OUT-OF-NETWORK PRE-AUTHORIZATION AND EXCEPTION REQUEST FORM

Complete and fax to: 800-843-1114

LifeWise Health Plan of Washington

This form is for out-of-network providers requesting application of in-network benefits for their services.

Form MUST be within the first two pages of fax and cannot be handwritten.

Request date: ______

MEMBER/PATIENT: ______ Date of birth: ______
Member ID: ______ Suffix: ______ Group #: ______

REQUESTING PROVIDER: ______	**SERVICING PROVIDER:** ______
Address: ______	Address: ______
City: ______ State: ______ ZIP: ______	City: ______ State: ______ ZIP: ______
Phone: ______ Extension: ______	Phone: ______ Extension: ______
Fax: ______	Fax: ______
Contact person: ______	Contact person: ______
Tax ID (**required**): ______	Tax ID (**required**): ______
NPI # (if available): ______	NPI # (if available): ______

REQUIRED: Complete all fields that apply for place of service. **To enable Site Of Service boxes download form before completing**

FACILITY: ______	☐ Outpatient hospital
Address: ______	☐ Inpatient hospital
City: ______ State: ______ ZIP: ______	☐ Office
Tax ID (**required**): ______	☐ Ambulatory surgical center
NPI # (if available): ______	☐ Ongoing treatment
Phone: ______ Fax: ______	☐ Home
	☐ Freestanding Infusion Center
	☐ Other ______

Date scheduled: ______ **Existing reference #:** ______ **Expiration date:** ______

☐ **URGENT REQUEST**

PLEASE NOTE: Scheduling issues do not meet the definition of urgent.

Urgent requests must be signed and include supporting documentation from the provider's office, noting that standard timeframes for making a non-urgent determination could:

- Seriously jeopardize the life/health of the patient or the ability to regain maximum function, **or**
- Seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, **or**
- In the opinion of a provider with knowledge of the member's medical or behavioral condition, subject the patient to adverse health consequences without the requested care or treatment.

I attest that this request meets the urgent definition described above: MD signature: ______

Reason for out-of-network provider request: **(Please note billed charges for SCAs must be over $1000 to be considered)**

Has the patient seen this provider in the past? Yes ☐ / No ☐ If yes, when was the last visit?

Is this request a follow-up to an emergency? (e.g., ER treatment/emergency surgery) Yes ☐/ No ☐
If yes, when was the last visit?

What are you requesting? Transition of Care ☐ Continuity and Coordination of Care ☐
Single Case Agreement (SCA) ☐ SCA Extension ☐ Benefit Level Exception ☐

If asking for SCA provide email address for contact: ______ (Link to OON Definitions & Info)

Service needed (procedure, test, inpatient care – please specify). Attach supporting medical records and include presenting symptoms and previous treatment.

Diagnosis code(s): ______ Procedure/CPT code(s): ______

Explain in detail why the services noted above can only be provided by this particular out-of network provider:

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.

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