WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

Redirection of Care Exemption

To submit a Redirection of Care Exemption request, the Health Care Provider, on the Participant's behalf, must notify Blue Cross Blue Shield of Wyoming ***in writing***. *Completion of the exemption request form does not guarantee approval.*

For additional information, please contact our Redirection of Care team at *redirectionofcare@bcbswy.com* or 307-823-6095. Please complete the following form and **attach clinical documentation of need**.

Requests can be emailed to:
Redirection of Care Services Department
redirectionofcare@bcbswy.com
To help protect your patient's privacy, only send an email if you can do so securely.

Requests can be mailed to:
Redirection of Care Services Department
Blue Cross Blue Shield of Wyoming
PO Box 2266
Cheyenne, WY 82003-2266

INCOMPLETE FORMS OR MISSING CLINICAL DOCUMENTATION WILL DELAY PROCESSING as they will not be considered until all information has been received.

Requests marked as **URGENT** must meet the criteria that ***failure to receive treatment will result in a life or limb threatening situation.**** Any authorization requests that do not meet the criteria will be treated as non-urgent and may be delayed in processing. BCBSWY does not recognize scheduling conflicts as an urgent request.

Patient Information *(please print)*

Patient Name: _____ (*Last*) _____ (*Middle*) _____ (*First*)

Benefit Plan #: _____ Date of Birth: _____

Treatment/Procedure Information

REQ: _____ or AVT: _____

Treatment/Procedure Requested: _____

Procedure Code(s)(CPT): _____

Diagnosis Details: _____

Diagnosis Codes (ICD10): _____

Request Begin Date: _____

Medication Required Dosage: _____

Quantity Requested: _____

Physician Information

Rendering Provider: _____

NPI: _____

Provider Phone #: _____ Fax #: _____

Mailing Address: _____ (*Street*) _____ (*City*) _____ (*State*) _____ (*Zip*)

Facility Rendering Service

Rendering Facility: _____

NPI: _____

Provider Phone #: _____ Fax #: _____

Mailing Address: _____ (*Street*) _____ (*City*) _____ (*State*) _____ (*Zip*)

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Please answer the following questions:

Has the member had any documented adverse reaction to the medication that warrants a higher level of care?

Does the member have a documented history of a comorbidity that is of significant concern in relation to the drug requested?

Does the member have any concerns of fluid overload status that precludes treatment at a less intensive site of care?

Is there any continuity of care issue that would preclude the member from changing to another site of care?

Is this medication part of a multiple medication treatment regimen?

Completed By: _____ Telephone #: _____

Please Print

Email: _____