Higher Level of Benefits Waiver Form

St. Luke's Health Plan
PO Box 91010
Seattle, WA 98111

(800) 467-5281
Fax: (206) 667-8060
stlukeshealthplan.org

St. Luke's Health Plan members receive the highest level of benefits when using St. Luke's Health Partners providers. Benefits are reduced when services are rendered by providers outside the St. Luke's Health Partners network.

If you believe your patient needs services that are not available within the St. Luke's Health Partners network, use this form to request a Higher Level of Benefits Waiver on behalf of your patient. Upon receipt, we will determine if there is a provider within the St. Luke's Health Partners network who can provide the services. If not, we may approve your patient to see the out-of-network or wrap network provider at the higher benefit level.

If we approve a higher level of benefits with a wrap or out-of-network provider:

- All other plan provisions, including benefit limitations, exclusions and preauthorization requirements apply.
- Coverage at the higher level of benefits is limited to the specific provider and specific services indicated in the approval.

Date: _____

Submit completed forms to: customercare@stlukeshealthplan.org

Both the member and the referring provider will be notified of our decision within 30 days of our receipt of the form.

Questions? Call Customer care at **833-478-5853.**

Member Information

Last Name:		First Name:	MI:	Gender:
Birth Date:	Group ID Number:	Member ID Number:		

Member Treatment Information

Referral Start Date:	Referral End Date:	Number of Visits:
Condition being Treated/Diagnosis:		
Diagnosis Code(s):		
Service/Treatment being Requested:		

CPT Code(s):

Reason for Wrap or Out-of-Network Referral

Please describe the reason(s) why you believe your patient needs to leave the St. Luke's Health Partners network:

Practitioner Information (Referring Provider)

Last Name:	First Name:	MI:
Provider Tax ID Number or SSN:	NPI Number:	
Mailing Address - Street:	State:	ZIP:

Specialty Information

Specialist Name:	Last:	First:	MI:
Specialist Tax ID Number or SSN:		Specialist NPI:	
Business/Practice Name:		Phone Number:	
Mailing Address - Street:	City:		State:
Office/Business Manager:	Phone Number:		Email Address:

For Internal Use Only

☐ Approved	☐ Denied
Date:	Signature:
Comments:	