Exception form

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

Standard/Urgent for ☐ All FEP/ARHome/Exchange/Octave: **501-301-1996**

For all other business:

☐ 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.).

Medicare Fax:

Standard Requests: **816-313-3014** | Expedited Requests: **816-313-3013**

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**

Requesting provider (referred by)			
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**

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

Authorization type (Please Check Only One Box)

☐ Benefit Exception

☐ Network Exception

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Inpatient

- ☐ Addiction Medicine IP
- ☐ Behavioral Health IP
- ☐ Hospice IP
- ☐ Hospital IP
- ☐ Rehabilitation IP
- ☐ SNF (Skilled Nursing Facility)
- ☐ Long Term Acute Care (LTACH)

Admission source

- ☐ Direct Admit from Clinic
- ☐ ER – Urgent Emergent
- ☐ Planned Admission – Non Urgent

Admission date

Expected discharge date	**Days requested**

Bed type

- ☐ Observation
- ☐ SNF
- ☐ Rehab
- ☐ LTACH
- ☐ Swing Bed
- ☐ Med/Surg
- ☐ Hosp at Home
- ☐ Labor/Maternity
- ☐ NICU
- ☐ NICU Stepdown
- ☐ Newborn Nursery
- ☐ Hospice
- ☐ BH – Residential
- ☐ BH – Inpatient
- ☐ BH – Substance Use
- ☐ BH Detox

Discharge planning contact name

Discharge planning contact number

Outpatient

- ☐ Addiction Medicine OP
- ☐ Autism
- ☐ Behavioral Health OP
- ☐ Cardiac Stress Testing
- ☐ Chiropractic
- ☐ Consultation
- ☐ Dialysis
- ☐ DME
- ☐ Genetic Testing
- ☐ Home Health
- ☐ Homemaking & Private Duty Nursing
- ☐ Hospice - OP
- ☐ Hospital - OP
- ☐ Imaging
- ☐ Maternity Services OP
- ☐ Neuropsych Testing
- ☐ OBGYN
- ☐ Orthopedic
- ☐ Pharmacy*
- ☐ Radiation Therapy
- ☐ Rehabilitation OP
- ☐ Renal Disease
- ☐ Sleep Study
- ☐ Surgery
- ☐ Therapy (PT/OT/ST)
- ☐ Transplant
- ☐ Transplant Evaluation

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

Service start date	**End date**

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**	
HCPCS/CPT/CDT code	**Code description**	**Dose, Frequency, Total Units requested**

Instructions: Please fill out all applicable sections on all pages completely and legibly before faxing. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, clinical and office notes, laboratory information, imaging reports, and any other necessary information to support this request. Information contained in this form is Protected Health Information under HIPAA.

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