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.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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 _____	**SERVICING PROVIDER** _____
Address _____	Address _____
City/State/ZIP _____	City/State/ZIP _____
Phone _____ Fax _____	Phone _____ Fax _____
***Optional information below** – please include if known.*	***Optional information below** – please include if known.*
Contact Person _____	Contact Person _____
Tax ID (REQUIRED): _____	Tax ID (REQUIRED): _____
NPI # (if available): _____	NPI # (if available): _____

REQUIRED: Place of service: please complete all fields that apply

FACILITY _____

Address _____

City/State/ZIP _____

Tax ID (REQUIRED): _____

NPI # (If available): _____

Phone _____ Fax _____

☐ Outpatient hospital
☐ Inpatient hospital
☐ Ambulatory surgical center
☐ Ongoing treatment

Date scheduled _____

Existing reference # _____

Expiration date _____

Reason for Out-of-Network Provider Request
What is the reason for the request?
Has patient seen this provider in the past? Y ☐ / N ☐ If yes, when was last visit?
Is this request a follow-up to an emergency (e.g., ER treatment/emergency surgery)? Y ☐ / N ☐ If yes, when was last visit?

Service needed (procedure, test, inpatient care – please be specific). Please 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.