NEW HAMPSHIRE MEDICAID

272H FFS
07/2023

For State use only. **APPROVED**
Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

REQUEST FOR SERVICE AUTHORIZATION
FOR OUT OF STATE INPATIENT ADMISSION
(Fee-for-Service (FFS) Program only –
Not for Managed Care program use)

*****PLEASE PRINT OR TYPE ALL INFORMATION (all fields are required)*****

RECIPIENT INFORMATION

RECIPIENT NAME: _____ RECIPIENT DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #:_____ MEDICAL RECORD #: _____

ALTERNATE INSURANCE: _____ ADMITTING DIAGNOSIS: _____

Providers are expected to follow all third party payors requirements for payment and all third party obligations shall be exhausted before billing Medicaid, in accordance with 42 CFR 433.139.

PROVIDER INFORMATION

CONTACT PERSON: _____ COTACT EMAIL: _____

CONTACT PERSON PHONE #:_____Ext:_____ CONTACT PERSON FAX #: _____

ADMITTING FACILITY NAME: _____ ADMITTING FACILITY MEDICAID ID #: _____

ADMITTING PHYSICIAN: _____ ADMITTING PHYSICIAN MEDICAID ID #: _____

ADMISSION DATE: _____ DISCHARGE DATE: _____

*** must be included with submission ***

CERTIFICATION OF MEDICAL NECESSITY

Pursuant to He-W 543.04, The NH Licensed Primary Care Provider must determine that the proposed treatment is not available from resources and facilities within the state of NH and the proposed treatment is medically necessary and cost effective in obtaining measurable, realistic goals for the recipient.

CLINICAL INFORMATION Please attach a signed and dated physician's order and clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Medical Care Plan, relevant diagnostic tests, and anticipated length of stay.

I certify that the requested treatments and/or procedures are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient pursuant to He-W 543.

_____ _____
Signature of Person Completing the Form Date

_____ _____
Please print: Name/Title Specialty

WEEKLY PROGRESS NOTES: MUST BE PROVIDED FOR ADMISSIONS THAT EXTEND BEYOND THE CURRENT SERVICE AUTHORIZATION

When sending weekly progress notes, please send this form with the following information filled out:

CASE MANAGER NAME: _____ CURRENT SA #: _____

CASE MANAGER TELEPHONE #: _____ CASE MANAGER EMAIL: _____

NUMBER OF DAYS ADMITTED: _____ ANTICIPATED DISCHARGE DATE: _____

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL

129 Pleasant St ■ Concord, NH 03301 ■ Email: ServiceAuthorizationFFS@dhhs.nh.gov ■ FAX: (603) 314-8101