LDSS-901 (2/98)

AUTHORIZATION FOR MEDICAL EXAMINATION AND PAYMENT REQUEST

NEW YORK STATE DEPARTMENT OF HEALTH

PROVIDER – NAME AND ADDRESS	ORIGINATING AGENCY

SECTION I: **AUTHORIZATION FOR SERVICE**

☐ Examination ☐ Consultation

NAME OF PATIENT	CASE NO. (if any)

ADDRESS (City, State, Zip code)

REMARKS

Please complete the PAYMENT REQUEST SECTION and return original and duplicate of this form, to the above originating agency accompanied by:

☐ PHYSICIAN'S STATEMENT FOR DETERMINATION OF DISABILITY FORM **LDSS-486 OR DSS-486T**

☐ MANDATORY EYE EXAMINATION REPORT **LDSS-3377**

☐ MEDICAL EXAMINATION FOR EMPLOYABLITY DISABILITY SCREENING **LDSS-4526**

☐ YOUR MEDICAL REPORT

SIGNATURE OF CASEWORKER	DATE	SIGNATURE OF AUTHORIZING OFFICAL	DATE
X		**X**	

SECTION II: **RELEASE**

I hereby grant permission to the physician indicated below to release results of the above noted examination or consultation to the originating Department of Social Services.

PATIENT'S SIGNATURE	DATE	WITNESS (If patient cannot write)	DATE
X		**X**	

SECTION III: **PAYMENT REQUEST SECTION – TO BE COMPLETED BY PHYSICIAN**

DATE OF EXAM.	FEE SCHEDULE	AMOUNT BILLED
		$

PAYEE CERTIFICATION - I certify that the care, service and supplies itemized have been furnished; the amounts listed are due and, expect as noted, no part thereof has been paid, payment of fees made in accordance with established schedules is accepted payment in full and that taxes from which the State is exempt are excluded; and there has been compliance with Title VI of the Federal Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973 without discrimination on the basis of race, color, national origin, or handicap; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid Program will be kept, and information will be furnished regarding any payment claimed therefore as the local social services agency or the State Department of Health may request; and that the vendor understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he may be prosecuted under applicable Federal and State laws for any false claims, statements, or documents or concealment of a material fact.

PROVIDER'S I.D. NUMBER	PROVIDER'S SIGNATURE	DATE
	X	

LEAVE BLANK – AGENCY USE ONLY

CHARGE TO ACCOUNT NO.	PROVIDER'S SIGNATURE	MONTH OF PAYMENT
	X	

AUDITED BY	DATE
X	

INSTRUCTIONS FOR FORM DSS-901

PREPARATION

Caseworker prepares this form in triplicate, completes Section I, and obtains patient's signature in Section II

INITIAL DISTRIBUTION

a. Original and one (1) copy forwarded to the provider together with one (1) copy of the appropriate medical examination form.

b. One (1) copy of Accounting. (Final distribution to confirm with the local agency's procedure).

FINAL DISTIBUTION

Provider returns the, with the Payment Request Section completed, together with the complete medical examination form. Both forms should be routed to the caseworker.

CASEWORKER

a. Send original Authorization for Medical Examination and Payment Request, form DSS-901, to Accounting.

b. Transmit completed medical examination form to the appropriate person.