Exception Form

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

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

☐ For all other business: ☐ Standard Requests: **501-301-1994** | ☐ Urgent Requests: **501-301-1986**

Or by email to: intaketeam@arkbluecross.com

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

HCPCS/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

Bed type

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

Discharge planning contact name	Discharge planning phone number

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.