



Out-of-Network – Behavioral Health Outpatient Request Form for Medicaid Members

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All behavioral health outpatient services rendered by an out-of-network provider for Blue Cross Blue Shield Texas (STAR, CHIP, Star Kids) members require prior authorization. Use this form to explain the reason for the out-of-network accommodation. Fax the completed form to **888-530-9809**.

For contracted providers, service authorization is not required for most outpatient behavioral health services. Refer to our **Medicaid prior authorization information**.

Date			
Check (only) one <input type="checkbox"/> New case request <input type="checkbox"/> Extension request			
Member information			
Subscriber name		Date of birth	
Subscriber ID			
Address		City	State Zip
Provider (rendering services)			
Provider name		Provider address	NPI
Is the provider registered with the Medicaid system? <input type="checkbox"/> Yes <input type="checkbox"/> No (All providers not registered with the Medicaid system, must call customer service for authorization.)			
Provider contact (for decision notification)			
Provider name		Provider fax	
Service information			
Start date request		Anticipated service end date	

Service type			
<input type="checkbox"/> Electroconvulsive therapy	<input type="checkbox"/> Psych/neuro psych testing	<input type="checkbox"/> Transcranial magnetic stimulation	<input type="checkbox"/> Outpatient
Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System code requested		Quantity of units requested	
CPT/HCPCS code requested		Quantity of units requested	
CPT/HCPCS code requested		Quantity of units requested	
CPT/HCPCS code requested		Quantity of units requested	
CPT/HCPCS code requested		Quantity of units requested	

Current behavioral health diagnoses		
Primary code#	Diagnosis	Specifier
Secondary code#	Diagnosis	Specifier
Tertiary code#	Diagnosis	Specifier

Reason member is unable to receive services from an in-network Medicaid provider

My signature confirms that I, or the facility I represent, will provide the requested services.	
Signature	Title
Date	

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