BlueCross BlueShield Federal Employee Program.

Contraceptive Exception Member Request Form

Send completed form to:
Service Benefit Plan
Attn: Reconsideration
P.O. Box 52080
Phoenix, AZ 85072-2080
FAX: 1-877-378-4727

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 <u>must be completed</u> to process this request:

I attest, as prescribing physician, to the following:

1. Drug request for (please specify drug name):

   ____

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

   ☐ Yes ☐ No

Prescriber Initials: ______________

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. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Blue Cross and Blue Shield. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.