Intensive Outpatient Program (IOP)
Network Exception Request Form

EVERNORTH℠

CLEAR FORM

This form should be completed by the clinician who has a thorough knowledge of the 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.*

CPT Code 90853 does not require authorization, do not submit this form.

TIPS FOR COMPLETING THIS FORM:

This form is ONLY for Out of Network IOP Providers wishing to request a Network Exception.

- To help expedite processing of this request, please complete all sections as **specifically** and **clearly** as possible.
- Typed responses are preferred.
- Please do not send encrypted messages.
- Omissions, generalities, and illegibility will result in this request being returned for completion or clarification.

All fields are required unless marked as '*(optional)*'.

Requested start date for treatment, if authorization is granted: _____

Diagnosis (F codes): _____ ☐ **Initial request** **OR** ☐ **Continued Stay request**

Is this a reconsideration request for a recently denied request? ☐ Yes ☐ No Is updated information included? ☐ Yes ☐ No

1. Customer name: _____ Customer date of birth: _____

ID #: _____ Policyholder Social Security number (SSN) *(optional)*: _____

Customer current home address: _____

2. Facility name: _____ Taxpayer Identification Number (TIN): _____

Service address: _____

Program Manager/Supervisor First Name: _____

Program Manager/Supervisor Last Name: _____

Utilization Reviewer name: _____ UR phone: _____ Ext.: _____

UR FAX Number *(to Receive Return Faxes)*: _____ Ext.: _____

3. Authorization Request

Previous authorization number *(optional)*: _____

Billing Code: ☐ 905 MH IOP/S9480 ☐ 906 CD IOP/H0015 or ☐ Other: _____

Number of visits requested: ☐ 30 ☐ 18 ☐ 12 ☐ Other: _____

Treatment Modality: ☐ In person ☐ Telehealth

Would Telehealth only be appropriate? ☐ Yes ☐ No

If not, explain:

Number of visits per week: _____ Number of hours per day: _____

Last substance use date *(optional)*: _____ ☐ N/A *(optional)*: Planned discharge date:

Current functional impairment *(optional)*: _____

Aftercare plan *(optional)*: _____

4. Eating disorder IOP ONLY *(optional)*:

Current height: _____ Ideal body weight: _____ Current weight: _____ Body Mass Index (BMI): _____

Eating disorder behaviors/symptoms:

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 providing in our existing network.

6. Please provide any additional/relevant information.

7. State Specifics:

Pennsylvania:

Is the treatment facility licensed by the Department of Pennsylvania Insurance AND is there a certification/referral from a physician or psychologist licensed by the Pennsylvania Department of Health?

☐ Yes ☐ No If yes, please submit any supporting documentation if possible.

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

Fax: 1.833.213.9211_(Recommended for more timely response)_**

Email: IOPRequests@Evernorth.com

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