Network Gap Exception

Judi Health covered members may request a Network Gap Exception if there is no in-network provider who can perform the necessary service within a 25-mile radius from the member's home address. Judi Health currently utilizes the Cigna network. Visit cigna.com to confirm your provider's network status.

How a Gap Exception Works:

Once a member (or provider) has determined a medically necessary service can only be performed by an out-of-network provider, a Gap Exception may be requested. Your provider should submit the request to Judi Health prior to services being rendered.

The availability of Gap Exception coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits. Depending on the actual request, a medical necessity determination and formal prior authorization may still be required for a service to be covered.

To complete this form:

- Please make sure all fields are completed. Completed forms must be signed by the provider and member who is requesting the Gap Exception. *Only complete this form if your provider is out-of-network with your Judi Health plan.*
- This form must be completed prior to services being rendered.
- A separate form must be completed for each member seeking a Gap Exception and for each provider with whom a member is seeking an exception.
- Please submit the completed form, along with relevant medical records and information within the above specified timeframe to Judi Health. Please note that while we implement reasonable safeguards to protect your protected health information (PHI) sent through email, there is some risk your PHI could be read or otherwise accessed while in transit. If you prefer, you may instead mail or fax your information. Completed forms can be sent to:
    - **E-mail:** support@judihealth.com
    - **Fax:** 833-FAX-JHLT (329-5458)
    - **Mail:** Judi Health Attn: Claims Dept 9450 SW Gemini Dr., #87234 Beaverton, OR 97008
- After receiving your request, Judi Health will review and evaluate the information provided. Incomplete forms will be returned to the requestor.

Judi Health™

Member Information:

Name of Person Being Treated:	ID Number:	Date of Birth:
Address:	City:	State/Zip Code:
Home/Cell Phone Number:	Employer Name:	
Member's Relationship to Employee: ☐ Self ☐ Spouse ☐ Dependent ☐ Other		
Authorization to Release Records: I authorize all physicians and other health care professionals or facilities to provide Judi Health information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for Gap Exception benefits under the plan.		
Member's Signature/Parent of Guardian's Signature if Member is a Minor:		**Date:**

Care Provider Section: your health care professional should complete the following information.

Name (Treating Physician):	National Provider ID (NPI):	Phone Number:
Address:	City:	State/Zip Code:
Facility Name, NPI, City and State (if applicable):		Facility Phone Number:
Reason for Request: Please specify the specialized experience, training or certification in a particular clinical area or patient population the requesting provider possesses that would support the need for an in-network exception request. Please attach any letter of Medical necessity and/or associated clinical information.		

Judi Health™

Current Condition and Treatment Plan(s):

Primary Diagnosis Code and Description:
Additional Diagnosis Code(s) and Description(s):
For maternity patients, include estimated due date:
For inpatient procedures, include scheduled date of admission:
List all services including procedure name, CPT code(s) and units.

Description:	Code	Units
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.

Where will the service be performed?

☐ Home ☐ Hospital – inpatient ☐ Hospital – outpatient ☐ Ambulatory Surgery Center

☐ Provider's Office ☐ Other (please specify): _____

Provider contact name and phone number for single case negotiation:	
Contact Name:	Phone Number:

Providers: If the member is eligible, you agree to provide the covered service, including any follow-up care covered under the member's plan, for the applicable time frame, and follow our policies and procedures.

If the member is eligible, we will provide coverage at the network benefit level, and payment will be consistent with the member's benefit plan or negotiated single case agreement. You agree to accept payment from us along with any cost-share for which the member is responsible under the plan as payment in full for covered services. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf.

Signature of Health Care Professional:	**Date:**