

OUT OF STATE MEDICAL SERVICES REQUEST

All questions must be completely answered for HRSA to review your request.

DATE

CLIENT NAME		PIC NUMBER (AB-122300-SMITH-A)	
REQUESTING PHYSICIAN NAME		TELEPHONE NUMBER	
CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER	
Please list all sources of medical insurance:			
NAME OF PHYSICIAN WHO WILL PROVIDE THIS SERVICE	TELEPHONE NUMBER	FAX NUMBER	
Name of hospital or facility: _____ Is the hospital/facility a Washington Medicaid Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is their provider number? (7 digits) _____			
Please Note: The hospital and providers must be willing to accept Washington Medicaid's out of state care reimbursement rate.			
CLIENT'S ICD-9-CM DIAGNOSIS CODE(S) AND DESCRIPTION			
Treatment /procedure/surgery description you are requesting including the applicable CPT procedure codes?			
ESTIMATED LENGTH OF STAY		<input type="checkbox"/> Inpatient or <input type="checkbox"/> Outpatient Services?	
ESTIMATED DATE OF DEPARTURE		ESTIMATED DATE OF RETURN	
Is there peer reviewed literature in support of this particular treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No Please attach copy.			
An evaluation and recommendation for the client's treatment from the following Centers of Excellence is required: University of Washington Medical Center, Sacred Heart Medical Center in Spokane, and Oregon Health Sciences University in Portland; or if request is for a child, Mary Bridge Children's Hospital and Health Center in Tacoma, Children's Hospital and Regional Medical Center in Seattle and Dorenbacher Children's Hospital in Portland. Please provide a copy of the evaluations with the recommendation for the client's treatment and where the service should be provided.			
Is this treatment/procedure/surgery available in the State of Washington? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate why this client requires out of state care: 			
What alternative diagnostic/treatment options were explored for this client in the State of Washington? 			

What other hospitals/facilities can perform this procedure? For each hospital, please supply the following information:

HOSPITAL/FACILITY NAME

CONTACT PERSON

TELEPHONE NUMBER

FAX NUMBER

Will the client need transportation? Yes No

If air ambulance is requested, what are the special instructions for transport?

Does the client require a respiratory therapist? Yes No

Is the client on a vent? Yes No

Will the client need to be escorted by a caregiver? Yes No

If yes, please state the name and relationship to the client:

We require the following information along with your request:

- Complete medical history with labs
- Evaluations and treatments already explored

Send to:

Medical Request Coordinator

Telephone: (360) 725-1584 – Fax (360) 586-1471