Request for Pre-Approval Waiver

Send completed form to UF Health Central Florida Exception Assistance
Phone – 800.830.1501 Fax – 803.264.0222

****ATTENTION UF HEALTH CENTRAL FLORIDA 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: Blue Options Provider or other Referring Physician
Purpose: Request authorization to seek care in the BCBS network when not available from UF Health Central Florida

**** 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 UF Health Central Florida:

Treatment for (diagnosis code optional): _____

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

_____

Will the service requested be performed at a UF Health Central Florida Facility: Yes or No

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

_____

Recommended BCBS Provider for treatment:

Physician Name: _____

Physician/Office Telephone #: _____ Fax #: _____

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 the highest level of coverage shall authorize Blue Cross Blue Shield to process the benefits described above for the patient identified above ("the covered individual") at the highest level of coverage under UF Health Central Florida's plan design. Pre-approval 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 is:
APPROVED: _____ **DENIED:** _____ **Date:** _____