Out-of-State Provider Application Cover Letter

Pursuant to 42 C.F.R. § 431.52, the Mississippi Division of Medicaid is only required to pay for services furnished in another state if certain conditions are met. For all applications with a servicing location outside of Mississippi, please complete the information below regardless of whether you are requesting payment for services rendered or you are requesting enrollment as an ongoing Mississippi Medicaid provider. Please refer to the Mississippi Medicaid State Plan and Miss. Admin. Code Title 23 for coverage and reimbursement requirements.

Please select the applicable option for enrollment:

☐ **Option 1** - I am applying in order to only receive reimbursement for a rendered service. Application must be submitted within one hundred twenty (120) days from the date of service. Dates of Service_____

Please indicate which of the conditions below apply to the services provided to a Mississippi Medicaid beneficiary.

- ☐ Medical services were needed because of a medical emergency as defined in Miss. Admin. Code Title 23, Part 201, Rule 1.2.G,
- ☐ Medical services were needed and the beneficiary's health would be endangered if he/she were required to travel back to Mississippi, or
- ☐ The Division of Medicaid has pre-arranged services with the applicant.

☐ **Option 2** - I am applying in order to enroll as an ongoing Mississippi Medicaid provider.

Please indicate which of the conditions below apply:

- ☐ Service(s) are needed and more readily available in your state (Explanation must be submitted with supporting documentation.)
- ☐ The location of services provided is within:
  - ☐ Thirty (30) miles from the Mississippi state border for a pharmacy, or
  - ☐ Sixty (60) miles from the Mississippi state border for all other provider types,
- ☐ Other examples include but are not limited to: Contracting with CCO, specialty hospital, etc. (Explanation must be submitted with supporting documentation.)

NOTE: The completed Out-of-State Provider Application Cover Letter must be submitted with supporting documentation. All required items must be submitted in order for your request to be considered. You must submit the claim(s) for reimbursement after you have been notified that your application has been approved.

Please complete the following:

Medicare Number _____ Date Approved _____

Medicaid Number _____ State _____ Date Approved _____

CHIP Number _____ State _____

NPI: _____

Attestation and Signature of the Applicant:

I certify that the information on this form, and any submitted statement(s) that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I am signing under penalty of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of Enrolling Provider or Authorized Official: _____

Printed Name: _____

Date: _____