Print Clear form

MASSACHUSETTS

# MANAGED CARE OUT-OF-NETWORK REQUEST FORM

Use this form when the member is not able to receive the same services from an in-network provider. The provider's NPI number and the reason the member needs to see an out-of-network provider **must be entered** below.

**Once completed, fax to:**

| | |
|---|---|
| Medicare HMO Blue/ Medicare Advantage: **1-800-447-2994** | All other managed care plans: **1-888-282-0780** |
| Behavioral 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 #: |
| | Is the requested care urgent or emergent? Yes ❒ No ❒ |
| | Has the PCP authorized the referral? Yes ❒ No ❒ |

Primary Care Provider (PCP) signature required only when referring to a medical specialist

| PRIMARY CARE PROVIDER SIGNATURE | |
|---|---|
| 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: | 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 ❒ |
| Phone #: | Date of service: |
| Specialty: | # 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 equivalent 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 for your out of network request: | | | |
| No network provider available in the member's area | ❒ | Change in the members insurance creating network mismatch | ❒ |
| Lack of private transportation | ❒ | Out-of-network outpatient sessions have been approved in the past by BCBSMA or another carrier | ❒ |
| Urgent or unusual circumstance | ❒ | Language issues (please specify): | ❒ |
| 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: | ❒ |
| 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.