

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ BLUE ADVANTAGE ID #: \_\_\_\_\_

GROUP NAME: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

Coverage & eligibility verified by: \_\_\_\_\_ Extension: \_\_\_\_\_

Please check one:

PPO EXCEPTION  TRANSPLANT REQUEST  PHARMACEUTICAL

\_\_\_\_\_  
\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTY \_\_\_\_\_

NOTE: NETWORK EXCEPTIONS WILL BE CONSIDERED ONLY WHEN COMPLETE MEDICAL INFORMATION AND TREATMENT PLAN IS SUBMITTED.

EXCEPTION REQUEST FOR:

HOSPITAL NAME \_\_\_\_\_ DATE OF SERVICE \_\_\_\_\_

PHYSICIAN NAME \_\_\_\_\_ DATE OF SERVICE \_\_\_\_\_

DRUG NAME \_\_\_\_\_

OTHER \_\_\_\_\_

MEDICAL CONDITION: PLEASE HAVE YOUR PHYSICIAN COMPLETE

DIAGNOSIS \_\_\_\_\_

TREATMENT \_\_\_\_\_

MEDICAL NECESSITY FOR SEEKING TREATMENT OUT OF PPO NETWORK:

\_\_\_\_\_  
\_\_\_\_\_

WAS THIS PATIENT REFERRED OUT OF NETWORK BY A PPO PROVIDER?

IF YES, PLEASE INDICATE NAME AND ADDRESS \_\_\_\_\_

IS THIS EPISODE OF CARE, PHYSICIAN CHOICE \_\_\_\_\_

PATIENT CHOICE \_\_\_\_\_ EMERGENCY \_\_\_\_\_

If additional space is needed to complete this form, please use additional paper and attach To this form. Also attach any medical records that support this request. Thank you.

FORM COMPLETED BY \_\_\_\_\_ TELEPHONE # \_\_\_\_\_