UnitedHealthcare Commercial Network Gap Exception Request Form

Instructions:

1. This form is to be completed for all commercial network exception Gap Requests.
2. A Prior Authorization Case must be entered prior to form submission.

Service Reference Number (Prior Authorization Case #):		
Member Information		
Member Name (Person being treated)	UnitedHealthcare Member ID Number	Date of birth (mm/dd/yyyy)
Address	City	State/ZIP Code
Home/Cell Phone Number	Work Phone Number	
Subscriber Name	Member's Relationship to Subscriber □ Self □ Spouse □ Dependent □ Other	
In Network Referring Physician Information		
Network **Referring** Physician	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number
Address	City	State/ZIP Code
Reason for referral		
Out of Network Physician Information		
Out of Network Physician/Specialist	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number
Address	City	State/ZIP Code
Servicing Facility Address (If different than above)	City	State/ZIP Code

Out of Network Facility Information		
Out of Network Facility (Out of Network Facility Gap Exception Requests **ONLY)**	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number
Address	City	State/ZIP Code
Reason for OON facility request (if specialized equipment is reason for request please include the specific equipment (name/brand/model/etc)		

Applicable Clinical Information	
Please select: □ New Patient □ Existing Patient □ Other	If Other selected, please explain:
Has a Gap Exception previously been granted? □ Yes □ Unknown □ No	If Yes, please explain and dates approved:
Has a Gap Exception previously been approved for a family member? □ Yes □ Unknown □ No	If Yes, please explain and dates approved:
Member Diagnosis:	Expected Date(s) of Service/Expected Length of Treatment:
Service(s) Requested (Include CPT codes & visits/units when applicable):	
Reason for Gap Exception Request:	

Please Attach Applicable Clinical Notes for Review