



NEW HAMPSHIRE MEDICAID

272H FFS
10/2018

**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.

For State use only.	APPROVED
Date: _____	By: _____
Dates of Service: _____	
EPSDT: _____ SA #: _____	

*****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: _____

PROVIDER INFORMATION

ADMITTING PHYSICIAN: _____	ADMISSION DATE: _____
CONTACT PERSON: _____	DISCHARGE DATE: _____
CONTACT PERSON PHONE: _____	EXPECTED LENGTH OF STAY IN DAYS: _____
ADMITTING FACILITY: _____	MEDICAID FACILITY ID#: _____
FACILITY TELEPHONE #: _____	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, 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

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

CASE MANAGER NAME: _____	CURRENT SA #: _____
CASE MANAGER TELEPHONE #: _____	CASE MANAGER FAX #: _____

NOTES:

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 ■ 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.

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

Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Fax all documentation and the Service Authorization Request form to 603-271-8194. You will receive a fax from the State with the approval information or a request for more information.

**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.