Request for Pre-approval waiver to Tier 1 Benefit - Central Florida Health (CFH)
Send completed form to: CFH Exception Assistance Phone: (800) 830-1501 Fax: (803) 264-0222
****ATTENTION CFH EMPLOYEE: You must wait for determination response to waiver before completing your procedure/visit. No payment or appeals allowed on services rendered prior to the waiver determination date**

Form completed by: CFH Tier 1 Provider or other Referring Physician
Purpose: Request authorization to seek care in the BCBS network when not available from CFH "Tier 1" network.

*****This form does not replace the plan's prior authorization requirements*****

*****NOT TO BE USED FOR AN APPEAL*****

TODAY'S DATE: _____

FROM:_____(Referring Physician)

Referring Physician's Street Address: _____

City/State/Zip: _____ Telephone #: _____

Explanation of Service/Equipment Not Available within Central Florida Health:

Treatment for (diagnosis code optional):_____

Services needed (include any pre-testing and follow-up care): _____

_____

_____

Will the Service requested be performed at a Central Florida Health facility: Yes or No

If no, please indicate where the Service will be rendered: _____

_____

Recommended BCBS Provider for treatment:

Physician Name: _____

Physician/Office Telephone Number: _____Fax number: _____

Facility or Group Practice Name: _____

Authorized Date(s) of Service:_____to _____

If date is unknown, indicate future date. (Note: All future dates must be within 60 days)

Policy Holder Name:_____Policy #/SSN#:_____

Patient Name:_____Patient DOB: _____

Pre-approval to Tier 1 level of benefit shall authorize the Blue Cross Blue Shield to process the benefits described above for the patient identified above ("the covered individual") at the Tier 1 level of coverage under Central Florida Health Plan design. Pre-approval to Tier 1 level of benefit is not a guarantee of coverage. If pre-approval is granted, members need to seek coverage from an In-Network provider and verify that the services rendered are covered under their benefit plan to ensure payment of benefits.

Referring Physician Approval:

_____ _____ _____

Physician Signature Date Print Name

Waiver to Tier 1 Benefit Determination:

APPROVED:_____ DENIED:_____ DATE: _____

Revised 11/19/2019