

**OUT-OF-NETWORK SPHN BENEFIT REQUEST
FOR SPARROW HEALTH SYSTEM ASSOCIATE PLAN #730**

When completed please fax this form to Physicians Health Plan of Mid-Michigan (PHPMM) TPA at (517) 364-8417
For questions please call (517) 364-8597, Option #3 or 1-866-203-0618, Option #3

Section I Request for Out of SPHN Network

Instructions: Complete this section first; if one or more of the following conditions are met proceed to section II. Check the item(s) that apply to this request.

- Specialty or service is not available within the SPHN Network
- Request is on the behalf of an SPHN Specialist in same specialty
- Second opinion required and not available in-network

PHPMM-TPA authorization is required before receiving any out-of-network appointment or treatments. See the covered person's handbook for covered benefits.

Section II Physician/Provider/Practitioner Contact Information

Person Calling/Contact: _____ Provider Phone No: () _____
PCP/Specialist Requesting: _____ Provider Fax No: () _____

Section III Supporting Documentation for the Out of SPHN Network Request-Provider to Complete

Please include physician notes, reports or other correspondence pertinent to this patient's case for determination of benefits, medical necessity, and reasons why this patient cannot receive services from an in-network SPHN provider. **Supporting documentation will expedite this request and reduce the possibility that it may be denied.** For non-urgent requests *PHPMM-TPA* will respond within 14 days with a decision.

Associate's Name: _____ Associate's PHPMM TPA ID#: _____
Patient's Name: _____
Patient's Date of Birth: _____ Date of Request: ____/____/____
Diagnosis: _____ ICD-9 Code: _____

Level of Care: (Please check only one) Initial consult ONLY
 Consult and testing for indicated diagnosis ONLY
 Consult, testing and treatment of indicated diagnosis ONLY

Requested services to be provided out-of-network: _____

Requested service code(s) (CPT/HCPCs): _____ Number of visits: _____

Which in-network specialist did the patient see? _____ Date: ____/____/____

What is the reason for using an out-of-network provider? (Please include correspondence from Specialist) _____

Out-of-network provider information:

Anticipated appointment date: ____/____/____ Phone: () ____ - ____

Provider name: _____ Specialty: _____

Address (street number and name): _____

City, State, Zip: _____

SECTION IV Benefit Determination Physicians Health Plan TPA to Complete

A letter of benefit determination will be mailed to the requesting provider and to the covered person.