OhioHealthy
PO Box 83301
Lancaster, PA 17608

OhioHealthy Exception Request Instructions

A Network Exception request is a request to pay benefits at the in-network benefit level (i.e. in-network insured percentage, covered expenses applied to the in-network deductible and out-of-pocket maximum) when an out-of-network provider renders services. **A Network Exception Request Form should be submitted prior to the out-of-network service being rendered.** A Network Exception is only available in the following situations:

- Network services are not available within the required treatment timeframe, which will jeopardize the life, health or ability to regain maximum function, or in the opinion of the treating physician would subject the patient to severe pain that could not adequately be managed without the care or treatment by an out-of-network provider. If approved, services must transition to a network provider within 90 days. **The date in which network services were available is required to be documented on the Network Exception Request Form.**

- The required treatment is not available by an OhioHealthy network provider. If approved, such services shall be subject to in-network benefit level for the requested time period.

Important Information:

Incomplete forms without supporting clinical documentation will not be considered for a Network Exception. Please return the Network Exception Request Form as follows:

Fax: 717-295-1208

If the service requires pre-certification for medical necessity, a separate review is required. Pre-certification may be initiated by faxing a Certification Request for Services form, along with supporting documentation to 717-295-1208.

By submitting this form, the submitter attests that s/he has the member's permission to submit on his/her behalf and that the information contained herein is the minimum necessary to request the services being requested.

All claims are subject to the eligibility guidelines, benefits, exclusions, and limitations outlined in the Plan as of the date services are incurred.

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OhioHealthy Network Exception Request Form

IMPORTANT: This form must be completed in its entirety for consideration, with supporting clinical documentation.

Patient Information	
Member ID#:	
First and Last Name:	Date of Birth:
Address:	
Out of Network Physician Information	
Provider Name:	Tax ID:
Provider Address:	
Office Contact:	Email Address:
Phone Number:	Fax Number:

The following information must be completed by the physician:

A Network Exception, to pay benefits at the in-network benefit level (i.e. in-network insured percentage, covered expenses applied to the in-network deductible and out-of-pocket maximum) for services from an out-of-network provider is requested for the qualifying reason(s):

☐ Network services are not available within the required treatment timeframe, which will jeopardize the life, health, or ability to regain maximum function, or in the opinion of the treating physician would subject the patient to severe pain that could not adequately be managed without the care or treatment by an out-of-network provider. If approved, services shall be subject to the "in-network benefit level" for the requested time period. [**Required] Document the earliest date in which network services were available: _____. (This information will be necessary if the required service is not available in-network within the required timeframe.)**

☐ The required services are not available by a network provider. If approved, such services shall be subject to the "in-network benefit level" for the requested time period.

Medical Information (***To be completed by physician)***

Describe the reason for requesting a Network Exception in detail and the requested date(s) for the Exception:

Diagnosis Code(s) and Procedure Codes with Description(s):

Treatment Plan:

Physician Name Completing Form: (*please print)* _____

Physician Signature: _____ **Date:** _____