NEW HAMPSHIRE MEDICAID

272H FFS
09/2021

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)
Instructions for filling out this form are attached.

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

RECIPIENT INFORMATION **TODAY'S DATE:**

RECIPIENT NAME: _____ RECIPIENT DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #:_____ MEDICAL RECORD #: _____

ALTERNATE INSURANCE: _____ ADMITTING DIAGNOSIS: _____

PROVIDER INFORMATION

CONTACT PERSON: _____ ADMISSION DATE: _____

EMAIL: _____ DISCHARGE DATE: _____

CONTACT PERSON PHONE: _____ EXPECTED LENGTH OF STAY IN DAYS: _____

CONTACT PERSON FAX: _____ ADMITTING FACILITY: _____

FACILITY NAME: _____ FACILITY TELEPHONE: _____

FACILITY MEDICAID ID#: _____ FACILITY FAX #: _____

CLINICAL INFORMATION (must be included with submission): 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.

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.

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

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

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: _____
ANTICIPATED DISCHARGE DATE? _____

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) 271-8194

INSTRUCTIONS FOR OUT OF STATE HOSPITAL ADMISSION: FORM 272H FFS REQUEST FOR SERVICE AUTHORIZATION FOR OUT OF STATE INPATIENT ADMISSION

Please do **NOT** send instructions in with your request.

This form must be filled out 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.

Please note that before this form is filled out, it is **your responsibility to verify eligibility** of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at 866-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections are the Recipient Information and Provider Information and should be filled out accordingly. Note that the referring provider, the rendering provider and the rendering facility will have different Medicaid ID numbers.

For your convenience, the section following is the legal information with references to the Medicaid rule. The signature should be that of the person completing this form.

To submit documents request a secured email link, by emailing ServiceAuthorizationFFS@dhhs.nh.gov. In the subject line write Requesting Approval for: then choose DME, Incontinence, Therapy etc. You will receive a secured email thread. Alternatively you can use your own process for securing Protected Health Information in documents sent by email. Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Return all documentation and the Service Authorization Request form to SerivceAuthorizationFFS@dhhs.nh.gov or fax to: 603-271-8194.

If the information sent is incomplete, you will receive a request for more information. This is not a denial. Send in the information as above for the request to be reconsidered.

If all information is complete and criteria is met, you will receive a form from the state with the approval information. Once the Request for Service Authorization has been approved by the State it is sent to the Fiscal Agent, Conduent, to create the authorization. Conduent has three business days to create and mail the authorization to the performing provider. If you have questions, please call Conduent at 1-866-291-1674.

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

For Utilization Review, Case Managers fill out the form as above and add your name and contact information at the bottom. Case Manager should sign the form under the "I certify" section.