



Out-of-Network Exception Request Form

RCCH HealthCare Partners Employees (formerly CMC)

This form is a request for an out-of-network exception prior to services. The out-of-network exception request will only be considered if services are not available by an in-network provider.

Patient's Name:
Patient's Date of Birth:
Employee's Name:
Health Plan ID Number:

Referring Network Physician must complete this portion

Diagnosis: _____

Was the treatment due to an accident or medical emergency? Yes No

Can this treatment be performed by a RCHP, Inc in-network provider? Yes No

If not, please explain _____

Duration of treatment _____

If surgery is needed, can this surgical treatment be performed locally? Yes No
If not, please explain _____

Physician's Name (print):
Physician's Signature:
Physician's Address:
Physician's Tax ID Number:
Physician's NPI Number:
Out of Network Provider being referred to:
Out of Network Provider Address:

Please attach any supporting documentation and Fax to 406-441-3008 or Mail to:

Blue Cross Blue Shield of Montana
Group Benefits Specialist-Claims
PO Box 4309
Helena, MT 59604