NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

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

NC Medicaid New Coverage/Service Request

Date:	
Provider's Name:	
NPI #:	
Address:	
City, State & Zip Code:	
Is Request Disaster Related (Yes/No)	

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 requesting clinical policy consideration for INSERT TITLE OF COVERAGE REQUEST HERE.

All procedures, products and services must be medically necessary and may not be considered solely cosmetic, experimental or part of a clinical trial.

Please provide the following information to expedite review of the request for flexible coverage. Indicate N/A if an item does not apply.

1. *Name of procedure, product or service (provide a brief description) for which coverage is being requested or where change or flexibility is being requested.*

Enter response here

2. *Does this request replace an existing coverage, change or add flexibility (PA waiver, telehealth, etc.) to an existing coverage? Explain in detail what replacement or flexibilities are being requested.*

Enter response here

3. *Has the request been mandated through federal or state legislation?*

Enter response here

4. *Does this request appear to have a potential cost savings to the Medicaid program? If yes, explain.*

Enter response here

5. *Please provide details around the types of providers and beneficiaries whose quality of care will be enhanced due to this request.*

Enter response here

6. *Indications, limitations and restrictions for use.*
   - *Diagnostic indication(s) [ICD-10 CM code(s)].*
   - *Proposed advantages of the new product, procedures or service.*
   - *Duration and frequency of use.*
   - *Gender restrictions.*
   - *Age restrictions.*

Enter response here

7. *Procedure (CPT or HCPCS) or revenue codes to be used or impacted by the request*

Enter response here

8. *Recommended place of service.*

Enter response here

9. *FDA approval status (attach copy of approval letter/documents to the email).*
10. *Supporting data from research studies, peer review journals etc. (attach copy of approval letter/documents to the email)*
11. *Extent to which the requested coverage/flexibility request is currently in use in North Carolina.*

Enter response here

13. *Is coverage/flexibility 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

14. *Does Medicare and/or other insurance company cover this request? (Attach policy, if available).*

Enter response here

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

Medicaid.Coverage.Request@dhhs.nc.gov