NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
JAY LUDLAM • Deputy Secretary, NC Medicaid

NC Medicaid Clinical Policy Revision Request

Date:	
Provider's Name:	
NPI #:	
Address:	
City, State & Zip Code:	

The North Carolina Medicaid Program provides payment for a variety of procedures, products and services for categorically needy and medically needy residents of the State. The requestor is proposing clinical policy revisions for INSERT POLICY NUMBER: INSERT TITLE OF POLICY REQUEST HERE.

Any suggested revisions to the policy must be medically necessary and may not be considered solely cosmetic, experimental or part of a clinical trial.

Please fill out the below form and email it to medicaid.policy.revision.request@dhhs.nc.gov as a single file in PDF format with supporting documentation embedded within. Submissions will only be processed if all required information is completed and submitted in one document (or as one file).

Please ensure your submission has sufficient evidence to support the request. NC Medicaid wants to ensure that we are providing the best evidence-based care for our beneficiaries, and there needs to be solid clinical evidence to support coverage of procedure(s), product(s) and/or service(s). Failure to provide the requested information may delay the review process.

1. *What section(s) of the policy are you requesting be revised? Please include the section number. (Example: 3.1 General Criteria Coverage)*

Enter response here

2. *What revision(s) are you requesting in the above-mentioned section(s)? Please be specific and indicate the language you want changed.*

Enter response here

3. *Please provide the supporting rationale for the requested revision(s) including but not limited to examples: FDA approval status, supporting data from research studies, and peer-reviewed journals (attach a copy of approval letter/documents to the email).*

Enter response here

4. *In addition to the attached documentation, please provide any relevant links below:*

Enter response here

5. *Has the requested revision(s) been mandated through federal or state legislation? If yes, please reference the appropriate legislation.*

Enter response here

6. *Does the requested revision(s) appear to have a potential cost savings to the Medicaid program? If yes, explain.*

Enter response here

7. *Please provide details around the types of providers and beneficiaries whose quality of care will be enhanced due to the requested revision(s).*

Enter response here

8. *Extent to which the requested revision(s) is currently in use in North Carolina.*

Enter response here

9. *Is the requested revision(s) supported by other state Medicaid programs (List states or entity, if known, and a contact person with telephone number or email address.)*

Enter response here

10. *Does Medicare and/or other insurance company cover this requested revision(s)? (Attach policy, if available).*

Enter response here

Please submit the information requested above within this document to the following inbox in PDF Format:

Medicaid.Policy.Revision.Request@dhhs.nc.gov