BlueCross BlueShield
Federal Employee Program

In-Network Benefit Request Form

Please fill out this section if you'd like to ask us to provide in-network benefits for care from a provider or facility that isn't in your network. Depending on the reason for your request, you may need to ask your provider to fill out some of the next page.

If you'd prefer to find a new provider or facility in your network, we can help.
Just go to **fepblue.org/find-doctor**, or give us a call at:
FEP Postal employees: 1-866-780-7742 | All other FEP employees: 1-800-572-1003

This request isn't valid until we approve it. If you get care before we approve your request, you'll get out-of-network benefits for that care, and you may have to pay more out of your own pocket.

Approval may be limited to specific timeframes or services, in accordance with applicable law and the terms of your plan.

Who will be getting this care?

Member ID Number: _____

Member Name: _____ Date of Birth: _____/_____/ _____

Street Address: _____

City: _____ State:_____ ZIP: _____

Who will be providing this care?

☐ Doctor/Provider ☐ Hospital/Facility

Requested Provider or Facility's Name: _____

Beginning Date of Care: _____ / _____ / 20 _____ Ending Date of Care: _____ / _____ / 20 _____

Provider Specialty: _____

Provider or facility's street address: _____

City: _____ State: _____ ZIP: _____

County: _____ Provider's PIN # or Tax ID #: _____

(you may need to ask your provider for this)

What type of care is this for?

☐ Medical ☐ Dental ☐ Mental / Behavioral Health

What's the reason you're making this request?

☐ There are no network providers/facilities available in my area

☐ I'm new to this network and my provider/facility isn't in my network

☐ Maternity-Related (please have your provider complete the third page)

Expected Delivery Date: _____ / _____ / 20 _____

☐ Provider/facility left my network during my treatment
(please have your provider complete the second page)

☐ My network changed during my treatment, or a new program was added that changed my benefits (please have your provider complete the second page)

☐ Complex medical and/or behavioral health conditions (please have your provider complete the second page)

Please give us any other information you think is important:

Member Signature: _____ Date: _____/_____ / 20 _____

Member's signature required for approval.

After you (and your provider, if necessary) have filled out this form, please put it on top of any support documents you include and return it to:

Blue Cross and Blue Shield Service Benefit Plan
1 Cameron Hill Circle, STE 0002
Chattanooga, Tennessee 37402-0002
Fax: **(423) 535-1959**

Clinical Information to Support Transitional/Continuity of Care Request

This Section to be Filled Out by Provider or Facility Representative

If we approve this request, we will provide in-network benefits for the member named above.

Approval may be limited to specific timeframes or services, in accordance with applicable law and the terms of the member's plan.

Please attach any medical records you'd like us to consider below this form.

Requested Provider or Facility's Name: _____

Requested Provider or Facility's NPI or Tax ID #:_____

Facilities this Provider is affiliated with:_____

Member's symptoms and diagnosis: _____

Length of time you've treated the patient:_____

Clinical reasons why an in-network provider/facility can't provide appropriate care:

Provider/Facility Representative Signature: _____

Provider/Facility Representative Name (print):_____

Title: _____ Date: _____/_____ / 20 _____

Provider's signature required for approval.

After you and your patient have filled out this form, please put it on top of any support documents and return it to:

Blue Cross and Blue Shield Service Benefit Plan
1 Cameron Hill Circle, STE 0002
Chattanooga, Tennessee 37402-0002
Fax: **(423) 535-1959**

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fepblue.org

NONDISCRIMINATION NOTICE

The Blue Cross and Blue Shield Service Benefit Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Blue Cross and Blue Shield Service Benefit Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your local Blue Cross and Blue Shield company by calling the customer service number on the back of your member ID card.

If you believe that this Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your local BCBS company. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your local BCBS company's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, **800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Language assistance

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、IDカードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید..