UW Medicine

Accountable Care Network Out-of-Network Waiver Form

Date:

Name of Person Completing Form:	**Email:**
PATIENT INFORMATION	
Patient Name:	**EPIC Referral #** ***(if applicable)*****:**
Patient Date of Birth:	**Member ID:**
REQUESTING PROVIDER INFORMATION: *Complete and return this form to your Organization Medical Director*	
Provider Name:	**Provider Phone:**
Name of Clinic:	**Provider Fax:**
REFERRAL TO	
Provider Name:	**Referral Provider Phone:**
Office Location:	**CPT code(s):**
Provider Tax ID or NPI:	
Date care is likely to begin:	**Date care is likely to end:**
CLINICAL INFORMATION	
Is this service/treatment available within UW Accountable Care Network (ACN)?	**YES** **NO**
Service/Treatment Requested: **Comments on Service Availability:**	
Reason for Request for Services/Treatment Outside of ACN	**Service Not Available** **Extension of Care** **Other:**
ORGANIZATION MEDICAL DIRECTOR: *Complete and return this form to your ACN Medical Director*	
Medical Director Name:	**Approved** **Denied**
Justification: **Medical Director Signature:**	**Date:**

Once the above form is completed, please leave ACN Medical Director portion blank and send your waiver request along with all supporting documentation to waivers@UWMedicine via sFTP file or fax to 206-744-9927. Please then confirm with a notification email to acnwaivr@uw.edu. Please do not include patient information in your email.

ACN MEDICAL DIRECTOR ***(or designee) completes this section***	
ACN Medical Director: Mika Sinanan, MD	
Authorized - Process this request for in-network waiver	
Request Denied - Return to referring provider with reason for denial:	
ACN Medical Director Signature:	**Date:**

If the referral you are making encompasses a procedure or service that may require pre-authorization, all appropriate information regarding the pre-authorization must accompany the waiver form and request. Including all professional and facility provider information, procedure codes (CPT and ICD codes) and any and all related medical records.