QualChoice® HEALTH INSURANCE

Out-of-Network Authorization Request Form

All out-of-network referrals must be pre-authorized. The QualChoice participating provider must complete and submit this form to request authorization for an out-of-network referral before the patient is instructed to seek care from an out-of-network provider. Out-of-network referrals will be approved only if medically necessary. In general, out-of-network referrals are not approved for services that are available within the QualChoice network.

Please Print

Section I: Patient Information

Patient's Name (Last, First, Middle Initial)	Date of Birth	Qualchoice ID Number

Section II: Medical Information

Diagnoses	ICD Code(S)

Section III: Out-of Network Information

Provider Name	Specialty	Phone Number

Address	City	State	ZIP

Has this out-of-network provider treated this patient previously? ☐ Yes ☐ No	If yes, give dates and treatment(s) rendered:	
	Dates	Treatment

Section IV: Participating Provider Evaluation

Previous In-Network Evaluation and Treatment	Provider Name	Date(s)

Specific Services Requested That Are Not Available In-Network

Medical Rationale for Out-of-Network Referral Request

Section V: Participating Provider Information

Provider Name	Provider Qualchoice ID Number
Office Contact Name (Person Completing Request)	Office Contact Phone Number
Provider Signature (Required)	Date (MM /DD /YYYY)

Section VI: Instructions

Complete this form in its entirety, or use it as a guide to write a Letter of Medical Necessity. Submit the form (or letter) and pertinent medical records to the following address at least five (5) business days prior to the anticipated date of any requested out-of-network service.

QualChoice
Quality and Care Management Department
P.O. Box 25610
Little Rock, AR 72221
Fax: 833.681.2498

Internal Use Only	Authorization Number: