Washington State Health Care Authority

Out-of-State Medical Services Request

DATE

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

CLIENT NAME		PROVIDERONE CLIENT ID
REQUESTING PHYSICIAN NAME	REQUESTING BILLING PROVIDER NPI	TELEPHONE
CONTACT PERSON	TELEPHONE	FAX
PLEASE LIST ALL SOURCES OF MEDICAL INSURANCE		
NAME OF PHYSICIAN WHO WILL PROVIDE THIS SERVICE	TELEPHONE	FAX

Name of hospital or facility ______________________________

Is the hospital/facility a Washington Medicaid Provider? ☐ Yes ☐ No

If yes, what is their Provider NIP? ______________________________

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	☐ Inpatient Services ☐ Outpatient Services
Estimated date of departure	Estimated date of return

Is there peer reviewed literature in support of this particular treatment? ☐ Yes ☐ No Please attach copy.

REQUIRED INFORMATION

An evaluation and recommendation for the client's treatment from ALL 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. The evaluation and recommendation for treatment from the required facilities must include a statement as to whether the requested out-of-state care can or cannot be provided at the in-state treatment facility composing the evaluation.

When the service is not available in the state of Washington and it is medically necessary to refer the client out of state, please contact the following hospitals first:

- Lucille Packard Children's Hospital for children
- Stanford University Medical Center for adults

HCA has a contract with these hospitals to provide services to eligible clients for services not available in the State of Washington or border hospitals. These services will require prior authorization.

Is this treatment/procedure/surgery available in the state of Washington? ☐ Yes ☐ 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?		
HOSPITAL/FACILITY NAME		
CONTACT PERSON	TELEPHONE	FAX

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: 1-800-562-3022
Fax: 1-866-668-1214

A typed and completed General Authorization for Information form (HCA) 13-835, must be attached to your request.