Anthem.

Hospital Outpatient Facility Request Form

This form is required when requesting a benefit exception to allow specific elective procedures to be performed in a Hospital Outpatient facility for patient safety or distance reasons, rather than at a Free-Standing Ambulatory Surgery Center (ASC), for SISC PPO members.

Instructions for Form Use:

- Only applicable to SISC PPO members residing in Ukiah
- Only applicable for the following elective procedures requiring Hospital Outpatient facility care for patient safety reasons or due to distance from an In-Network Ambulatory Surgery Center (ASC)
    1. Colonoscopy
    2. Cataract
    3. Arthroscopy
    4. Upper GI Endoscopy
    5. Upper GI Endoscopy with Biopsy

NOTE: **If using ASC, form is not required; contact customer service for benefit information**

- Use 1 form for each member
- Complete all requested member and provider information. Lack of completion will result in return of form to sender.
- Choose 1 service
- Check appropriate reason(s) for Hospital Outpatient facility need
- Physician signature required for processing
    - **Lack of signature will result in return of form to sender**
- Upon completion please fax completed form. Fax number can be obtained by calling the customer service number indicated on the member ID card.
- Form will be processed and sender will be notified of completion via return fax.
- Please allow 72 business hours for processing.

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Hospital Outpatient Facility Request Form – Ukiah Only

Member Information:

- Name: ____
- Anthem ID Number: ____
- DOB/Age: ____

Facility and Provider Information:

- Date Proposed: ____
- Facility Name: ____
- Facility Zip Code: ____
- Facility Tax ID: ____
- Physician Name: ____
- Physician License and NPI #:____________________________________
- Physician phone #: ________________FAX # :_____________________

Service Requested:

Please choose one procedure from the list referenced on Page 1. (Example: Colonoscopy- CPT Code)

____

Service Requires a Hospital Outpatient Facility Due to:

Patient Safety:

____Co-morbid clinical condition(s) (specific *co-morbid* condition[s] must be listed below):

____

____'Other' extenuating circumstances (Please explain)

____

Distance:

____ Closest in-network, Free-Standing ASC is greater than 30 miles from address on file.

Physician Signature:

"By signing, I certify the below information to be factual for this member; due to concerns for the patient's safety it is unsafe to have the selected procedure performed in a free standing ambulatory surgical center; or, that the closest in-network ASC is greater than 30 miles from the member's home address."

Physician Signature: ____ Date: __________________________

Form will NOT be processed without physician signature

*** Anthem Use Only***	
Date:	
Reference Number:	

Final Status (circle one) **Approved** **Denied**