## **VERMONT MEDICAID ADMISSION NOTIFICATION FORM**

**FOR OUT-OF-NETWORK HOSPITALS**

**URGENT AND EMERGENT ADMISSIONS**

(For admissions to out-of-network hospitals excluding [out-of-state in-network hospitals](https://dvha.vermont.gov/providers/provider-network-info) for all Medicaid members regardless of member’s Accountable Care Organization (ACO) status)

Prior authorization is not needed for out-of-network (OON) urgent or emergent inpatient admissions. Notification of the admission must be faxed to the DVHA Clinical Unit by the next business day. The hospital and treating provider must be enrolled with Vermont Medicaid to be reimbursed for hospital stay. Please fax completed form to 802-879-5963 **or** email to AHS.DVHAClinicalUnit@vermont.gov .

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| **Member/Admission Information** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Admission: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Anticipated Discharge Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Date of Procedure: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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