PREMERA HMO

Out-of-Network Pre-Authorization and Exception Request Form

Instructions

- **This form must NOT be handwritten.**
- Use the following numbers for faxing. This form must be the first two pages of the fax submission.
  - Fax: 800-843-1114

A. Member/patient information

Member/patient name		Date of Birth	Date Scheduled
Member ID Number Details	Alpha prefix	ID Number	Suffix

B. Urgent request: Note scheduling issues do not meet the definition of urgent.

☐ Check this box if this is an urgent request.
Urgent requests **must be signed by the requesting provider** and include supporting documentation from the provider's office, Services more than five days out are not considered urgent. Note: 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.

MD Signature: **I attest that this request meets the urgent definition described above.**	Print name	
X_____	Print title	Date signed

C. Provider information: Every field in this section is required.

Name of requesting provider		Contact person	
Address	City	State	ZIP code
Phone number with area code		Fax number with area code	
Tax ID		NPI number	

Is the servicing provider the same as the requesting provider?
❍ Yes. Skip to section D.
❍ No. Continue with servicing provider information below. This information is required.

Name of servicing provider		Contact person	
Address	City	State	ZIP code
Phone number with area code		Fax number with area code	
Tax ID:		NPI number	

D. Substance Use Disorder Providers

Part 2 providers are required to obtain written patient consent before submitting records and to include notice required under federal confidentiality rules (42 CFR part 2).

E. Facility information – select the type of facility

❍ Outpatient hospital (Required) Does provider have privileges at an ASC within 30 miles? ❍ Yes ❍ No If yes, provide reason for exception: ☐ Necessary equipment is unavailable ☐ Individual is ≤ 18 years of age ☐ Guidelines prohibit ASC due to health condition or BMI ≥ 50 ☐ Additional services being performed require outpatient hospital department ☐ Other:_____ ❍ Ambulatory surgical center ❍ Freestanding infusion center ❍ Home ❍ Office ❍ Other: _____	❍ Inpatient hospital: ❍ Medical ❍ Surgical ❍ Neonatal intensive care unit (NICU) ❍ Detox (ASAM Level 4.0 – WM) ❍ Psychiatric ❍ Eating Disorder ❍ Substance Use (ASAM Level 4.0) ❍ Substance Use Rehabilitation (ASAM Level 3.7) ❍ Lower level of care (LLOC): ❍ Inpatient Rehab (IPR) ❍ Neuro Rehab ❍ Skilled Nursing (SNF) ❍ Long-term Acute Care (LTAC) ❍ Residential Treatment Center (RTC) - Detox (ASAM Level 3.7 - WM)

Name of facility	Contact person		
Address	City	State	ZIP code
Phone number with area code	Fax number with area code		
Tax ID (required):	NPI # (required)		

F. 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? ❍ No ❍ Yes If yes, when was the last visit?

Is this request a follow-up to an emergency (e.g., ER treatment/emergency surgery)
❍ No ❍ Yes If yes, when was the last visit?

What are you requesting: Link to OON Definition & Info

☐ Transition of Care	☐ Continuity and Coordination of Care
☐ Benefit Level Exception	☐ BLE Extension
☐ Single Case Agreement (SCA)	☐ SCA Extension

If asking for SCA provide the email address for contact: _____

Procedure code/CPT code:	Modifier: (LT/RT/NU/RR)	Units:	ICD diagnosis code:

Explain in detail why the services noted above can only be provided by this particular out-of-network provider: (Must attach supporting medical records and include presenting symptoms and previous treatment.)

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.

Confidentiality Notice: The information contained in this fax message is privileged or confidential and intended only for the individual or entity named above. If the reader isn't the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you're hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you've received this communication in error, please call us immediately at 877-342-5258.