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			Gender ☐ **Male** ☐ **Female**
City		State	ZIP	Member ID

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