BlueCross BlueShield Federal Employee Program.

Family Planning Exception Member Request Form

Call the number on the back of your ID for mailing instructions

Member Information (required)

Patient Name:				Date:	
Street Address:			Date of Birth:	Sex: ☐ Male ☐ Female	
City:	State:	Zip:	Cardholder ID: R		

Prescriber Information (required)

Provider Name:		Specialty:	
Office Phone:	Office Fax:	**NPI**:	
Office Street Address:	City:	State:	Zip:

Physician Signature: _____

Prescriber Certification: I certify that I am the physician and all information provided on this form to be true and correct to the best of my knowledge and belief.

NOTE: Prescribing physician signature must be completed to process this request:

I attest, as prescribing physician, to the following:

1. Procedure request for (please provide specific procedure code and description):

_____

2. The prescribed surgical procedure is Medically Necessary for the patient as a preventive voluntary contraceptive surgical service?

❑Yes ❑No

Prescriber Initials: