPT Code**: _____
If this request is for services after the initial consult, <u>number of requested visits</u> : _____			
*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 the instructions for section 2, #6 below <b>Please note: If prior authorization is approved, it is only for office visit(s). Do not proceed with other procedures or tests until you have first determined and documented that the service cannot be performed by an in-network provider.</b>			

**CONSIDERATIONS**

1. SECOND OPINIONS:

- A second opinion with out-of-network provider may be requested after treatment options with providers and facilities within the Vermont Medicaid Network have been exhausted.
- UVMHC and DHMC are considered within the Vermont Medicaid Network.
- If medical necessity is met, **ONE** out-of-network office visit will be approved for second opinion and consultation regarding plan of care. If future out-of-network visits are requested, an explanation of why plan of care cannot be provided in-network will be required.

2. TRANSPORTATION:

- For Vermont Medicaid members who will require transportation to an appointment with a specialist, that specialist must be the nearest qualified provider/facility to the member's home.
- Vermont Medicaid will only cover transportation to an enrolled provider.

3. TELEHEALTH:

- Audio-visual 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.

## INSTRUCTIONS

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

### **Section I:**

- 1) Section I must be completed in its entirety by an in-network provider. If you have any questions, call 802-879-5903.
- 2) DVHA uses the [CMS definition for clinical trials](#).
- 3) Date of request: date the form is being completed by the in-network provider.
- 4) Referring provider must be a Vermont Medicaid network **specialist**. If not, please explain (for example, an in-network specialist is not available). In this case, the referring provider may be the PCP).
- 5) Check the attestation box to indicate that the referring provider confirms this request meets the following criteria:
  - a. There is medical necessity for an out-of-network provider’s service AND
  - b. A determination that the level of care requested is not available in a timely fashion to treat the member by an in-network specialist OR
  - c. A second opinion cannot be provided by another in-network specialist (see Considerations section above).
- 6) After Section I is completed, forward the form to the out-of-network supplying provider including the instruction pages.

### **Section II:**

- 1) Section II must be completed in its entirety by the out-of-network supplying provider. 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: the supplying provider and the associated VT Medicaid provider number must match. These should be documented by providing the VT Medicaid number of the provider, hospital or facility that will be billing for the visits. The provider must be an active and enrolled 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) Date of initial appointment if known. In the date of the appointment is not scheduled, write “unknown.”
- 5) Reimbursement is limited to the following CPT codes: 99202-99215, 99381-99456, 99341-99360.
- 6) When completed, fax this form and any supporting clinical materials/medical records to **(802) 879-5963**.

**MEDICAL RECORDS MAY BE SUBJECT TO A DVHA RECORD AUDIT**