



Behavioral Health Out-of-Network Request Form

Please fax this form to: **1-888-641-5199**

For BCBSMA/EDS employees & dependents, fax to: **1-888-608-3693**

Please fill out this form completely and in detail to facilitate a timely review for both Transition of Care Requests and ongoing Out-of-Network Requests. Please attach any additional information that you feel BCBSMA should consider regarding out-of-network authorization for this member. If treatment has begun, please also submit the Treatment Request Form (this document can be obtained by calling our Fax-on-Demand service at **1-888-633-7654** and requesting document **759**).

Date: _____

Patient Information

Patient Name: _____	Patient BCBSMA ID: _____
Patient date of birth: _____	Patient telephone: _____
Requested service: _____	1st date of service: _____

Requested Out-of-Network Provider or Facility Information

Out-of-network provider or facility name: _____

Address: _____

Telephone #: _____

 Fax #: _____

Our policy requires that we handle PHI in accordance with HIPAA protections. Is this fax number 'secure' for the receipt/transmission of PHI?

Yes No

Qualifying Conditions

Please check below to indicate the reason for your out of network request:

- | | |
|---|---|
| <input type="checkbox"/> No network provider available in member's area | <input type="checkbox"/> Lack of private transportation |
| <input type="checkbox"/> Change in the member's insurance creating network mismatch | <input type="checkbox"/> Out-of-network outpatient sessions have been approved in the past by BCBSMA or another carrier |
| <input type="checkbox"/> Language issue: Please specify: _____ | |
| <input type="checkbox"/> Urgent or unusual circumstance. Please specify: _____ | |
| <input type="checkbox"/> Unique services required by the member that are not available in the service area. Please specify: _____ | |
| <input type="checkbox"/> Member cannot safely transfer to a network provider. Please specify: _____ | |
| <input type="checkbox"/> Other. Please specify: _____ | |

Are you are willing to accept the network rate while continuing to treat this member? Yes No