EVERNORTH℠

Partial Hospitalization (PHP)
Network Exception Request Form

CLEAR FORM

Evernorth Behavioral Health provider website: Provider.Evernorth.com

This authorization request form should be completed by the clinician who has knowledge of the Evernorth customer's current clinical presentation and treatment history. *Please note: Evernorth may release the information contained in this form to the customer or the customer's representative.*

*Charges for non-medical living arrangements, including but not limited to, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, or supportive living programs are excluded from coverage.

Please complete this form and fax it to 844-266-3156
If you are unable to submit your requests via fax, please call provider services at 800.926.2273

TIPS FOR COMPLETING THIS FORM:
This form is ONLY utilized when an out of network provider is requesting a Network Exception for Partial Hospitalization Program.

- Verify coverage prior to submitting this request.
- To help expedite processing, please complete all sections as **specifically** and **clearly** as possible.
- Typed responses are preferred.
- Omissions, generalities, and illegibility will result in this request being returned for completion or clarification.
- Please note that Evernorth assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the documents prior to receipt by Evernorth.

1. **Level of care requested:** ☐ Mental Health PHP ☐ Substance Use Disorder PHP ☐ DUAL PHP ☐ Eating Disorder PHP

   Billing code used: ☐ H0035 MH PHP ☐ S0201 SUD PHP ☐ Other _____

2. **How many days a week (Monday-Sunday) is the PHP program?** _____

3. **Date of admission:** _____
   Admission status: ☐ Waiting ☐ Admitted (select one)

4. **Planned Discharge Date:** _____
   Planned Aftercare Plan (optional): _____

5. **Name of primary contact for initial request:** _____
   Direct telephone number: _____
   Fax number (for follow up/authorization information): _____

   Utilization reviewer (UR) contact information for follow-up (optional):
   Contact name: _____
   Contact telephone number: _____
   Contact fax number: _____

6. **Patient information**

Patient name: _____

Member ID#: _____

Patient date of birth: _____

Patient current home address: _____

Last four digits of the policyholder's social security number (optional): _____

Is the patient their own guardian? ☐ Yes ☐ No

a. If yes, please provide patient's telephone number: _____

b. If no, please provide parent/guardian name: _____

Parent/guardian telephone number: _____

7. **Facility information**

Requesting facility name: _____

Requesting facility Taxpayer Identification Number (TIN): _____

Requesting facility servicing address: _____

If the requesting and servicing facilities are not the same, please complete the following:

Servicing facility name: _____

Servicing facility Taxpayer Identification Number (TIN): _____

Servicing facility address: _____

8. **Attending Provider (MD-level) information:**

Provider name: _____

Provider facility Taxpayer Identification Number (TIN) or National Provider Identifier (NPI): _____

9. **Behavioral diagnosis code; begin with primary diagnosis code:** _____

10. **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 provider in our existing network:**

_____

11. **Please provide any additional/relevant information:**

_____

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