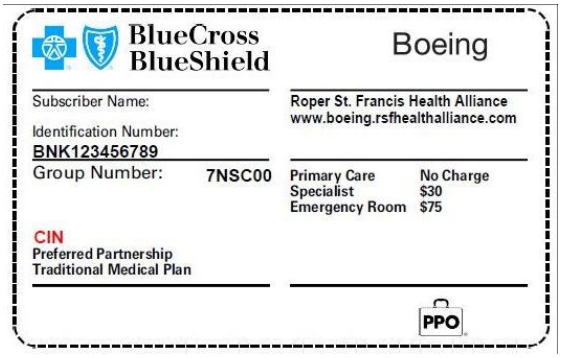
2020 Boeing Preferred Partnership

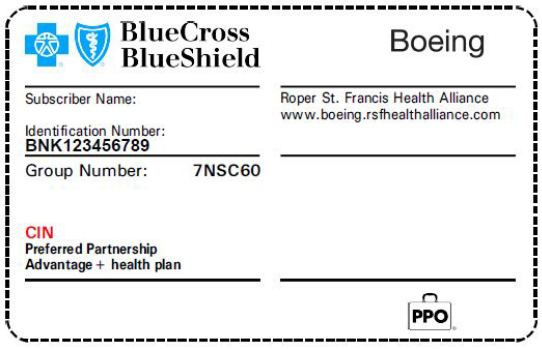
Out-of-network Exception Request

This following one-page form must be completed in order for a Boeing Preferred Partnership plan member to receive in-network benefits for covered, medically necessary services not provided by the Roper St Francis Health Alliance (ex. organ transplants).

Boeing Preferred Partnership plan members have BCBS insurance with a "BNK" prefix.

Boeing Preferred Partnership Insurance Cards:





Please complete the top section of the form on the following page and send to RSF Health Alliance via secure email (RSFHealthAlliance@RSFH.com) or fax (843-727-8525).

Contact the RSF Health Alliance at RSFHealthAlliance@RSFH.com with any questions.

Boeing.RSFHealthAlliance.com

Boeing ACO
Request for In-Network Services
Waiver Form

BlueCross BlueShield of Illinois

Completion of this form by any party shall not be construed as a confirmation of benefits or authorization of services. ***Benefit payment will be made based on eligibility at the time of service and covered services as outlined in the Summary Plan Description. To verify benefits, eligibility, and BCBSIL medical policy, please contact BCBSIL Customer Service at 1-888-802-8776.***

Attending physician/requesting provider: *complete and return this form to the ACO Medical Director* ***Date****:_____

Patient's Full Name*: _____ Date of Birth*_____
(First Name) (Middle Name) (Last Name)

Subscriber Name: _____ Subscriber ID: _____
(First Name) (Middle Name) (Last Name)

Patient or Parent/Guardian Phone Number*: _____

Requesting Provider Full Name*:_____ Requesting Provider NPI: _____
(First Name) (Middle Name) (Last Name)

Requesting Provider Clinic Name*:_____

Requesting Provider Phone Number*:_____ Requesting Provider Email*:_____

Reason for request for services/treatment outside of ACO network*: ☐ Services not available ☐ Extension of care ☐ Other

Provide details on reason for request*:_____

_____

Service/treatment being requested*: _____

_____

Condition being treated*:_____

_____

Provider's Full Name to whom patient is being referred*:_____
(First Name) (Middle Name) (Last Name)

Date care is likely to begin*: _____ Date care is likely to conclude*:_____

Date range for waiver has a maximum of 6 months. This is contingent on member staying in the same plan. If care exceeds 6 months an additional waiver is required. If services are back dated, please explain in additional comments section below.

Additional Comments: _____

_____

_____

ACO Medical Director *(or designate) completes this section* ***Date****:_____

ACO Name: _____ Medical Director Name: _____

Medical Director Email: _____ Medical Director Fax: _____

☐ Authorized – BCBSIL process this request for In-Network Waiver ***(fax signed form to 312-653-9452)***

☐ Request Denied – Explanation *(return form to requesting provider)*: _____

_____

Signature: _____ ***Date:***_____

Title: _____ **Phone:** _____

*Required field