

Outpatient Behavioral Network Exception Request Form



Evernorth Provider website Provider.Evernorth.com

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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): _____				
2. Customer Name: _____		Customer Date of Birth: _____	Member's U# / ID#: _____	Policyholder SSN: _____
Customer 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Clinic and/or multiple providers (If applicable)				
4. Diagnosis (F codes): _____				
What CPT codes are requested*: <input type="checkbox"/> 90791 <input type="checkbox"/> 90792 <input type="checkbox"/> 90834 <input type="checkbox"/> 90837 <input type="checkbox"/> 99205 <input type="checkbox"/> 99211 <input type="checkbox"/> 99212 <input type="checkbox"/> 99213 <input type="checkbox"/> 99214 <input type="checkbox"/> 99215 <input type="checkbox"/> Other: _____				
*Psychological Testing (for Neuro PT, do not use, call Cigna Medical):			Total Hours PT requested: _____	
<input type="checkbox"/> 96130	<input type="checkbox"/> 96131	<input type="checkbox"/> 96136	<input type="checkbox"/> 96137	<input type="checkbox"/> 96138 <input type="checkbox"/> 96139 <input type="checkbox"/> 96146
5. Location of Services (select all that apply): <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Telehealth <input type="checkbox"/> Other: _____				
Would telehealth only be appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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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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