OhioHealthy
PO Box 2582
Hudson, Ohio 44236-2582

OhioHealthy Exception Request Instructions

A Network Exception request is a request to receive in-network benefits when an out-of-network provider renders services. **A Network Exception Request Form should be submitted prior to the out-of-network service being rendered.** A Network Exception is only available in the following situations:

- Network services are not available within the required treatment timeframe, which will jeopardize the life, health or ability to regain maximum function, or in the opinion of the treating physician would subject the patient to severe pain that could not adequately be managed without the care or treatment by an out-of-network provider. If approved, services must transition to a network provider within 90 days. **The date in which network services were available is required to be documented on the Network Exception Request Form.**

- The member is newly enrolled (within 90 days of their effective date of coverage) in their employer's OhioHealthy Network plan and out-of-network treatment is in process and has not yet transitioned to a network provider. **The Network Exception Request form must be received within 30 days of the effective date.** If approved, services must transition to a network provider within 90 days.

- The required treatment is not available by an OhioHealthy network provider. If approved, the Network Exception will be applicable for up to 180 days.

Important Information:

Incomplete forms will not be considered for a Network Exception.

Please return the Network Exception Request Form as follows:

Fax: **330-656-1194**

Email: **OhioHealthy-NetworkExceptions@MemberAdvocate.com**

Web Portal: **https://www.ohiohealthyplans.com/**

Or mail to: OhioHealthy
Attn: Network Exception Request
PO Box 2582
Hudson, Ohio 44236-2582

If the service requires pre-authorization for medical necessity, a separate review is required. Preauthorization may be initiated by faxing an Authorization Request for Services form, along with supporting documentation to 800-385-7085 or 330-656-2449.

By submitting this form, the submitter attests that s/he has the member's permission to submit on his/her behalf and that the information contained herein is the minimum necessary to request the services being requested.

All claims are subject to the eligibility guidelines, benefits, exclusions, and limitations outlined in the Plan as of the date services are incurred.

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OhioHealthy Network Exception Request Form

IMPORTANT: This form must be completed in its entirety for consideration.

Patient Information	
Member ID#:	
First and Last Name:	Date of Birth:
Address:	
Out of Network Physician Information	
Provider Name:	Tax ID:
Provider Address:	
Office Contact:	Email Address:
Phone Number:	Fax Number:

The following information must be completed by the physician:

A Network Exception, to pay benefits at the network benefit level for an out-of-network provider, is being requested for the qualifying reason(s):

☐ Network services are not available within the required treatment timeframe, which will jeopardize the life, health, or ability to regain maximum function, or in the opinion of the treating physician would subject the patient to severe pain that could not adequately be managed without the care or treatment by an out-of-network provider. If approved, services must transition to a network provider within 90 days**. [Required] Document the earliest date in which network services were available: _____.**

☐ The member is newly enrolled (within 90 days of their effective date of coverage) in their employer's OhioHealthy Network plan and out-of-network treatment is in process and has not yet transitioned to a network provider. The request must be received within 30 days of the member's effective date. If approved, services must transition to a network provider within 90 days.

☐ The required treatment is not available by a network provider. If approved, the Network Exception will be applicable for up to 180 days.

Medical Information (***To be completed by physician)***
Describe the reason for requesting a Network Exception in detail and the requested date(s) for the Exception:
Diagnosis Code(s) and Procedure Codes with Description(s):
Treatment Plan:

Physician Name Completing Form: (*please print)* _____

Physician Signature: _____ **Date:** _____