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BEHAVIORAL HEALTH OUT OF NETWORK
 PRIOR AUTHORIZATION REQUEST FORM
 Behavioral Health Department
 PHONE: (413) 787-4000 EXT. 5028 FAX: (413) 233-2800

**Please complete thoroughly. Fax to Behavioral Health Department for review and decision.
 MUST ENCLOSE CLINICAL INFORMATION TO SUPPORT REQUEST**

***REQUIRED**

MEMBER INFORMATION:

*DATE: _____ *NAME: _____

*HNE ID#: _____ * DATE OF BIRTH: _____

REFERRING IN-PLAN PROVIDER INFORMATION:

* NAME: _____ *HNE PROVIDER ID #: _____

*ADDRESS: _____

*Contact Person name and phone/ext. #: _____

*OUT OF NETWORK PROVIDER NAME: _____ * DEGREE: _____

*FACILITY: _____

*ADDRESS: _____

*PHONE: _____

Please note: HNE does not verify the credentials of Non-Plan Providers; only In-Plan Providers go through HNE's Credentialing process.

*Service (s) Requesting: _____

Scheduled Appointment Date/Time: _____

***REASON FOR REFERRAL:**

***Must include reason(s) why services are not available in plan/network.**

PSYCHIATRIC AND MEDICAL HISTORY:

Mental Health Diagnosis: _____

Substance Abuse Diagnosis: _____

Medical Diagnosis: _____

Relevant/Significant Medical Treatment: _____

Mental Health Treatment History: _____

Substance Abuse Treatment History: _____

Psychiatric Medication History: _____

Prior approval is not a guarantee of payment. All payment of claims is contingent upon verification of:
 (1) The member's eligibility on the date of service, (2) The medical necessity of the care, and (3) Coordination of Benefits/Subrogation status

PLEASE NOTE: THE REQUESTED SERVICES ARE NOT AUTHORIZED UNLESS APPROVED BY HNE IN ADVANCE OF TREATMENT.
 [3/10]