CAPE COD HEALTHCARE

Expert physicians. Quality hospitals. Superior care.

Cape Cod Healthcare Employee Health Plan
Dependent EXCEPTION FORM
(For Calendar Year: _____)

Please complete and fax this form to the CCHC Human Resources Benefits Office at 774-552-6945 or email to CCHCHRBenefits@CapeCodHealth.org.

This exception request is for covered dependents, including a spouse or child(ren) who resides outside the employee/subscriber's residence and which is outside of the CCHC DPO network. Granted exceptions will allow for services at a non-CCHC DPO provider to be covered at the tier 1 benefit level. A new dependent exception must be requested each year.

NOTE: THIS IS AN EXCEPTION FOR THE LEVEL OF BENEFITS APPLIED TO CLAIMS ONLY. PLEASE NOTE THAT PRIOR AUTHORIZATIONS, MEDICAL NECESSITY REVIEW, AND BENEFIT COVERAGE ALLOWANCES STILL APPLY TO ALL SERVICES, AS REQUIRED UNDER THE PLAN. YOU SHOULD ALWAYS CHECK WITH THE PLAN FOR THESE REQUIREMENTS.

EMPLOYEE INFORMATION:

Employee Name: _____

Employee Daytime Phone Number: _____

Harvard Pilgrim Member ID#: _____

DEPENDENT INFORMATION:

Dependent Name: _____

Dependent Address: _____

Dependent Phone Number: _____

I hereby authorize you to forward a copy of this information to the provider, if necessary, to conduct an internal review.

Requestor Signature: _____ Date: _____

CCHC Determination of Exception Request:

☐ Approved

☐ Declined - Reason: _____

CCHC Authorized Signature: _____ Date: _____