Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

REQUEST FORM OUT OF NETWORK SINGLE CASE AGREEMENT

An Out of Network Single Case Agreement (SCA) is defined as an agreement between Trillium Health Resources (Trillium) and a non-contracted, out of network provider who wishes to render services to a member. Trillium requests that services are delivered by a Provider that is currently in the network when available and able to meet the member's clinical needs. Provider should attest that efforts have been made to link the member with an in-network provider.

Provider and staff must maintain all applicable licenses, certifications, accreditations, and registrations required for its facilities and service delivery while providing services under an SCA. Additionally, the Provider or its staff must not be excluded from participating in Federal Health Care Programs under section 1128 of the Social Security Act and/or 42 CFR Part 1001, CMS or any other State Medicaid program.

Trillium cannot process this request unless Medical Necessity has been confirmed and all applicable fields are complete. If Medical Necessity cannot be confirmed, the OON process will stop and the provider will be redirected to contact Utilization Management (UM). NEW providers must also submit the required documents with this request form.

This request does not guarantee approval or reimbursement and services should not be delivered without prior approval from UM. Additionally, Provider should confirm that MN was given for all desired services. Services not reviewed by UM and determined as medically necessary will not be included in the SCA agreement.

SCA requests submitted by a fully contracted provider cannot be completed following this process and will be redirected to NetworkServicesSupport@TrilliumNC.org.

SUBMISSION INFORMATION – Once completed, submit this request form and required documents to:

Email: OON@TrilliumNC.org Fax: 1- 252-215-6887

Mail: Trillium Health Resources, Attn: Contracts, 201 W. First Street, Greenville NC, 27858

SECTION I – REQUESTOR INFORMATION

Please confirm that you have accessed our Provider Directory to locate a participating provider that can provide equivalent services (Visit Trillium Provider Directory)

☐ YES, I have verified there are no in-network providers available.

Person Submitting this Request: _____ Date: _____

Email: _____

Phone: _____

Is a Care Manager involved? ☐ YES ☐ NO

Care Manager Name: _____

Care Manager Email: _____

Care Manager Phone Number: _____

Is a Targeted Case Management (TCM) provider involved? ☐ YES ☐ NO

TCM Agency Name: _____

TCM Agency Contact: _____

TCM Agency Contact Email: _____

SECTION II – PROVIDER INFORMATION

SECTION II(a) – BILLING PROVIDER ☐ NEW PROVIDER ☐ EXISTING PROVIDER

Provider Name: _____

DBA (if applicable): _____

Owner/Signer: _____

Signer Email: _____

Billing/Mailing Address: _____

Street

_____ _____ _____

City *State* *Zip + 4 is required*

County: _____

Tax ID: _____

Billing NPI(s): _____

Billing Taxonomy(ies): _____

SECTION II – PROVIDER INFORMATION

SECTION II(b) – RENDERING PROVIDER / PRACTITIONER INFORMATION

If this request contains service(s) that require a Rendering Licensed Practitioner, the practitioner information must be provided below. NOTE: The NPI(s) and Taxonomy(ies) listed for each Practitioner in this SECTION II(b) must be Actively enrolled in NCTRACKS, have an Active Medicaid Health Plan, and be affiliated correctly with the Provider and Service Location.

Ⓐ Practitioner Name: _____ _____ _____
First *MI* *Last*

License Type: _____ License Number: _____

Date Issued: _____ Renewal Date: _____

Rendering NPI: _____

Taxonomy(ies): _____

Effective Date: _____

Address of Service Affiliation: _____ _____
Street *City*

Ⓑ Practitioner Name: _____ _____ _____
First MI Last

License Type: _____ License Number: _____

Date Issued: _____ Renewal Date: _____

Rendering NPI: _____

Taxonomy(ies): _____

Effective Date: _____

Address of Service Affiliation: _____ _____
Street City

Ⓒ Practitioner Name: _____ _____ _____
First MI Last

License Type: _____ License Number: _____

Date Issued: _____ Renewal Date: _____

Rendering NPI: _____

Taxonomy(ies): _____

Effective Date: _____

Address of Service Affiliation: _____ _____
Street City

SECTION II – PROVIDER INFORMATION

SECTION II(b) Additional Comments:

SECTION III – SITE INFORMATION & SERVICE CODE(s)

SECTION III(a) – SITE INFORMATION

Requested Effective Date: _____

Site Name (if applicable): _____

Physical Address: _____

Street (P.O. Box not accepted)

_____ _____ _____

City *State* *Zip + 4 required*

County: _____

NPI(s): _____

Taxonomy(ies): _____

Is this Site Licensed? ☐NO ☐YES If YES, a copy of the facility license must be included with this request

SECTION III(b) – SERVICE CODE(s)

All requested service(s) must be included in Trillium's Benefit Plan and listed in this Section III(b). List the desired service(s) by providing a brief description and the service code with modifier (if applicable). If a license or accreditation is required for any of the requested services or sites, a copy of the license and/or accreditation must be submitted with this request. – i.e. Facility License, Day Treatment, etc.

Service Description(s)	Service Code(s) with Modifier(s)

SECTION IV – MEMBER INFORMATION

Member Name: _____

Date of Birth: _____

Current Address: _____

Street

_____ _____ _____

City *State* *Zip + 4*

SECTION V – REVIEW AND SIGN

This request meets at least 1 of the following QUALIFYING CONDITIONS

No In-Network Provider is available in the member's area

The member requires a unique service that is not available in the service area.

Specify: _____

Continuity of Care

Specify: _____

Language Barriers

Specify: _____

SECTION V – REVIEW AND SIGN

Urgent or unusual circumstance

Specify: _____

Other _____

Specify: _____

NEW SCA PROVIDER: Failure to submit the required documents or meet any of the following requirements that apply to your agency will cause this request to be delayed and/or denied.

Confirm the following by selecting each box.
I am a new SCA providers and have completed and attached the required documents to this application:

- ☐ W-9
- ☐ Insurance Requirements and Attestation
- ☐ Trillium Code of Ethics
- ☐ Provider Direct System Administrator Designee Request Form
- ☐ Trading Partner Agreement

Trillium will conduct checks to verify the following. Please verify that your agency's:

- ☐ NPI is not listed on the Office of Inspector General (OIG) Exclusion List. Visit oig.hhs.gov
- ☐ NPI and Medicaid Health Plan is Active in NCTracks. This can be confirmed by reviewing your NCTracks Secure Portal.
- ☐ Service Site address is associated with your NPI in NCTracks as a location 3 or above. Visit your NCTracks Secure Portal.
- ☐ Status is active with the Secretary of State. Visit sosnc.gov

Additional Comments:

ATTEST AND SIGN

By signing below, I confirm that the information provided is accurate to the extent of my knowledge. Additionally, I acknowledge that this request form does not guarantee approval or reimbursement and a fully executed agreement must be in place prior to service delivery.

Person Submitting Request	Title

TRILLIUM HEALTH RESOURCES INTERNAL USE ONLY	
Reviewed By:	Date:
APPROVED:	
COMMENTS:	
COULD NOT PROCESS	
COMMENTS:	