Ascension

Ascension
Personalized Care

Out-of-Network Request Form

Please fill out this form completely and return to SHP-Authorization@ascension.org or fax it to 512-380-7507. Please note that if you choose to email this form that we cannot guarantee the security of the email during its transmission.

This form must be approved prior to receiving services in order for the services to be covered at in-network price sharing. This form cannot be used retroactively. Turnaround time for the OON Request Form will mirror the timelines available for prior authorization for prospective urgent and prospective non-urgent request types. If this form is related to a service that requires prior authorization, your clinician must also submit a request for prior authorization using the established process. For more information about decision timeframes and prior authorizations please refer to the Clinician Manual, which is available on the Ascension Personalized Care website.

This form is not for medical emergencies. You do not need to complete this form to receive care out-of-network for medical emergencies.

Member Information	
Today's Date ____ /____ /_____	Member Date of Birth ____ /____ /_____
Member Name:	Member ID Number:
Member Phone Number:	Member Email Address:
Member Primary Care Provider:	Do you have an existing relationship with the provider(s) identified below? ☐ Yes ☐ No
NOTE: Having an existing relationship with a provider will be taken into account when evaluating which provider, if approved, you're able to utilize for out-of-network services. However, there is no guarantee that the provider you have an existing relationship with will be the provider approved for you to use to seek care, another alternate provider may be identified as the approved provider.	

Ascension

Ascension
Personalized Care

Out-of-Network Provider/Facility Information	
Provider Name:	Specialty:
Provider NPI (if known): *To assist you in identifying the NPI, this tool is available: https://npiregistry.cms.hhs.gov/*	Provider TIN (if known):
Provider Phone Number:	Provider Fax Number:
Provider Address (include city, state, zip):	
If this request is for a procedure that will be performed at a facility, please fill out this additional facility related information:	
Facility Name:	Facility Phone Number:
Facility Fax Number:	Facility NPI: *To assist you in identifying the NPI, this tool is available: https://npiregistry.cms.hhs.gov/*
Facility TIN (if known:)	
Facility Address (include city, state, zip):	

Ascension

Ascension
Personalized Care

Information About Services Requested	
What disease or condition are you looking to see the provider for? Please include any ICD-10 Diagnosis Codes, if known. *If you are unsure about which disease or condition you need to see a provider for, please contact your primary care provider.*	What procedure (if any) are you looking to have completed? Please include any CPT Procedure Code(s), if known. *If you are unsure about what procedures you need to see a provider for, please contact your primary care provider.*
Please explain why you are seeking services from an out-of-network provider?	
☐ Non-urgent service	☐ Clinically urgent service
☐ Date of service not scheduled yet ☐ Date of service scheduled on ____/____/_____ ☐ Number of visits requested: _____	
Service location: ☐ Office (example: provider office) ☐ Outpatient (example: surgery center) ☐ Inpatient (examples: hospital) ☐ At your home	

By signing below, I certify all information is true and correct to the best of my knowledge.

_____ _____ /_____ /_____

Signature Date

Ascension Personalized Care
PO Box 1707, Troy, MI 48099
833-600-1311
ascensionpersonalizedcare.com

Ascension Personalized Care benefits are underwritten by US Health and Life Insurance Company
Form last updated February 21, 2022