Ambetter from Home State Health

Out of Network Request Form

Phone: 1-855-650-3789

Fax: 1-855-690-5433

Date of Request:

Member Information

Member's First Name:	**Member's Last Name**	**Member's Middle Initial:**
Member's ID:	**Date of Birth:**	**Phone #:**
Other Insurance Carrier (if applicable):	**Policy # (if known):**	
List all appropriate clinical reasons for the request for the member to receive services out of network:		

CPT Code: (required)	Place of Service:	Description:	Number of units: (including daily quantity)	Duration of need:

Servicing Provider (provider who will dispense and bill for services)

Provider Name:				
Address:				
Provider Phone:	**Provider Fax:**	**Servicing Provider ID#:**	**NPI:**	**TIN:**

Requesting Provider

Referring Provider Name:			**Referring Provider Address:**	
Contact Person's Name:			**Contact Phone Number:**	**Contact Fax Number:**
Referring Provider ID#:	**NPI:**	**TIN:**		
Doctor's Original Signature (no stamps or photocopies):				

**** ALL CLINICAL INFORMATION TO SUPPORT REQUESTED SERVICES IS REQUIRED TO BE SUBMITTED WITH THIS FORM ****

Revised: 2/2020