VERMONT

State of Vermont
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Agency of Human Services
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OUT-OF-NETWORK PREADMISSION REQUEST FORM

(For admissions to out-of-network hospitals excluding out-of-state in-network hospitals)

For all elective Out-of-Network (OON) Inpatient Admissions. 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.

Section I:

To be completed by the admitting OON provider for all Medicaid members, regardless of member's Accountable Care Organization (ACO) status. The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned admission. The admitting facility must complete this form and fax with required supportive clinical documentation to (802) 879-5963.

Is elective admission associated with a qualified clinical trial? ☐Yes ☐ No
If yes, the Medical Attestation Form must be completed and submitted with this request.

Date of Request: ____/_____/______

Member/Admission Information			
Name: ______________________	Date of Birth: ___/____/_____	Gender: ☐ Female ☐ Male	Medicaid ID #: _____________
Date of Admission: ____/_____/______		Anticipated Discharge Date: ____/_____/______	

Provider Information		
Name: ______________________	Medicaid Provider #: ______________________	
Provider NPI: ______________________	Provider Taxonomy: ______________________	
***Provide both NPI and taxonomy if Medicaid Provider # is unknown.**		
Address:		
Contact Person Name: ___________	Phone #: __________________	Fax #: __________________

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

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: __________________

<u>Section II:</u> In-Network Provider Attestation
By checking the box, the provider is confirming that supporting clinical documentation exists and will be provided to support clinical review of medical necessity. Supporting documentation will include information about the member's current medical status and condition requiring out of network inpatient admission, treatment plan, and relevant medical history.

☐ Check box if the referring provider attests to the following:

a. There is medical necessity for an out-of-network procedure AND
b. The level of care required to meet the member's need is not available in network **OR**
c. The level of care required is not available in a timely fashion to treat the member by an in-network specialist OR
d. The admitting out-of-network is the closest facility to member's home that offers the required service

MEDICAL RECORDS MAY BE SUBJECT TO A DVHA RECORD AUDIT