

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

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



Complete and fax to Care Management at 800-866-4198.

Request Date: _____

URGENT – Urgent requests must 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, in the opinion of a provider with knowledge of the member's medical condition, subject the patient to severe pain that they can't adequately manage without requesting care or treatment.

MEMBER/PATIENT: _____ Date of birth: _____ Member ID: _____ Suffix: _____ Group #: _____	
REQUESTING PROVIDER: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (REQUIRED): _____ NPI # (if available): _____	SERVICING PROVIDER: _____ Address: _____ City/State/ZIP: _____ Phone: _____ Fax: _____ Contact person: _____ Tax ID (REQUIRED): _____ NPI # (if available): _____

REQUIRED: Complete all fields that apply for place of service.

FACILITY: _____ Address: _____ City/State/ZIP: _____ Tax ID (REQUIRED): _____ NPI# (if available): _____ Phone: _____ Fax: _____	<input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Ambulatory surgical center <input type="checkbox"/> Ongoing treatment Date scheduled: _____ Existing reference #: _____ Expiration date: _____
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Reason for out-of-network provider request:

What is the reason for the request?

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?

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.

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