

Network Exception Request Form

As a member of Franciscan Missionaries of Our Lady Health System (FMOLHS) Group Health Plan, if you need services that are not available within the EPO or PPO Tier 1 or Tier 2 Network, you may receive Network benefits for those services provided you receive approval from BlueCross BlueShield of South Carolina **before** the services are rendered.

Once the exact service(s) is known, you or your provider should complete this *FMOLHS: Network Exception Request Form* and provide all of the necessary information to BCBS SC. Once the request and documentation are reviewed, BCBS SC will review the request and render a decision or if necessary submit the request to the FMOLHS Plan Administrator for a final review and decision.

If the request is approved, BCBS SC will notify the requester of the determination. If the request is not approved, BCBS SC will notify the requester and member in writing that the services will be considered Out-of-Network.

Should your request be denied due to available network options, please access FMOLHS Network Navigation services by calling 1-855-875-6265 and a Network Guide will assist you in finding a network provider.

Submit all completed requests in writing via fax to 803-870-9528, or email to FMOLHSEXCEPTION@BCBSSC.COM. You may also mail the forms to:

BlueCross BlueShield of South Carolina
Attn: Network Waiver, FMOLHS Exception
AX-820
PO Box 100300
Columbia, SC 29202

BlueCross BlueShield
FMOLHS: Network Exception Request Form
(Please use a separate form for each condition.)

Employee's Name _____ ID # _____

Address _____ City/State/ZIP _____

Effective Date _____

Phone: (Home) _____ (Work): _____

Patient's Name _____ DOB _____ ID # _____

Relationship to Subscriber: Self Spouse Dependent

Health Condition: _____

Physician/Provider(s) Involved (May need to confirm here the Providers the member is requesting to see)

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Date of First Treatment: _____ Date of Last Visit: _____

Current Treatment or Proposed Surgery: _____

Expected Length of Treatment or Date of Surgery: _____

Referring Physician Name _____ Referring Physician Signature _____ Date _____

Provider's Name _____ / _____ Member Health Plan ID # _____

Address _____ / _____ City/State/ZIP _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize _____
Non-Participating Specialist's Name

Address and Phone Number

To release to BlueCross BlueShield of South Carolina all information relating to past, present and future health care examinations, conditions and treatments for:

Brief Description of Medical Condition

This information is to be used for determining the appropriate level of benefit reimbursement for services that are provided on or after the effective date of my BlueCross BlueShield coverage if I continue treatment with the above-named provider for the above diagnosis/medical condition.

I understand that this exception is subject to contractual limitations and exclusions set forth in the subscriber contract. I understand and agree that this exception does not extend the contractual benefits in any way except to provide the in-network level of benefits for a non-network provider for a temporary time period, during which this determination is being made. I also authorize BlueCross BlueShield of South Carolina to notify my provider of any exception decisions with the non-participating specialist.

Patient's Name: _____ Health Plan ID #: _____

Patient's Signature: _____ Date: _____

Employee's/LegalGuardian'sSignature*: _____ Date: _____

*If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.