Embright

Request for In-Network Services Waiver Form	Date:

Please type or print legibly

Name of person completing form:	Email:

PATIENT INFORMATION	
Patient name:	EPIC referral # (if applicable):
Patient date of birth:	Member ID:
Referring provider name:	Provider phone:
Name of clinic:	Provider fax:
REFERRAL TO	
Provider name:	Referral provider phone:
Office location:	CPT code(s):
Provider Tax ID or NPI:	
Date care is likely to begin:	Date care is likely to end:

CLINICAL INFORMATION

Is this service/treatment available within the Embright clinically integrated network?

☐ Yes ☐ No

Service/treatment requested:

Comments on service availability:

Reason for request for services/treatment outside of Embright:

☐ Service not available ☐ Continuity of care ☐ Other (comment below)

Other justification:

NETWORK MEDICAL DIRECTOR REVIEW

This Section For Internal Use Only

Organizational Medical Director name:

☐ Approved ☐ Denied	Justification:
Organizational Medical Director signature:	Date:

Once the referral information is completed, please leave the Network Medical Director Review and Embright Medical Director portions blank and send your waiver request along with all supporting documentation via fax to 1.206.589.6600.

EMBRIGHT MEDICAL DIRECTOR (OR DESIGNEE)	
Embright Medical Director:	
☐ Authorized – process this request for in-network waiver ☐ Request denied – return to referring provider with reason for denial. Reason for denial:	
Embright Medical Director signature:	Date:
If the referral you are making encompasses a procedure or service that may require pre-authorization, all appropriate information regarding the pre-authorization must accompany the waiver form and request. This includes all professional and facility provider information, procedure codes (CPT and ICD codes) and any and all related medical records.	