



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

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 <input type="checkbox"/> No <input type="checkbox"/>	If yes, no referral is required.
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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 <input type="checkbox"/> No <input type="checkbox"/>
	Has the PCP authorized the referral? Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	If you are an out of state provider, are you a participating provider with your local Blue Cross plan? Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 Office Resources>Plans & Products>Find a Doctor & Estimate Costs) Yes <input type="checkbox"/> No <input type="checkbox"/>	

Qualifying Conditions			
Please check below to indicate the reason for your out of network request:			
No network provider available in the member's area	<input type="checkbox"/>	Change in the members insurance creating network mismatch	<input type="checkbox"/>
Lack of private transportation	<input type="checkbox"/>	Out-of-network outpatient sessions have been approved in the past by BCBSMA or another carrier	<input type="checkbox"/>
Urgent or unusual circumstance	<input type="checkbox"/>	Language issues (please specify):	<input type="checkbox"/>
Unique services required by the member that are not available in the service area. Please explain:	<input type="checkbox"/>	Member cannot safely transfer to a network provider. Please explain:	<input type="checkbox"/>
Other (please specify):			<input type="checkbox"/>

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.