Outpatient Behavioral Network Exception Request Form

EVERNORTH℠

CLEAR FORM

Evernorth Provider website Provider.Evernorth.com

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

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)*: _____

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

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

Patient 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

Fax Number: ☐ 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: _____

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

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

5. Location of Services *(select all that apply)*:

☐ Home ☐ Office ☐ Telehealth ☐ Other: _____

Would telehealth only be appropriate? ☐ Yes ☐ No

If not, explain:

* "Evernorth Behavioral Health" refers to Evernorth Behavioral Health, Inc. and subsidiaries of Evernorth Behavioral Health, Inc., including Evernorth Behavioral Health of California, Inc., and Evernorth Behavioral Health of Texas.

6. 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.

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

Provider Signature: _____ Date: _____

Type/Print requesting provider name: _____ FAX: _____

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