



## **Benefit Review Request Form**

The Internal Benefit Review Committee (IBRC) reviews health services to determine if there is a sufficient body of evidence and makes coverage determinations, which could include an enhancement, reduction, or elimination to the Medicaid program. Please complete the form and submit it to [EBBRAC@health.ny.gov](mailto:EBBRAC@health.ny.gov). The IBRC will review the form to determine if an internal decision can be made or if the topic requires review from the Evidence Based Benefit Review Advisory Committee (EBBRAC).

Date of Request

Requestor (Full Name)

Organization

Title

Telephone Number

E-mail Address

Technology/ Health Service

Procedure Code (CPT, HCPCS)

Technology/Health Service Description

In what setting(s) would the service be used? *(Hold CTRL or Command to choose multiple options)*

Identify the target population for this health service, including relevant factors such as age, gender, and medical conditions.

Rationale for coverage

Specify the provider types expected to use this technology or health service (See the [provider manuals](#) for list of providers in Medicaid)

Summarize existing alternative treatments or technologies