



Medical Indemnity Fund

Form for Submitting Prior Approval Requests to
The New York State Medical Indemnity Fund

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

Four horizontal lines for listing requested items and services.

REASON FOR REQUEST:

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

Four horizontal lines for providing the reason for the request.

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

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

Please send this request form to:

New York State Medical Indemnity Fund
c/oAliCare
1005 West 9th Avenue
King of Prussia, PA 09406
ATTN: Barb Shaffer