Reset Form

Mental Health & Substance Use Disorder Medicare Advantage Plans Out-of-Network Prior Authorization

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request. Review our provider manual criteria references.

For questions, call Mental Health and Substance Use Disorder Services at: **715.631.7442** or **1.855.931.5264**

Fax form and any relevant documents to: **715.787.7314**

Submit Request: : mhsudservicesMA@aspirushealthplan.com

MEMBER INFORMATION

Aspirus ID _____

Member Name _____ DOB _____

Address _____

City, State, Zip _____

ICD-10: _____ Phone _____

ORDERING PRACTITIONER INFORMATION

Practitioner Name _____ NPI Number _____

Address, City, State, Zip _____

Contact Phone _____ Fax _____

SERVICING CLINIC INFORMATION

Practitioner Name _____ NPI Number _____

Clinic Location Address _____

Facility Phone _____ Fax _____

REQUESTER INFORMATION

Request Sent By _____ Phone _____

Fax (if different than above) _____ Total Pages Faxed _____

Email _____

MH&SUD Out-of-Network (Continued)

PLEASE SELECT STANDARD OR EXPEDITED REQUEST BELOW

◯ STANDARD REQUEST

- Medicare decision within 10 business days.

◯ EXPEDITED REQUEST

- Only request an urgent/emergent review if waiting for the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function.
- Medicare decision within 72 hours.
- Billing and retrospective authorizations are not expedited.

1. Proposed date of service: _____
   - Billing and retrospective authorizations are not expedited.
2. Clinical reason for urgency (**unrelated to scheduling issues**):
3. Provide a contact name and number available for this request:
   - Due to the expedited processing time, please ensure that the designated contact is readily accessible should further information be required.

REASON FOR OUT-OF-NETWORK AUTHORIZATION REQUEST

☐ **Referred from another practitioner**

Referring practitioner name _____

Clinic/Facility _____ Contact Phone Number _____

☐ **Access Issues**

☐ **Benefit Exception**

☐ **Member Preference**

☐ **Network Exception** (a request to allow a member to receive services from an out-of-network provider)

☐ **Previous Insurance Approval** (*attach previous authorization as necessary*

SERVICE REQUEST/DATES/PROCEDURE CODES/UNITS

DATES REQUESTED	Start Date	End Date

Please list all necessary code(s) and units associated with your visit.

Service Requested: _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

MH&SUD Out-of-Network (Continued)

ADDITIONAL INFORMATION

Please include any additional information that may support medical necessity/rationale for out-of-network request: