Outpatient Behavioral Network Exception Request Form

EVERNORTH℠

Evernorth Provider website Provider.Evernorth.com

This form should be completed by the clinician who has knowledge of the Evernorth customer's current clinical presentation and his/her treatment history. *Please note: The information contained in this form may be released to the customer or the customer's representative.*

CLEAR FORM

Please complete this form, save it to your computer, then email it to: NER@Evernorth.com (preferred) or fax 860-687-7329.

TIPS FOR COMPLETING THIS FORM:

- To help expedite processing of this request, please complete all sections as **specifically** and **clearly** as possible.
- Typed responses are preferred.
- Our email is secure and authenticated; we cannot open encrypted messages.
- Omissions, generalities, and illegibility will result in this request being returned for completion or clarification.

NOTE: Do NOT use this for IOP, ABA, or TMS requests - see those respective forms

1. Requested Start Date of Network Exception, if authorization is granted: _____

Has treatment started yet with the customer? ☐ Yes ☐ No

If yes, start date for this episode of care *(if different from the start date for the Network Exception)*: _____

Previous Authorization Number *(if requesting NER renewal)*: _____

2. Customer Name: | Customer Date of Birth: | Member's U# / ID#: | Policyholder SSN:

Customer Current Home Address:

3. Outpatient Provider Name: | Degree(s): | TIN:

Provider's independent license: | License #: | In the State of: | Phone Number: | Extension:

Service Address:

Contact at provider's office: | Phone Number: | Extension: | Is voicemail confidential? ☐ Yes ☐ No

☐ Clinic and/or multiple providers *(If applicable)*

4. Diagnosis (F codes):

What CPT codes are requested*:

☐ 90791 ☐ 90792 ☐ 90834 ☐ 90837 ☐ 99205 ☐ 99211 ☐ 99212 ☐ 99213 ☐ 99214 ☐ 99215

☐ Other: _____

Location of Services: ☐ Home ☐ Office ☐ Telehealth ☐ Other: _____

*Psychological Testing *(for Neuro PT, do not use, call Cigna Medical):* Total Hours PT requested: _____

☐ 96130 ☐ 96131 ☐ 96136 ☐ 96137 ☐ 96138 ☐ 96139 ☐ 96146

5. List primary issues being treated:

Clinical Rationale for requesting the Network Exception Request.

Please describe why any clinical treatment specialties are clinically relevant for this Evernorth customer and would be uniquely available from this provider as opposed to another clinician in our existing network.

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6. Please provide any additional relevant information *(do not attach extra pages)*:

Provider Signature: _____ Date: _____

Type/Print requesting provider name: _____ FAX: _____

Please complete this form, save it to your computer, then email it to:
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