Network Exception Request Form

As a member of Franciscan Missionaries of Our Lady Health System (FMOLHS) 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. You may also visit **www.myhealthtoolkitla.com/links/fmolhs**, log in, and search for an In-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

All fields must be completed on the form and include the provider's signature to be accepted for review.

FMOLHS Exception Request Form

Choose One: _____PPO Plan requesting Tier 2 benefits for provider outside Tier 2 network
_____EPO Plan requesting services from Non-EPO provider
_____EPO Plan where the provider is in the EPO network, but the facility is outside the EPO network
_____Consideration for Out of Network provider

Please note: For the PPO plan, Tier 1 coverage for a Tier 2 or PPO provider will not be approved. Tier 2 coverage is the highest level approved

Subscriber Name: _____ ID# _____

Patient Name: _____DOB: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Email: _____

Referring Provider Name: _____ Specialty: _____

Provider Signature: _____

Address: _____ Phone: _____

Requested Provider Name: _____ Specialty: _____

Address: _____ Phone: _____

NPI : _____

Facility Name: _____ TIN/NPI: _____

Address:_____ Phone:_____

Requested Service/Treatment Plan:

_____
_____
_____
_____

Date of Service/Treatment: _____ Expected Timeframe if applicable: _____

Reason Seeking Services Out of Network:

_____
_____
_____
_____
_____

Have you already seen or received services in the past from the requested provider: No ____ Yes ____ If yes, provide explanation

_____
_____
_____

Administrative use only: Date Approved: _____ Date Range: _____ Other: _____
Received: _____ Date Denied: _____
Notes: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize _____

_____

Non-Participating Specialist's Name, Address and Phone Number

To release to Blue Cross 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 Blue Cross 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 Blue Cross to notify my provider of any exception decisions with the non-participating specialist.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Employee's/Legal Guardian's Signature*: _____

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.