



Out-of-Network – Behavioral Health Outpatient Request Form for Medicaid Members

All services rendered by an out-of-network provider require prior authorization. Please utilize this form to explain the reason for the out-of-network accommodation.

For contracted providers, service authorization is not required for most outpatient behavioral health services. (Please reference our **Medicaid prior authorization code list**.)

For Blue Cross Community Health PlansSM members, fax to **888-530-9809**.

Date:			
Check (only) one <input type="checkbox"/> New Case Request <input type="checkbox"/> Extension Request			
Member Information:			
Subscriber Name:		Date of Birth:	
Subscriber ID:			
Address:	City:	State:	Zip:
Provider (Rendering Services):			
Provider Name:	Provider Address:	NPI:	
Is the provider registered with the IMPACT system? <input type="checkbox"/> Yes <input type="checkbox"/> No (All providers not registered with the IMPACT system, must call customer service for authorization)			
Provider Contact (for decision notification):			
Provider Name:	Provider Fax:		
Service Information:			
Start Date Request:	Anticipated Service End Date:		

Service Type:

<input type="checkbox"/> Electroconvulsive Therapy	<input type="checkbox"/> Psych/Neuro Psych Testing	<input type="checkbox"/> Transcranial Magnetic Stimulation:	<input type="checkbox"/> Outpatient
CPT/HCPCS Code Requested:		Quantity of Units Requested:	
CPT/HCPCS Code Requested:		Quantity of Units Requested:	
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CPT/HCPCS Code Requested:		Quantity of Units Requested:	

Current Behavioral Health Diagnoses:

Primary Code#	Diagnosis:	Specifier:
Secondary Code#	Diagnosis:	Specifier:
Tertiary Code#	Diagnosis:	Specifier:

Reason member is unable to receive services from an in-network Medicaid provider:

My signature confirms that I, or the facility I represent, will provide the requested services.

Signature:	Title:
Date:	