

Urgency of Request: Emergent Less than one week Routine Retroactive

Member Name: Last		First	M.I.	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Member Payer		Member ID Number		Date of Birth
Subscriber Name (if different from member)			Subscriber ID Number (if different from member)	
Address (No P.O. Box)			Telephone	
Section 1: Treatment Information for Member				
A. Referral Start Date		B. Referral End Date		C. Number of Visits
D. Condition Being Treated/Diagnosis				E. Diagnosis Code
F. Service Treatment Being Requested				G. CPT Code
H. Reason(s) for Out-of-Network Treatment/Service <input type="checkbox"/> Service Not Available In-network <input type="checkbox"/> Transition of Care <input type="checkbox"/> Other – Explain:				
Section 2: Referring Provider				
A. Provider Name: Last		First	M.I.	
B. Provider Tax ID Number or SSN (mandatory)			C. Provider NPI number (optional)	
D. Provider Service Location Address (no P.O. box)				
E. Provider Phone			F. Provider Fax	
Section 3: Specialist Information				
A. Specialist Name: Last		First	M.I.	
B. Specialist Tax ID Number or SSN (mandatory)			C. NPI Number (optional)	
D. Specialist Service Location Address (no P.O. box)			E. Specialist Telephone Number	
Section 4: Signature of Referring Provider				
Referring Provider Signature			Date	

Please see reverse for decision and contact information

Section 5: Decision (MCC Designee Completes this Section)

A. Designee Name: Last			First	M.I.
B. <input type="checkbox"/> Waiver Approved (with explanation and decision on ancillary services (lab, imaging, etc.) if applicable)				
 <input type="checkbox"/> Waiver Denied (with explanation):				
Signature			Date	

Please return completed form to MultiCare Connected Care by fax at (253) 864-4088

If you have any questions, please call (253) 545-2226

***Please note that waiver is not approved unless approved by MultiCare Connected Care