Medical Necessity Form – Out-of-Network

TO: UPMC Health Plan
Clinical Operations Department
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

Phone: 1-800-425-7800
Fax: 412-454-2057

Out-of-network provider requests must be approved by the Health Plan Clinical Operations Department prior to obtaining services. The referring physician must complete and sign all sections of this form.

Patient last name: _____ Patient first name: _____

Date of birth: _____ Insurance ID #: _____

Address: _____

Phone number: _____ Other insurance: _____

Referring in-network physician: _____ Office contact: _____

Address: _____

Office phone: _____ Fax: _____

Referring in-network physician signature (required): _____

Out-of-network provider: _____ Office contact: _____

Address: _____

Office phone: _____ Office fax: _____

Out-of-network provider NPI: _____ Out-of-network provider tax ID: _____

Out-of-network Medicare ID (if applicable): _____

Specialty: _____

Office phone: _____ Fax: _____

Service/Procedure requested: _____

Symptoms/Diagnosis (use most appropriate ICD-10 codes): _____

Service/Procedure codes (use most appropriate CDT, CPT®, or HCPCS codes): _____

Is the requested service/procedure available in-network? ☐ Yes ☐ No

☐ Office/Follow-up visit ☐ Inpatient ☐ Outpatient procedure ☐ Behavioral health ☐ Consult

☐ Consult and treatment ☐ Transition of care/Continuity of care

Number of visits: _____ Duration of services: ____/____/____ to ____/____/____

Reason for out-of-network request: _____

_____

_____

_____

Attach any additional documentation such as progress notes, labs, or consultation reports for review. Please note: An approved request does not guarantee payment. Payment of services is subject to member eligibility and benefit plan on the date of service.

UPMC HEALTH PLAN