



TYSON OUT OF NETWORK PROVIDER EXCEPTION REQUEST FORM			
DATE REQUEST SUBMITTED:			
SECTION 1 - REQUESTER INFORMATION			
Doctor/Facility Name:			
Address:		Suite/Building:	
City:	State:	ZIP Code:	
Phone #:	Fax #:	Contact Person:	
SECTION 2 - PATIENT INFORMATION			
Patient Name:		ID #: (include Alpha Prefix)	
Address:		Apt #/Building:	DOB:
City:	State:	ZIP Code:	
Policy Holders Name:			
<b>NOTE- FOR SECTION 3 AND 4</b> <b>IF REQUEST IS FOR OUT-OF-NETWORK PHYSICIAN/SURGEON – COMPLETE SECTION 3 ONLY</b> <b>IF REQUEST IS FOR AN OUT-OF-NETWORK FACILITY – COMPLETE SECTION 4 ONLY</b> <b>IF REQUEST IF FOR AN OUT-OF-NETWORK PHYSICIAN/SURGEON AND FACILITY – COMPLETE SECTIONS 3 &amp; 4</b>			
SECTION 3 – PHYSICIAN/SURGERY (OON)			
Name of Physician or Surgeon:			
Address:		Suite/Building:	
City:	State:	ZIP Code:	
Phone #:	Fax #:		
SECTION 4 – FACILITY (OON)			
Name of Facility:			
Address:		Suite/Building:	
City:	State:	Zip Code:	
Phone #:	Fax #:		
SECTION 5 - MEDICAL INFORMATION			
Diagnosis Codes: (ICD 10)			
CPT 4 Codes:			
HCPC Codes:			
Treatment Plan: (If necessary use additional pages)			
Please indicate reason for patient seeking treatment from an out-of-network provider:			

**Please note – This form does not constitute that an exception has been allowed, unless you receive written confirmation from BlueAdvantage Administrators. Failure to obtain an approval may result in a reduction of payment based on the plan benefit.**

**Network Exceptions will only be considered when complete medical information and a treatment plan are submitted with this request. Please submit any supporting documentation that would be of assistance for this request.**