How Dependents Can Receive Coverage When Living Outside of Massachusetts

In addition to emergency and urgent care, child dependents in HMO, POS, and POS+ plans living outside of Massachusetts can receive 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 HUHS or Atrius PCP and ask for a referral to a provider that has a local contract agreement in their state.

The PCP will complete a Managed Care Out-of-Network Authorization Request Form.* PCPs have access to this form and will submit it using the information you provide them; a blank form can also be found on the back of this flyer.

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

* This form is required for all planned care and for each separate provider. PCP must be designated at Harvard University Health Services, Atrius, or Harvard-Vanguard

<table>
<thead>
<tr>
<th>If you have any questions regarding the approval status, please contact:</th>
<th>HUGHP Member Services</th>
<th>617-495-2008</th>
<th><a href="mailto:mservices@huhs.harvard.edu">mservices@huhs.harvard.edu</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Smith Campus Center</td>
<td></td>
<td>Monday-Friday, 8:30 am - 5:00 pm</td>
</tr>
<tr>
<td></td>
<td>75 Mt. Auburn Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cambridge, MA 02138</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 here

**Please select PPO or Indemnity networks instead of HMO.

Examples of Services not eligible for coverage outside of Massachusetts:

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

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association. ® Registered Marks of the Blue Cross and Blue Shield Association. © Registered Marks are the property of their respective owners. © 2019 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
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 providers 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): __________________________
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.