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

Complete and fax to: 800-843-1114

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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 handwritten faxes are not accepted.

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: _____

Address: _____

City: _____ State: _____ ZIP: _____

Tax ID (**required**): _____

NPI # (if available): _____

Phone: _____ Fax: _____

- ☐ Outpatient hospital
- ☐ Inpatient hospital
- ☐ Office
- ☐ Ambulatory surgical center
- ☐ Ongoing treatment
- ☐ 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) ☐ SCA Extension ☐ 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.