Protocol Exception Form for use with Aetna Best Choice EPO Plan

Broward Health
Human Resources

Benefits Team: 954-473-7192
Email Document(s) To secured mailbox:
BenefitExceptions@browardhealth.org

I understand that for Broward Health Benefit Exception Committee to review my request, they may need medical records or other information. Accordingly, I authorize persons or entities that have any medical or other records or knowledge of me or my dependents to release such information to the Broward Health Exception *Committee for them to complete the review of my protocol exemption request.* *If employee or dependent proceeds with the service or procedure (non-emergent) *without the Exception Committee's approval; the employee will be responsible for all expenses related to the service/procedure provided.* *Dependents over 18 years of age must complete and sign this form if legally competent, otherwise their Legal Guardian must sign this form.*

These persons or entities may include any the Committee may need to reach out to:

- Licensed physician
- Medical practitioner
- Hospital
- Clinic or another medical related provider
- Insurer
- Employer
- Other Organization, institution, or person

I specifically authorize the release of such records and/or information relevant to my request, including, as applicable, information associated with sensitive medical conditions or treatments, such as but not limited to:

- *A positive test results.*
- *Autosomal recessive disorder.*
- *Acquired Immunodeficiency syndrome.*
- *Alcohol or drug dependency*
- *Mental and nervous disorders*

I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing by presenting my revocation to the Broward Health Benefit Exception Committee. Unless otherwise revoked, this authorization will expire three (3) months from the date listed below.

Today's Date:		**Patient or Parent/Legal Guardian Signature Below:**	
EE Email:			
PLEASE PRINT CLEARLY AND COMPLETE ALL OF THE INFORMATION REQUESTED BELOW			
Patient's Last Name:		Patient's First Name:	
Patient's Date of Birth:		Employee ID #:	
Patient's Phone Number:		Patient's State and Zip Code:	
Treating Physician Name & Specialty:		Group/Plan Number on ID Card: ***Broward Health Aetna -Best Choice EPO***	
Where are looking to have the procedure or service conducted?		Why are you looking to have this done outside Broward Health? Check one that applies: ☐ Out of Network Exception (Tier 2) ☐ Medical Necessary Exception	
Proposed Date of Service:		Priority of Request (**Urgent or Standard**): *Circle which applies.*	
Condition/Diagnosis (**Use additional sheets, if necessary):**			

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IMPORTANT: To help the Exception Committee perform a comprehensive medical review, please submit all required documents promptly. Send your form and supporting materials to the secured email address listed above. Your cooperation is essential for a timely assessment.

Please describe in detail why protocol exemption should be allowed (why the member should not get the services at Broward Health facility – be specific in reference: medical procedure, or course of treatment are required, any other alternative treatment. Supportive documentation and/or literature research is required so we can make the best decision for the member.
Use additional sheet(s) if necessary.

Internal Use Only

Date Received Request: _____

- Approved - Not Approved

- Approved for # days _____
- Approved for # visits _____

Signed: _____ Date_____

Letter Sent to Member: _____

Length of time exception approved for: _____