How Dependents Can Receive Coverage When Living Outside of New England

In addition to emergency and urgent care, dependents in HMO, POS, and POS+ plans living outside of New England can get in-network coverage for non-emergency medical and behavioral health care, when requested by the dependent’s primary care provider. To request coverage, your dependent must follow these steps:

- **Your dependent should contact their primary care provider (PCP).**
  - The PCP will fill out a Managed Care Out-of-Network Authorization Request Form.* PCPs have access to this form and will complete it using the information you provide them; a blank form can also be found on the back of this flyer.

  * This form is required for all planned care and for each separate provider.

- **Once we reach a decision, we’ll send a letter to your dependent.**
  - Approval process turnaround time:
    - 48–72 hours for inpatient review
    - 15 days for all outpatient services, such as physical therapy, behavioral health services, and non-elective surgeries
    - 30 days for post-surgical care referrals

If you have any questions regarding the approval status, please call Member Service at 1-888-389-7732.

**Urgent and Emergency Care Are Always Covered**

Your dependents are covered if they get sick or injured, and need immediate medical care at an emergency room or urgent care center. For urgent care, please contact Member Service within 48 hours for urgent care authorization.

**Need to Find a Doctor?**

Visit Find a Doctor & Estimate Costs at bluecrossma.com/findadoctor.

**Services not eligible for coverage outside of the New England area:**

- Annual preventive services, including exams, labs, and other tests
- Infertility treatment
- Bariatric surgery
- Planned arthroscopic surgery
- Cosmetic/reconstructive surgery

*Please select PPO or Indemnity networks instead of HMO.*
Managed Care Out-of-Network Request Form

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

This form should be used when the member is not able to receive the same services from an in-network provider. The provider’s NPI number and the reason why the member must see an out-of-network provider must be completed below.

**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, no referral is required.

**Patient Information:**
Name: ___________________________________
BCBSMA ID #: ____________________________
Date of Birth: _____________________________
Telephone Number: (____)__________________
Diagnosis: __________________________________________
Date of Injury (if applicable): ________________________

**Referring Provider Information:**
Name: ___________________________________
Signature: ________________________________
Referral Contact Name: _______________________
Telephone Number: (____)__________________
Has the PCP authorized this referral?   ☐ Yes   ☐ No
National Provider Identifier (NPI): ________________
Telephone Number: (____)__________________
Fax Number: (____)_________________________
Is fax number ‘secure’ for PHI receipt/transmission per HIPAA requirements?   ☐ Yes   ☐ No

**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: ____________________________
NPI: ________________________________
Telephone Number: (____)__________________
Fax Number: (____)_______________________
Is fax number ‘secure’ for PHI receipt/transmission per HIPAA requirements?   ☐ Yes   ☐ No

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 on to www.bluecrossma.com/provider to use our Find a Doctor directory to locate a participating provider who can provide equivalent services?   ☐ Yes   ☐ No

Why are you sending the member to an out of network provider?
☐ No participating provider in area  ☐ Participating providers cannot give specialized care
☐ Member request

3. Please explain treatment options the non-participating provider offers that could not be provided in-network:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

4. Is the requested care urgent or emergent?   ☐ Yes   ☐ No

Provider Signature: ____________________________
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.