FIRST PRIORITY HEALTH
Independent Licensee of the Blue Cross and Blue Shield Association

Outpatient Non-Participating Provider Request Form

Submission Instructions:
Please print all information.
IMPORTANT! THIS REQUEST FOR AUTHORIZATION REVIEW **CANNOT** BE PROCESSED WITHOUT SUPPORTING CLINICAL DOCUMENTATION AND/OR INFORMATION – **NO EXCEPTIONS.**
Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.

Please fax completed form to the Utilization Management Department:
855.329.8195 *(Legacy business for NEPA)* or **888.236.6321** *(Migrated business for Highmark)*

Requesting Physician Information:	Non-Participating Provider Information:
Physician Name:	Specialist Name:
☐ Specialist ☐ PCP	Specialty:
Address:	Address:
Phone #: Fax #:	
Office Contact Person:	Phone #: Fax #:

Member Information:	Non-Participating Facility Information:
Member ID #:	Name:
Member/Patient Name:	Address:
Date of Birth:	
Address:	
Phone #:	Phone #:

☐ Consult Only ☐ Evaluate and Treatment # of visits requested: _____

Who is requesting this non-participating request? ☐ PCP ☐ Specialist ☐ Member

Specific Diagnosis/ICD-9 code(s)_____

Specific Procedure/CPT code(s)_____

This service is medically necessary because: _____
Document rationale supporting medical necessity. Attach clinical documentation that supports this request.

_____

_____

_____

Internal use only

Received by IC: _____ Date: _____ Nurse Reviewer: _____

Administrative Denial, Retro Services: _____

Medical Director Decision: Approved: _____ Denied: _____ MD Initials: _____

Authorization Number:_____ Provider notified/Date: _____ Time: _____