

# Total Joint Replacement

## EXCEPTION REQUEST FOR ALTERNATIVE PROVIDER AND FACILITY



If you live more than 50 miles from the closest Premera-Designated Center of Excellence and have a non-medical condition that prevents you from safely traveling or you have a medical condition, you can use this form to make an exception request.

### To submit this form, complete the checklist below:

- ☐ **Step 1:** Complete and sign this form (Total Joint Replacement Exception Request).
- ☐ **Step 2:** Attach the relevant documents (see examples in the list on page 2 of this form), which demonstrate the medical hardship or the non-medical hardship which traveling to a Premera-Designated Center of Excellence would create for you.
- ☐ **Step 3:** Give this form to the doctor you would like to perform your surgery. Ask the doctor to submit this Exception Request to Premera, along with a Prior Authorization (PA) request. (Please note: if they have already sent a PA, they do not need to send a new one along with this form.)

### SECTION A - GENERAL INFORMATION

First and Last name			Date of birth (MM/DD/YY)
ID prefix (see ID card)	ID#	Suffix	Group/Policy #
Address			Phone number
City	State	Zip code	

If you're filling this out for someone else, complete Section B.

If you're filling this out for yourself (or are the contracted provider), skip to Section C.

### SECTION B - IF YOU'RE NOT THE MEMBER, TELL US WHO YOU ARE

#### Do you have legal documents to act on the member's behalf?

- ☐ Yes, I'm the legal guardian ☐ Yes, I'm the power of attorney

Please attach legal documentation and go to Section C

- ☐ No, I'm not the legal guardian or power of attorney

Please have member complete the section below

#### Who can submit this form on your behalf? (completed by member noted in Section A)

First and Last name		Phone number
Relationship to member		Fax
Address	City/State	ZIP Code

By signing this form I understand and agree to the following: Premera, or any of its affiliates ("the Company"), may disclose my health records with the authorized representative listed above.

I understand that the healthcare information may include benefit, claim, diagnosis, and treatment records, including information about the following sensitive healthcare diagnoses and treatments, unless I cross one or more from the list: Alcohol and/or chemical dependency, Sexually transmitted diseases (HIV/AIDS), Genetic Information, Reproductive health (including abortion), Psychiatric disorders/Mental illness.

You can change your mind and withdraw this release at any time by informing the Company in writing at the address listed at the bottom of this form. The Company will make sure the change goes into effect within 5 business days after receiving your withdrawal request and will not be liable for any information release before your change goes into effect. This release is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits, or payment of claims on giving this release. This release will last 24 months from the signature date below, or until the exception process is complete, whichever is earlier.

Member Signature:

Today's date:

**Submitting an exception for the following reason:**

- ☐ Medical condition that prevents traveling
- ☐ Legal restriction that would impact ability to travel
- ☐ Sole full-time caregiver of a dependent

(You or your doctor should attach supporting documents. Need more space? You may attach a written statement.)

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's resting on a surface.

## SECTION D - SIGNATURE

Member signature:

Date:

Parent, legal guardian, power of attorney, authorized person:

Date:

Printed name:

Email address:

**Please keep in mind:** If your Exception Request is denied and you still choose to have the service with a provider and/or facility that is not part of the Premiera-Designated Centers of Excellence, you will be responsible for the full cost.

### Instructions for doctor's office:

Submit your exception request via the standard process for pre-service reviews.

Fax number: 800-843-1114

### Need help? We're here for you.

Call: 800-995-2420 (TTY:771)

Monday through Friday

5 a.m. to 8 p.m. Eastern Time

## Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាផ្សេងៗ ដើម្បីទទួលបានសេវាជំនួយផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ ሙሉሪዎቻችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໃຫ້ເພື່ອນບໍລິການພິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwonń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

**Discrimination is against the law.** Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineServices/cc/pub/complaintinformation.aspx>.