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MASSACHUSETTS

OUT-OF-NETWORK REQUEST FORM

Submit this form with the clinical record and state the reason for making the out-of-network request. You only need to use this form when the member does not have out-of-network benefits, such as those who are enrolled in an HMO, EPO, or HPN plan. Do not use this form for members who have out-of-network benefits, such as those who are enrolled in commercial PPO plans.

Once completed, fax with clinical record to:

Medicare Advantage: **1-800-447-2994**	All other plans (excluding PPO): **1-888-282-0780**
Mental health out-of-network requests: **1-888-641-5199**	Blue Cross employees and dependents: **1-888-608-3693**

Date:	Does this member have an out-of-network benefit? Yes ❒ No ❒ *If yes, no referral is required.*

PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
Patient name:	Provider type:
BCBSMA ID # with prefix:	Name:
Date of birth:	Address:
Patient phone #:	Phone #:
Requested service:	Fax #:
	NPI #:
Mental health providers only: Provider type: License type: State licensed in: License #:	

PRIMARY CARE PROVIDER SIGNATURE (REQUIRED FOR MEDICAL SPECIALIST REFERRALS, NOT REQUIRED FOR MENTAL HEALTH REFERRALS OR EPO MEMBERS)	
Signature:	Print name:

OUT-OF-NETWORK PROVIDER OR FACILITY INFORMATION	
Are you willing to accept the in-network rate? Yes ❒ No ❒	If you are an out of state provider, are you a participating provider with your local Blue Cross plan? Yes ❒ No ❒
Provider or facility name:	NPI #:
Address:	Phone #:
	Fax #:
	Our policy requires that we handle PHI in accordance with HIPAA protections. Is this fax number 'secure' for the transmission of PHI? Yes ❒ No ❒
	Start date of service:
Specialty:	*For medical specialist referrals only (excluding mental health)* # of visits requested:
Diagnosis:	Date of injury if applicable:
Describe history of present illness:	
Have you accessed our provider directory to locate a participating provider who can provide services? (Visit www.bluecrossma.com/provider and click **Patient Resources>Plans & Products>Find a Doctor & Estimate Costs**) Yes ❒ No ❒	

QUALIFYING CONDITIONS: PLEASE CHECK BELOW TO INDICATE THE REASON(S) FOR YOUR OUT-OF-NETWORK REQUEST			
No network provider available in the member's area	❒	Change in the member's insurance creating network mismatch	❒
Lack of private transportation	❒	Out-of-network outpatient sessions have been approved in the past by BCBSMA or another carrier	❒
Unique services required by the member that are not available in the service area. Please explain:	❒	Member cannot safely transfer to a network provider. Please explain:	❒
Language issues (please specify):	❒	Other (please specify):	❒

The above requested information is required for claim to process. Failure to submit this information in full may result in prior authorization denial or incomplete claims processing.