BlueCross BlueShield of Montana

Bitterroot Health
Out of Network Exception Request Form

This form is a request for an out-of-network exception prior to services. The out-of-network exception request will only be considered if services are not available by an in-network Tier 1 provider.

Patient Name:	Patient Date of Birth:
Subscriber Name:	Date of request:
Group and ID Number:	Date of service (If Scheduled):
Subscriber and/or Patient Contact:	Phone Number:

Referring Network Physician must complete this portion

Diagnosis *Please list ICD10*: _____

Was the treatment due to an accident or medical emergency? ☐ Yes ☐ No

Can this treatment be performed by an in-network Tier 1 provider? ☐ Yes ☐ No
If no, Please explain:

_____

_____

Duration of treatment (x office visit(s), or a set period of time (Weeks, Months, Episode of care?)

_____

If surgery is needed, can this be done at a in-network Tier 1 facility? ☐ Yes ☐ No
If no, Please explain where services would need to occur and why:

_____

_____

_____

Referring Physician Name:
Referring Physician Signature:
Out of Network Physician Being referred to:
Out of Network Provider Specialty:
Out of Network Provider Address:
Out of Network Provider Phone:

Please attach any supporting documentation and FAX to 312-653-9452 or mail to:

Blue Cross and Blue Shield of Montana
Group Benefits Specialist-Claims
P.O. Box 660255
Dallas, TX 75266-0255