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| **Out-of-State Provider** Please select one of the four questions which best meets the reason you are requesting Out-of-State Provider Services and specify how the request meets the selected reason. **Services provided out-of-state for circumstances other than these specified reasons shall not be covered: The medical services must be needed because of a medical emergency;** |
| *1. Is there documentation of a psychiatric/ behavioral health emergency?* **Medical service must be needed and the Individual’s health would be endangered if they were required to travel to their own state of residence;** **Please Describe:**       |  |
| *2. Is there documentation that the individual’s psychiatric/behavioral health condition will continue to decompensate if required to travel back to Virginia?* **The state determines on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;** **Please Describe:**       |  |
| *3. Based on a physician’s advice, is the Psychiatric Residential Treatment Facility (PRTF) service more readily available in the other state? That is, what documentation is there that these services are not available in Virginia? Are there particular service needs that can only be addressed by this particular out of state provider? If so provide supporting documentation of all needs and the services to be provided.* **Please Describe:**       |  |
| *4. What locality is the individual a resident of?*       |  |
| *a. Is it the general practice for individuals in this locality to use psychiatric/behavioral health resources out of state?*       |  |
| *b. If yes, which state?*       |  |
| *c. Is this a Department of Medical Assistance Services (DMAS) recognized “border state”?* **[ ]  Yes [ ]  No** | **[ ]  Yes [ ]  No** |
| *d. If the request is for a different state than noted in “c”, why this state?*       |  |

**I understand that precertification does not guarantee payment; and that precertification only identifies medical necessity and does not identify benefits. I understand that submitting false information to gain service authorization is prohibited and may result in further legal action including a referral to the applicable agency, such as the Medicaid Fraud Control Unit within the Office of the Attorney General. By submitting information, I attest that the information is true and accurate.**