Out of Network Prior Authorization Request Form

SANFORD HEALTH PLAN

Use this form when the member is not able to receive the same or comparable services from an in-network provider.

Use of in-network, contracted providers provide the best value and member protection. Referrals to non-contracted providers may result in balance billing to the member. Using an in-network, contracted provider provides protection against balance billing as contracted providers must accept the Plan's payment as payment in full and final for covered services.

Patient Information

Today's Date	Patient DOB Month / Day / Year	
Member Name	Member ID#:	
Member Phone Number (Area Code + Number)		

Ordering Provider Information

Provider Name	Clinic Name		
NPI Number	Address		
Federal Tax ID Number	City	State	Zip
Clinic Contact Name	Telephone Number	Fax Number	

Initial Request | Extension Request | Non-urgent Service | Clinically-urgent Service | Retroactive

Out-Of-Network Provider Information

Provider Name and Specialty	Clinic Name		
NPI Number	Address		
Federal Tax ID Number	City	State	Zip
Clinic Contact Name	Telephone Number	Fax Number	

Facility Information

Facility Name	Telephone Number	Fax Number	
NPI Number	Address		
Federal Tax ID Number	City	State	Zip

Service Location:

☐ Office ☐ Outpatient Hospital ☐ Inpatient Hospital ☐ Home ☐ Other

Prior Authorization Information

CPT Code(s)/HCPCS Code(s)	Care Level: ☐ 1. Consult in the office/second opinion only ☐ 2. Consult & Diagnose ☐ 3. Consult, Diagnose & Treat
Diagnosis/ICD-10 Code(s) **Must be a billable code	
Anticipated Date Range	

Is the requested care elective?		Yes		No		
Has the patient seen this out-of-network provider in the past?		Yes		No		
If so, when was the last visit? (month/year)	Month:		Year:			

Please include last visit records in the request if applicable.

Complexity of Care Requests

The **clinical expertise** to address the specific health care needs of the Member is not available from any in-network provider. **Choose all that apply**:

	The member has a **rare medical condition** and there is no in-network provider with the necessary specialization, training, or expertise to provide treatment. **Please explain:**
	The Member requires a **specialized medical procedure** for which there is no in-network provider with the necessary specialization, training, or expertise to perform the procedure. **Please explain:**
	In-network providers with the clinical expertise required to address the Member's diagnosis or medical condition are **not reasonably available within the Plan's geographic access standards** or within the availability standards of the Member's plan. **Please explain:**
	The Member was treated by an out-of-plan specialist in an **emergency department** and included an inpatient admission as a direct result of that emergency department treatment out-of-network specialist provider. **Please explain:**

Continuity of Care Requests

Continuity of Care Requests for new Members ***or*** active/current Members when provider or facility disenrolls from the Plan:

	The Member is **Pregnant**. Please document due date:
	The Member is considered **terminally ill** (life-expectancy <6 months). Please explain:
	The Member is undergoing active treatment for an **acute condition or a non-routine condition**. Please explain:
	Other. Please describe reason for requesting continuity of care:

Provider Signature (Required)	Date (MM/DD/YYYY)

Complete this form in its entirety and/or use it as a guide to write a Letter of Medical Necessity. Submit the form (or letter) and pertinent medical records. All fields are required for processing your request. Failure to do so may result in processing delay and/or denial. Complete form via our portal on sanfordhealthplan.com. For instructions on how to request this access to the portal, please email providerrelations@sanfordhealth.org.