

# 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)

<b>Contact name</b>		<b>Direct phone &amp; Ext</b>
<b>Email</b>	<b>Preferred fax for determination and correspondence</b>	

## Member information

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

## 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

<b>Admission date &amp; time</b>	<b>Expected discharge date &amp; time</b>	<b>Days requested</b>
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**Bed type**

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

<b>Discharge planning contact name</b>	<b>Discharge planning phone number</b>
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**For procedures**

<b>Start date</b>	<b>End date</b>	<b>Unit type</b>				<b>Units requested</b>
		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.