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

(For Admissions to Out-of-Network Hospitals Excluding Border Hospitals)

**Elective Out-of-Network (OON) Inpatient Admissions –** Elective inpatient admissions to all OON hospitals require a prior authorization from the DVHA Clinical Unit. 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.

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

**Beneficiary / Admission Information**

Patient Name: (last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Date of Admission: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Date of Procedure: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Anticipated Discharge Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Discharge Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**Provider Information**

Admitting Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VT Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Taxonomy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Facility Information**

Facility Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** VT Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Taxonomy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ICD-10 PCS and CPT codes are required for approval**

Procedure: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Diagnosis: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ICD-10 Code: **\_\_\_\_\_\_\_**

ICD-10 PCS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ICD-10 Code: **\_\_\_\_\_\_\_**

CPT Procedure Code: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Diagnosis: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ICD-10 Code: **\_\_\_\_\_\_\_**

**Patient Medicaid ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MANDATORY:***

*Supporting documentation (Dated and Signed) is required from the patient’s specialist provider within Vermont, at a listed In-Network facility, or from the Vermont primary care provider if there is no available specialist within Vermont or at an In-Network facility. 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.*

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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Admitting Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

*Note: This patient’s medical record may be subject to a DVHA medical record review*.