MEDICAID OUT OF STATE SERVICES CERTIFICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 606 (2-2012)

Clear Fields

ONLY TO BE COMPLETED WHEN THE 'UNAVAILABLE' EXCEPTION IS REQUESTED

Name of Child	Medicaid ID Number

In accordance with Medical Services Division ***Out-of-State - Unavailable Services Policy*** and through my care of the above-named child, I have determined that necessary services (described on the corresponding Request for Prior Authorization for Out-of-State Services (SFN 769)-**required**) are unavailable for this child for the following reasons (select one or more):

☐ To ensure continuity of care, and if the in-state referring provider has determined that the follow up should be provided at the facility that performed the surgery or services; a follow up to a previously approved and performed out-of-state surgery or specialty service.

Comments (Required)

☐ A set of related inter-dependent services for diagnosis and treatment are needed and the entire set of services is not available in-state.

Comments (Required)

☐ After the in-state referring provider consults with the in-state specialist, it is determined that the wait time for in-state speciality services is expected to negatively impact the diagnosis or treatment.

Comments (Required)

☐ Only one in-state specialist is available to provide the service; however, adverse previous client or referring provider experience with the specialist substantiates the need to seek services out-of-state.
Required - Attach a written complaint/report which is prepared by the referring provider or the family.

I acknowledge that the services requested will be reviewed by the Department of Human Services for medical necessity. I also acknowledge that the Department will conduct post audits and that my certification is subject to this review.

Signature-Provider Requesting Out-of-State Services	Date
Signature-Pediatric Practice Director or Medical Director	Date