## **Exception Form**

Please return this completed form and supporting documentation by fax to:

Standard/Urgent FEP / ARHome / Exchange/Octave: 501-301-1996

For all other business: Standard Requests: 501-301-1994 Urgent Requests: 501-301-1986

Or by email to: intaketeam@arkbluecross.com

By checking the Urgent Requests box or faxing to this number you certify that waiting could place the members life, health or ability to regain maximum function in jeopardy.

Contact information (for the person with whom we need to communicate about this request)

Contact name Direct phone & Ext

Email Preferred fax for determination and correspondence

Member information

First name Middle initial Last name

Member ID number (including prefix) | Member date of birth (mm/dd/yyyy) | Phone

Member address City State ZIP

Medical service/Procedure/Course of treatment/Device information

**Authorization type** (Please Check Only One Box)

If this is related to an existing authorization, please provide the authorization number:

Inpatient treatment

Type: Inpatient place of service:

Medical Acute Inpatient Facility IPR (Inpatient Rehab)

Surgical SNF (Skilled Nursing LTAC

Behavioral Facility) Neuro Restorative

Hospice Inpatient Hospice
Delivery Observation
Swing Bed

**Outpatient treatment** 

Type: Outpatient place of service:

MedicalOutpatient HospiceSchoolAmbulatory Surgery CenterSurgicalCT/PET Scans, MRIsOfficeOutpatient Hospital

Behavioral High-Tech Radiology Home
Home Health Medical Oncology

PT/OT/ST Craniofacial

DME

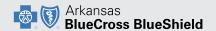
**Drug, under medical benefit** (any healthcare professional administered injection and/or infusion, CAR-T, or gene therapy billed under the medical benefit by provider, facility or specialty pharmacy)

Type: Drug place of service:

Medical Office Home

Medical Oncology Inpatient Facility Outpatient Hospital

Is this a step therapy protocol? Yes No









Requesting provider											
Provider name					Tax ID #		NPI#	Spec		alty	
Group/Facility name						Gr	oup/Fa	up/Facility NPI # Phone			
Group/Facility address			City					State ZIP			
Out of Network or Bene	fit Except	ion Servicir	ng provid	der						1	
Provider name		Tax ID # NPI # Specialty					alty				
Group/Facility name	oup/Facility name			Group/Facility NP			Phone		P	referred Fax	
Group/Facility address			City	City				State ZIP			
Complete for Out of N	etwork R	equests On	ıly								
Has the patient seen t	his out-of	-network pr	ovider in	the pa	ast?						
Yes No If so,	when wa	s the last vis	sit?								
Summary of in-netwo	rk special	ist this patie	ent has s	een rel	lated to abov	e di	agnosis	:			
Explain why the request care level:  Care level:  Consult in office		ices can onl			y this out of			ovider:			
Diagnosis and procedure	e codes (i	f you have mo	re than thr	ree code	s for either sect	ion,	just type	the codes	separa	ted by commas)	
Diagnosis ICD (list primary first) ICD Descrip			ption								
HCPCS/CPT/CDT code	scription	Medical	reasor	Start da	ate	End o	late		and frequency equested		









Details									
For inpatient a	admissi	ons							
Emergent	Elect	ive							
Admission date & time					Ex	pected dis	Days requested		
Bed type									
ICU Adult	ICU P	ediatric	NICU	Med Surg Ad	ult	Med Surg	Pediatric	Labor	and Delivery
Discharge planning contact name  Discharge planning phone number									
For procedures									
Start date		End date	•	Unit type Units	Days	Hours	s Visits	Ur	nits requested

**Instructions:** Please fill out all applicable sections on all pages completely and legibly before faxing the form to the number listed. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support this request. Information contained in this form is Protected Health Information under HIPAA. If this request is for a prescription drug on the pharmacy benefit or for a transplant, please fill out the applicable form.







