

Connecticut Network Prior Authorization Gap Exception Request Form

You can request a network gap exception when there aren't enough health care professionals in a local area or in a specific specialty. You can request a network gap exception if participating providers do not have appointment times available without unreasonable delay.

Instructions



Step 1: Request a Network Gap Exception

Request a Network Gap Exception by contacting Member Services.

- Call the toll-free number on your health plan ID member card.
- You will be assigned a service reference (case) number. You must include the service reference number on the Network Gap Exception Form.



Step 2: Complete the Network Gap Exception Request Form

Please complete the required fields:

- Service reference number
- All member information, including member ID and date of birth
- All health care professional information, including the in-network referring health care professional, if applicable. The in-network referring health care professional is typically the member's primary care provider (PCP) but can also be any in-network health care professional who refers the member.
- If a specialty request, list the specific clinical reason for the network exception.
 - If you are requesting specialized equipment, include the make/model information.
 - If you are requesting specialized training or techniques, you must provide details for what training, treatment, technique, etc., you are requesting.



Questions?

If you have issues, to find chat options and contact information, visit

uhc.com/contact-us



Step 3: Submit the Network Gap Exception Form and clinical documentation

- Fax: Print the form and your clinical documentation (e.g., clinical history/notes, diagnostic testing and conservative treatment), if available, then fax it to 1-800-696-8151.

Connecticut Network Gap Exception Request Form Instructions

Instructions:

1. Complete this form for all commercial network exception gap requests
2. A service reference number must be entered prior to form submission

Service reference number (prior authorization case number): _____

Member information

Member name (person being treated) 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 Dependent Spouse Other

In-network referring physician information, if available

Network **referring** physician NPI or Tax ID Number Phone number

Address City State/ZIP code

Fax number Reason for referral

Out-of-network physician information

Out-of-network physician/specialist

NPI or Tax ID number (TIN) Phone number

Address City

State/ZIP code Fax number

Servicing facility address (if different than above)

City State/ZIP code

Out-of-network physician information continued

Member diagnosis:

Expected date(s) of service/expected length of treatment:

Service(s) requested (include CPT® codes and visits/units when applicable):

Reason for gap exception request:

Out-of-network facility information

Out-of-network facility (out-of-network facility exception requests **only**)

NPI or Tax ID number (TIN)

Phone number

Address

City

State/ZIP code

Reason for out-of-network facility request [if specialized equipment is the reason for the 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 No Unknown

If Yes, please explain and dates approved:

Has a gap exception previously been approved for a family member?

Yes No Unknown

If Yes, please explain and dates approved:

Please attach applicable clinical notes for review, if available

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