Network Exception Request Form

NOTE: ALL FIELDS ARE MANDATORY, THE FORM WILL NOT BE PROCESSED IF ALL INFORMATION IS NOT PROVIDED.

Network exceptions are only granted when an in-network provider is not available, you must provide evidence of lack of a network provider in order for an exception to be approved.

Member Information

Name: | *Date of Birth:* | *Member ID:*

Mailing Address: | *City:* | *State:* | *ZIP Code:*

Claim # (if available) | *Email Address:* | *Phone:*

Referring In-Network Provider Information

Provider Name: | *Provider TIN:*

Provider Address: | *City:* | *State:* | *ZIP Code:*

Provider Phone #: | *Fax #:* | *Provider Specialty:*

Provider Sub Specialty: | *Name of person completing form:*

Contact Information:

Is there an In-Network Provider of the same specialty available (please provide supporting information)

If yes, why is an Out-of-Network provider being requested?

Servicing Out-of-Network Provider Information

Provider Name: | *Provider TIN:*

Provider Address: | *City:* | *State:* | *ZIP Code:*

Provider Phone #: | *Fax #:* | *Provider Specialty:*

Provider Sub Specialty: | *Name of person completing form:*

Service Information

Beginning Date of Service: | *End Date of Service:*

Type of Service: | *Number of visits\days being requested:*

ICD 10 Diagnosis Code(s): | *CPT/HCPCS Code(s):*

Please provide description of services or any additional information regarding the request for the network exception:

Description:

Fax or Mail to Health Plans, Inc.

By Mail: HPI, PO Box 5199, Westborough, MA 01581 | Fax (508) 329-4812

Clear Form