Request for Non-Par Provider for Covered Service

Date of Request: _____

Member Information:

Member Name		Member Date of Birth		Medicaid ID Number	

Care Coordinator Information (if known):

Care Coordinator Name		Care Coordinator Agency	
Care Coordinator Phone		Care Coordinator Email	

Person Completing Form:

Name		Title		Agency	
Telephone Number		Fax Number		Email	

Provider being requested:

Provider Name		Provider Address	
Provider Phone Number		Provider Fax Number	
Provider NPI		Provider Tax ID	

Is Provider ODM Registered: ☐ Yes ☐ No

Start Date / Length of Stay:

Start Date		Length of stay	
End Date		Frequency of Visits	

Service Codes	# of Units Requested	Frequency	Comments

Does provider accept ODM fee schedule for the above services today? ☐ **Yes** ☐ **No**

**If No, please provide information on the person who has the authority to negotiate Single Case Agreements at your agency/program:*

Name		Title	
Phone Number		Email	

Fee Schedule Link: *https://bh.medicaid.ohio.gov/Portals/0/2-1-2022%20BH%20Manual%20Version%201_21%20FV.pdf*

Member Diagnosis:

Check reason for requesting non-par provider:

- ☐ No par/in-network provider availability within timely availability
- ☐ No par/in-network provider within reasonable geographic distance from member location
- ☐ No par/in-network provider with this specialization that is clinically necessary for member
- ☐ For continuity of care
- ☐ Other (**Fill in reason**)

Once completed, please fax this form to 1-855-948-3770.