Out-of-Network Exception Request Form

This form is a request for an out-of-network exception **prior to services**. The out-of-network request will only be considered if services are medically necessary, covered by the member's policy and our coverage criteria, and not available by an in-network provider.

Patient's Name:
Patient's Date of Birth:
Patient ID Number:
Patient's Phone Number:
Parent Name, if Patient is Child:

Referring Network Physician must complete this portion

Diagnosis: _____

What out-of-network test and/or treatment is requested? _____

_____

Can this service be safely and effectively performed by a CoOportunity Health provider who is **in** the member's network? Yes No

If not, please explain _____

_____

_____

Duration of expected treatment_____

Referring Physician's Name (print):
Referring Physician's Signature:
Referring Physician's Address:
Out-of-Network Provider's Name (print):
Out-of-Network Provider's Address:

Please attach any supporting documentation and submit to:

CoOportunity Health
Member Services Department
Attn: Benefit Exceptions
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309