Fax Submission: Out-of-network Prior Authorization Form & Instructions

Please review the following instructions to ensure that the request is processed in a timely manner.

Coverage of out-of-network services requires an authorization approval to determine the medical necessity of the services, and an out-of-network exception approval that confirms eligibility for an exception under the member's benefit plan. Please use this form when the same or comparable care services are not able to be performed by an in-network provider.

Submit the Out of Network Gap Exception packet

- **This packet includes the following forms:**
  - Fax Submission: Out-of-network Prior Authorization Request form
  - Network Gap Exception form
  - For faster processing, please attach relevant medical records to this request. If records are not submitted with this request, Oscar will reach out to the indicated provider to request relevant medical records. If relevant records are not received in a timely manner, this request may be denied due to lack of information.

- **Submit the packet to Oscar via:**
  - Fax to 844-965-9053
  - Include applicable clinical documentation

Both forms are encouraged to be submitted at the same time. If the Out-of-Network Exception Form is not submitted with the initial request, then a determination on the requested Out-of-Network provider or facility may be delayed until received and processed. Oscar recommends that providers submit on behalf of the member to ensure a seamless submission and that all necessary clinical information is included. Please call 855-672-2755 for updates.

Fax Submission: Out-of-network Prior Authorization Request Form

Please use this form to request non-emergency medical care outside of Oscar's network. You are strongly encouraged to also complete and submit the "Network Gap Exception" Form at the same time. Attach relevant clinical information, and fax both forms to (844) 965-9053.
To check the status of the authorization request, please call 855-672-2755 for updates.
* Indicates a required field

Member information	
*First name	*Last name
*Member OSC ID#	*Date of Birth

Ordering Provider Information	
*Provider full name	
*Specialty	
*Provider NPI	*Provider TIN
*Contact first name	*Contact last name
*Phone # (+ext.)	*Fax #
*Address	
*Affiliation: ◯ Attending ◯ Referring ◯ Facility	

Rendering/Attending Provider information	
◯ Check if same as ordering	
*Provider full name	
*Specialty	
*Provider NPI	*Provider TIN
*Phone # (+ext.)	*Fax #
*Address	

Facility/Vendor information (if applicable)	
*Facility NPI	*Facility TIN
*Facility name	
*Facility address	
*Phone # (+ext.)	*Fax #

Diagnosis codes (list primary first)
*ICD 10

Dates of service	
Date of Surgery	*Number of requested days: (inpatient only)
*Requested start date (MM/DD/YY)	*Requested end date (MM/DD/YY)

Existing Case Number (if extension/renewal)

Select either inpatient or outpatient, then one service type and one place of service from the corresponding sections.

◯ Inpatient

Service type

- ◯ Post-Acute Inpatient Admission
- ◯ Elective Surgical or Non-Surgical Service
- ◯ Inpatient Hospice
- ◯ CAR T
- ◯ Rehabilitative Service

Place of service

- ◯ Inpatient Hospital
- ◯ Skilled Nursing Facility (SAR)
- ◯ Comprehensive Rehab Facility
- ◯ Long Term Acute Care Hospital (LTACH)

◯ Outpatient

Service type

- ◯ Imaging Services
- ◯ Consultation and Diagnostic Services
- ◯ Home Health Care
- ◯ Durable Medical Equipment
- ◯ Non-Emergent Transportation
- ◯ Physician-Administered Specialty Drugs
- ◯ Laboratory Services
- ◯ Elective Surgical or Non-Surgical Service
- ◯ CAR T
- ◯ Rehabilitative Services

Place of service

- ◯ Outpatient Hospital
- ◯ Office
- ◯ Home
- ◯ Ground Ambulance
- ◯ Water Ambulance
- ◯ Air Ambulance
- ◯ Independent Laboratory
- ◯ Comprehensive Rehab Facility
- ◯ Ambulatory Surgical Center

Procedures	
*Select a unit of measurement: ◯ Unit *or* ◯ Visit	
Procedure code	Quantity
Procedure code	Quantity
Procedure code	Quantity
Procedure code	Quantity

◯ **Expedite this request:** *I certify that this request requires expedited processing due to exigent circumnstances as defined by state and federal law.*

Network Gap Exception Form

This form is to be used to provide additional information to support your request for an exception to receive out of network services. Please complete this form **in addition to** the required "Fax Submission: Out-of-network Prior Authorization Request" form. Completing and submitting both forms together will help expedite the review process. Fill out all fields and fax to (844) 965-9053.

*Is this request for mail order or delivery (e.g. for medical equipment)?
◯ Yes ◯ No

Member OSC ID#

Requested OON Provider Information

*Is the member an established patient with this OON provider? If yes, provide the last visit
◯ Yes ◯ No
Last Visit (month/year):

*Is the provider within the member's residential state?
◯ Yes ◯ No

City, State, Zip Code

*Does this provider only perform services at an out of network facility?
◯ Yes ◯ No

*What other facilities does this provider perform services at?

Referring Provider Information

*Is the referring provider the same as the requested OON provider?
◯ Yes – skip this section
◯ No – please complete this section if the referring provider is different than the requested OON provider

*Who is referring provider?
◯ Primary Care Provider (PCP)
◯ Specialist
◯ Other

*First name

*Last name

*NPI

*TIN

*Phone # (+ ext.)

*Fax #

*If specialist was selected above, Indicate specialty:

*If other was selected above, please explain provider type:

Consultation/Visits

If there are no planned medical services with this provider or this request is for routine office visits, submit the form for consultations/visits. If this request is for consultation/visits, please indicate the initial consult/visit codes and the visit count.

*Is this request for consultation/visits?
◯ Yes – please review for consultation/visits
◯ No – please review specific planned services or procedures

Care Level
◯ Consult in the office
◯ Consult & Diagnose
◯ Consult, Diagnose & Treat:

In Network Providers

*Has the member seen any in network provider(s) for this condition previously?
◯ Yes ◯ No

If yes, was the in network provider(s) able to treat the member for this condition?
◯ Yes ◯ No

Please list all of the in network provider(s)/facilities that have been unable to provide treatment and explain why they were unable to treat the member:

Continuity of Care / Transition of Care

- **Continuity of Care:** Existing Oscar members currently receiving care for qualifying conditions from providers who will be leaving the Oscar network.
- **Transition of Care:** Newly enrolled Oscar members currently receiving care for qualifying conditions from a healthcare provider who does not belong to the Oscar provider network.

*Are you submitting for Continuity or Transition of Care?
◯ **Continuity of Care (CoC):** The provider has left the Oscar network
◯ **Transition of Care (CoC):** This is a new Oscar member

Is the member currently experiencing any symptoms related to the condition/diagnosis?
◯ Yes ◯ No

If yes, please describe:

Optional Questionnaire

Is the member pregnant?
◯ Yes ◯ No

Is the member currently hospitalized or admitted at a health care facility?
◯ Yes ◯ No

Is the member receiving care for a serious acute condition?
◯ Yes ◯ No

Is the member receiving treatment as a result of a recent procedure or surgery?
◯ Yes ◯ No

Is the member receiving care for a serious or chronic health condition?
◯ Yes ◯ No

Is the member involved in a course of chemotherapy, radiation therapy, cancer therapy or care for cancer?
◯ Yes ◯ No

Is the member receiving care for a life-threatening illness?
◯ Yes ◯ No

Is the member receiving dialysis treatment?
◯ Yes ◯ No

Is the member receiving care for a terminal illness?
◯ Yes ◯ No

Is the member a candidate for organ transplant?
◯ Yes ◯ No