

**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.

Form MUST be within the first two pages and handwritten faxes are not accepted.

Complete and fax to:
800-843-1114



Request date: _____

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): _____
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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: _____	<input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Office <input type="checkbox"/> Ambulatory surgical center <input type="checkbox"/> Ongoing treatment <input type="checkbox"/> Home <input type="checkbox"/> Other _____ <small>* For non-FEP medical and psychiatric lower levels of care, use our Admission/Concurrent Review Fax Form.</small>
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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:

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
[\(Link to OON Forms\)](#) Letter of Agreement Benefit Level Exception

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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