



Network Exception Form

Note: Network Exceptions will be considered only when complete medical information and treatment plans are submitted.

Date Request Submitted:
Member(Patient's) Name: Member ID
Member (Patient's) Date of Birth: Group Name Group ID #
Coverage & Eligibility verified by: Extension:

Please check one: Network Exception • Transplant Request • Pharmaceutical •

Insureds Name (if different from patient) Date of Birth:
Address:
City: State: Zip Code:

EXCEPTION REQUEST FOR

Facility/Hospital Name: Date of Service:
Address:
Phone #: Fax #:
Physician Name: Date of Service:
Address:
Phone #: Fax #:
Drug Name:
Other (lab, x-ray, etc.):

MEDICAL CONDITION: THIS AREA TO BE COMPLETED BY PHYSICIAN

Diagnosis:
Treatment:
Medical Necessity for seeking treatment out of network:

Name of Physician Completing form:
Physician Address:
Physicians phone number: Physicians fax number:
Physician Signature:

Are you the patient's PCP? Yes or No FirstSource Provider? Yes or No Health Advantage Physician? Yes or No
Is this episode of care: Physician Choice • Patient Choice • Emergency•

Form may be faxed to #501-378-6647, Attn: Medical Review Division or mailed to

Arkansas BlueCross and BlueShield, Attn: Medical Review Division at PO Box 2181, Little Rock, AR 72203-2181.