



DATE: _____

NAME: _____ USABLE ADMINISTRATOR 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 # _____