New York Medicaid Managed Care Plan
Approval for Related Services Form
Cell and Gene Therapy

Enrollee Information

Enrollee Last Name: _____ Enrollee First Name: _____

Date of Birth (MM/DD/YYYY):

		/			/				

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):

Address: _____

City, Town or Post Office: _____

State: _____ ZIP Code: _____

Prescriber Information

Prescriber Last Name: _____ Prescriber First Name: _____

Specialty: _____

National Provider Identifier (NPI) Number: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ Prescriber Fax: _____

Enrollee Last Name: _____ **Enrollee First Name:** _____

Drug Information

Drug Name:

_____

The facility or provider administering the drug (listed above) has been approved to provide pre and post treatment related services (e.g., consultations, evaluations, infusion procedures, inpatient care, etc.)

Expected date of drug administration (MM/DD/YYYY):

		/			/				

Attestation

I attest that all of the information on this form is accurate to the best of my knowledge and is available for review if requested by the New York State Medicaid Program.

_____

Managed Care Plan Representative (Print Name)

_____ _____

Managed Care Plan Representative (Signature Required) **Date (MM/DD/YYYY)**

The completed worksheet must be submitted via SECURE email to NYRx@health.ny.gov