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 here.

Member County:

☐ Bucks Co ☐ Cambria Co ☐ Lehigh Co ☐ Montgomery Co ☐ Northampton Co

Services Requested:

☐ Partial Hospitalization Program ☐ Substance Use Disorder Services (1.0, 2.1, 2.5, 3.1, 3.5, 3.7WM) ☐ IBHS
☐ Psych Rehabilitation ☐ Family Based Services ☐ Case Management ☐ Crisis Residential

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 here.

Services Requested: ☐ Substance Use Services ☐ 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.