

Exception Form

Please return this completed form and supporting documentation by fax to:

Standard Requests: 501-301-1994 | Urgent Requests: 501-301-1986

By checking the Urgent Requests box or faxing to this number you certify that waiting could place the members life, health or ability to regain maximum function in jeopardy.

Contact information (for the person with whom we need to communicate about this request)

Contact name		Direct phone & Ext
Email	Preferred fax for determination and correspondence	

Member information

First name	Middle initial	Last name		
Member ID number (including prefix)	Member date of birth (mm/dd/yyyy)	Phone		
Member address	City	State	ZIP	

Medical service/Procedure/Course of treatment/Device information

Authorization type (Please Check Only One Box)

If this is related to an existing authorization, please provide the authorization number: _____

Inpatient treatment

Type:

Medical
Surgical
Behavioral
Hospice
Delivery
Swing Bed

Inpatient place of service:

Acute Inpatient Facility
SNF (Skilled Nursing Facility)
Inpatient Hospice
Observation

IPR (Inpatient Rehab)
LTAC
Neuro Restorative

Outpatient treatment

Type:

Medical
Surgical
Behavioral
Home Health
PT/OT/ST
DME

Outpatient Hospice
CT/PET Scans, MRIs
High-Tech Radiology
Medical Oncology
Craniofacial

Outpatient place of service:

School
Office
Home

Ambulatory Surgery Center
Outpatient Hospital

Drug, under medical benefit (any healthcare professional administered injection and/or infusion, CAR-T, or gene therapy billed under the medical benefit by provider, facility or specialty pharmacy)

Type:

Medical
Medical Oncology

Drug place of service:

Office
Inpatient Facility

Home
Outpatient Hospital

Is this a step therapy protocol? Yes No

Requesting provider			
Provider name	Tax ID #	NPI #	Specialty
Group/Facility name	Group/Facility NPI #		Phone
Group/Facility address	City	State	ZIP

Out of Network or Benefit Exception Servicing provider			
Provider name	Tax ID #	NPI #	Specialty
Group/Facility name	Group/Facility NPI #	Phone	Preferred Fax
Group/Facility address	City	State	ZIP

Complete for Out of Network Requests Only

Has the patient seen this out-of-network provider in the past?

Yes No If so, when was the last visit? _____

Summary of in-network specialist this patient has seen related to above diagnosis:

Explain why the requested services can only be provided by this out of network provider:

Care level:

Consult in office Consult and Diagnose Consult, Diagnose, and Treat

Diagnosis and procedure codes (if you have more than three codes for either section, just type the codes separated by commas)

Diagnosis ICD (list primary first)	ICD Description

HCCPS/CPT/CDT code	Code description	Medical reason	Start date	End date	Dose and frequency requested

Details**For inpatient admissions**

Emergent Elective

Admission date & time	Expected discharge date & time	Days requested
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Bed type

ICU Adult ICU Pediatric NICU Med Surg Adult Med Surg Pediatric Labor and Delivery

Discharge planning contact name	Discharge planning phone number
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For procedures

Start date	End date	Unit type				Units requested
		Units	Days	Hours	Visits	

Instructions: Please fill out all applicable sections on all pages completely and legibly before faxing the form to the number listed. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support this request. Information contained in this form is Protected Health Information under HIPAA. If this request is for a prescription drug on the pharmacy benefit or for a transplant, please fill out the applicable form.