Independent Licensee of the Blue Cross and Blue Shield Association

Managed Care
Out-of-Network Request Form

Fax this form to:
1-800-447-2994 for Medicare HMO Blue / Medicare Advantage PPO
1-888-282-0780 for all other managed care plans

BCBSMA Blue Choice Plans offer an out-of-network benefit. Members with an out-of-network benefit do not require authorizations since they share financial responsibility for the services rendered out of network.

Date: _____

Does this member have an out-of-network benefit? ❒ Yes ❒ No

If yes, do you wish to have the services you are requesting covered as an in network or out of network benefit?
❒ Out-of-network. There is no need to complete this form.
❒ In-network. Please complete the information below to substantiate that the member is not able to receive the same services from an in-network provider.

Patient Information:

Name: _____
BCBSMA ID #: _____
Date of birth: _____
Telephone #: (___)_____
Diagnosis: _____
If injury, date of injury: _____

Referring Provider Information:

Name: _____
Signature: _____
Referral Contact Name_____
Telephone# (_____)_____
Has PCP authorized this referral? Yes__ No__
Provider #: _____
Telephone #: (____)_____
Fax #: (____)_____

Out-of-Network Provider or Facility:

Requested Service:_____Date of Service:_____ Number of visits requested_____
Name of out-of-network provider or facility: _____
Address: _____
Specialty:_____
Telephone #: (____)_____Fax #: (____)_____

1. Please describe history of present illness, including duration/frequency/severity and treatment provided:
   _____
   _____
   _____
2. Have you accessed the BCBSMA *Managed Care Provider Directory* or logged onto our on-line directory at www.bluecrossma.com to locate a participating provider who can provide equivalent services? ☐ Yes ☐ No
3. Please explain treatment options the non-participating provider offers that could not be provided in-network:
   _____
   _____
   _____
4. Is requested care elective? ☐ Yes ☐ No If no, please explain:
   _____
   _____

Name: _____ Telephone: (____)_____

Please use additional pages if necessary. Thank you.

Notes: We may contact you for additional information. It is the responsibility of the sender to ensure receipt of fax information to BCBSMA. Please check your systems activity report/receipt to make sure your fax was sent correctly.