Medical
Indemnity Fund

Prior Approval Request Form

Request being made on behalf of (Name of Enrollee): ____________________________________

MIF Enrollee ID: NYS__ __ __ __ __ __ __ __ __

Name of Person(s) Submitting Request: ____

Signature of Person(s) Submitting Request: ____

Relationship to Enrollee: ____

Date Request Submitted: _____________________

ITEM AND/OR SERVICES REQUESTED: *(services you are requesting)*

I am requesting approval of the following item(s) and/or services from the New York State Medical Indemnity Fund:

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PROVIDER(S) SUPPLYING ITEM AND/OR SERVICES REQUESTED:

Name	Address	Phone Number

REASON FOR REQUEST:

The reason(s) for this request is/are:

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Medical Indemnity Fund

Please provide a Letter of Medical Necessity for each service and/or item requested from the appropriate healthcare provider for the enrollee. The letter should include any specifications that the provider recommends.

If a Letter of Medical Necessity is not included with this request, one will be sought by the enrollee's Case Manager from the appropriate healthcare provider for the enrollee.

Please send this request form to:

Medical Indemnity Fund c/o PCG
P.O. Box 7315, Albany, NY 12224

You can also send by fax to: 518-344-1293 or scan and email your Case Manager.

If you communicate by e-mail, you agree to be fully responsible if sending protected health information by unsecured means