

Request for Single Case Agreement for Out of Network Provider to be Authorized to Deliver Care at In-Network Benefits Level

Member Name: _____ Member ID# _____

Mailing Address: _____

Preferred Phone Contact: _____ DOB: _____

Provider Requested: _____

Type of Behavioral Health Care Sought:

- _____ Adult Psychiatric Appointment
- _____ Child Psychiatric Appointment
- _____ Suboxone Induction and Treatment for Opiate Addiction
- _____ Outpatient Opiate Detox
- _____ Outpatient Ambulatory Alcohol Detox
- _____ Other: _____

Reason for Request for Single Case Agreement: **No In-Network Psychiatrists available within my geographic region to provide the above services within standard access to care guidelines per NH DOI regulation INS 2701 and NCQA (i.e., 6 hours emergent care, 48 hours urgent care, and 10 business days for routine care)**

My Request is for the following level of outpatient psychiatric care:

- _____ Emergent (within 6 hours)
- _____ Urgent (Within 48 hours)
- _____ Routine (Within 10 business days)

Member Signature (or Signature of Parent or Guardian): _____

Printed Name of Member (or Parent or Guardian): _____

Please Fax to: The Counseling Center: 603.883.0007

Your appointment cannot be kept without receipt of this signed request for an out of network authorization.