Online Submission: Network Gap Exception Form

This form is to be used to provide additional information to support your request for an out-of-network exception. Oscar now accepts out-of-network pre-service requests directly in Availity. When submitting online, this is the only form required for review. If you are unable to submit an authorization in Availity, download the "Fax Submission: Out-of-Network Prior Authorization Request Form & Instructions" packet from https://www.hioscar.com/forms/2026

*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