OUT-OF-NETWORK PRE-AUTHORIZATION AND EXCEPTION REQUEST FORM

Complete and fax to: 800-843-1114

This form is for out-of-network providers requesting application of in-network benefits for their services.

Form MUST be within the first two pages and cannot be handwritten.

Request date: ______

MEMBER/PATIENT: ______ Date of birth: ______
Member ID: ______ Suffix: ______ Group #: ______

REQUESTING PROVIDER: ______	**SERVICING PROVIDER:** ______
Address: ______	Address: ______
City: ______ State: ______ ZIP: ______	City: ______ State: ______ ZIP: ______
Phone: ______ Extension: ______	Phone: ______ Extension: ______
Fax: ______	Fax: ______
Contact person: ______	Contact person: ______
Tax ID (**required**): ______	Tax ID (**required**): ______
NPI # (if available): ______	NPI # (if available): ______

REQUIRED: Complete all fields that apply for place of service. To enable Site Of Service boxes download form before completing

FACILITY: ______	☐ Outpatient hospital
Address: ______	☐ Inpatient hospital
City: ______ State: ______ ZIP: ______	☐ Office
Tax ID (**required**): ______	☐ Ambulatory surgical center
NPI # (if available): ______	☐ Ongoing treatment
Phone: ______ Fax: ______	☐ Home
	☐ Freestanding Infusion Center
	☐ Other ______

Date scheduled: ______ **Existing reference #:** ______ **Expiration date:** ______

☐ **URGENT REQUEST**

PLEASE NOTE: Scheduling issues do not meet the definition of urgent.

Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, **or**
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, **or**
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

I attest that this request meets the urgent definition described above: MD signature: ______

Reason for out-of-network provider request: (Please note billed charges for SCAs must be over $1000 to be considered)

Has the patient seen this provider in the past? Yes ☐ / No ☐ If yes, when was the last visit?

Is this request a follow-up to an emergency? (e.g., ER treatment/emergency surgery) Yes ☐/ No ☐
If yes, when was the last visit?

What are you requesting? Transition of Care ☐ Continuity and Coordination of Care ☐
Single Case Agreement ☐ SCA Extention ☐ Benefit Level Exception ☐
If asking for SCA provide email address for contact: ______ (Link to OON Definitions & Info)

Service needed (procedure, test, inpatient care – please specify). Attach supporting medical records and include presenting symptoms and previous treatment.

Diagnosis code(s): ______ Procedure/CPT code(s): ______
Explain in detail why the services noted above can only be provided by this particular out-of network provider:

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.

Confidentiality Notice: The information contained in this facsimile message is privileged or confidential, and intended only for the individual or entity named above. If the reader is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately at 877-342-5258.

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