Out of Network Request Form

This form is required to request services for Out of Network services for any a NEHP member **NOT** going to MA, CT, VT, ME, NH, and/or any BlueChip member.

Please ***include office notes/clinical related to this request*** and complete below.

Fax completed form along with clinical to Utilization Management at 401-272-8885

Date: _____

Patient's Name:

_____

Policy Number: _____ DOB: _____

Referring Physician Info:

Name: _____

Address: _____

Telephone: _____ Fax: _____

BlueCHiP #: _____ NPI: _____

Referred To:

Name: _____

Address: _____

Telephone: _____ Fax: _____

NPI: _____

Complete the following:

☐ Diagnosis (ICD-10): _____

☐ Is there an appointment scheduled at this time?

☐ No date as this time. ☐ Yes, the date is _____

☐ Who(m) referred the member out of network?

_____

☐ Has the member seen a specialist in the network for the above diagnosis? If so, who(m)?

_____