Out-of-State Travel Notification Form

This a notification form for members who are receiving services out-of-state.

- If licensed professionals are involved, NC Medicaid cannot waive other state licensure laws.
- Medicaid will not be responsible for room, board or transportation cost.
- Provider agencies, Employers of Record or Agencies with Choice must assume all liability for their staff while out of state.
- Individual support plans must not be changed to increase services while out of state.
- Respite, based on the definition, is not available as natural supports are present during the travel or are not available to individuals receiving residential supports.
- Waiver services may not be provided outside of the United States of America.

Per Clinical Coverage Policy 8P, Alliance allows continued reimbursement for Innovations services delivered outside North Carolina to the extent they would have been authorized and provided in-state and only for the benefit of the Innovations member. Providers must ensure that the requirements of Policy 8P are met and assume liability for their staff traveling with members, as well as for meeting staffing needs, ensuring supervision and monitoring of care. Alliance's review of this travel notification serves as an acknowledgement of Alliance's approval of continued reimbursement for currently authorized services when delivered by the provider in compliance with Policy 8P and with provider's contract with Alliance.

Provider information

1

Name of provider agency: _____

Date of notification (mm/dd/yyyy): _____

Provider site: _____

Destination(s): _____

Provider contact: _____ Contact email: _____

Name(s) of staff providing services out of state: _____

Member information

2

First name: _____ Last name: _____

Date of birth (mm/dd/yyyy): _____

Dates of travel:
From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

Services information

All services require prior authorization

3 Please indicate which services are to be delivered out-of-state (check all that apply):

- ☐ Community living supports
- ☐ Community networking
- ☐ Residential supports
- ☐ Other (list) _____

Schedule of services

4 Please include the schedule of services to be delivered while out-of-state:

Hours	Mon	Tue	Wed	Thu	Frl	Sat	Sun

Comments

5 Please provide any additional information as necessary:

Authorization

6

By signing below, the provider agency agrees to comply with the requirements of Clinical Coverage Policy 8P related to services provided outside of North Carolina and to all conditions listed above.

*Agency supervisor full name (print): _____

*Agency supervisor signature (name or typed)		*Date (mm/dd/yyyy)
x		

*Agency With Choice full name (print): _____

*Agency With Choice signature (name or typed)		*Date (mm/dd/yyyy)
x		

*Agency staff full name (print): _____

*Alliance staff signature (name or typed)		*Date (mm/dd/yyyy)
x		

Submission instructions

Please submit all out of state notification forms to Contracts@AllianceHealthPlan.org.