



Magellan Behavioral Health of Pennsylvania, Inc.
Pennsylvania HealthChoices
Ad Hoc / Out of Network Provider Request

Please complete this form in its entirety. Each field is important in being able to review and process an out of network service request. If you have any questions about how to complete this form, please outreach HealthChoices Magellan at 877-769-9779. Do not use this form for Mental Health Outpatient. That form is located at here. Do not use this form for Substance Use Disorder Non-24-hour levels of care. That form is located here.

Member County:

- Bedford Bucks Cambria Lehigh Montgomery Northampton Somerset

Services Requested:

- Partial Hospitalization Program IBHS Family Based Services Psych Rehab Case Management

Type of Request: Initial Concurrent

Is this member currently placed through the Office of Children, Youth, and Families or Juvenile Probation?

- Yes No

Member Information:

Member Name: Member DOB: Medicaid #:

Member CURRENT Street Address / Placement:

City: State: Zip: County:

What is the reason that an out of network request is needed?

- Geographic Continuity of Care Specialty Needs No in-network provider with appointment available

Explain rationale for your choice above:

Does Member have TPL / Primary Insurance? Yes No

If yes, does the Primary Insurance cover the requested services? Yes * No

* If yes, this form does not need to be completed. Provider can submit secondary claims without an authorization.

Provider Information:

Provider Requesting Non-Par/Rendering Service:

Provider Address where services will be rendered:

City: State: Zip:

Billing Address (if different than above):

City: _____ State: _____ Zip: _____ Phone #: _____
** Please Note: an out of network agreement cannot be completed unless the provider has an active PA Medicaid Enrollment **

MA Enrollment / Promise ID #: _____ Tax ID #: _____

NPI#: _____ HealthChoices Magellan MIS # if known: _____

Provider Contact Person: (Responsible for follow up questions regarding this form)

Phone #: _____ Ext: _____ Fax #: _____

E-mail Address: _____

Contracting Contact Person: (Responsible for signing the single case agreement contract)

Phone # for Contracting Contact Person: _____

Email for Contracting Contact Person: _____

For members whose Medical Assistance will be switching to a new county of residence, please only request a 60-day authorization from Magellan to allow the new BH-MCO to be active.

The Start Date of this request needs to be within 2 business days of this form being submitted to Magellan. If the dates of service are earlier that that, please submit this via a retrospective review form located at [here](#).

Services Requested: Mental Health Services

Name of Service	CPT Code	Frequency of Service	Total # of Units	Start Date	End Date *

* Requests should not exceed 6 months

Clinical Information

ICD-10 Diagnosis: _____

Name of Physician / Clinician: _____

Credential of Physician / Clinician: _____

**Once you have completed this form in full, please fax it to 866-667-7744.
Please indicate attention to Adult or Children's Outpatient Team, as appropriate.**