Northern Buckeye Education Council
Out of Area Authorization Waiver Form

Authorization # _____

This waiver form should be completed by an employee who is seeking medical healthcare out of the Northern Buckeye Education Council network area for himself/herself or a covered dependent.

Employee/Dependent Information

Covered Employee's Name _____ Employee SSN _____

Address _____ Employer _____

City-State-Zip _____

List all individual(s) and their date of birth who will be out of the network area:

_____

_____

_____

_____

Medical Information

Reason(s) for seeking out of area medical care (i.e., live or attending school out of area) _____

_____

_____

_____

Out of Area Address _____ City _____ State _____

The request is for the following period: From: _____ To: _____

Note: This waiver is valid until you or your dependents return to the Northwest Ohio network area (**maximum 1 year**). Upon return into the network area, you must notify the NBEC.

This form should be attached to any bill you submit for reimbursement. Bills without an approved Out of Area Authorization Waiver Form will NOT be paid by the Plan. Send bills directly to:

American Administrative Group
PO Box 93670 Lubbock, Texas 79493-3870

All hospital confinements and certain outpatient procedures require pre-admission certification.
Call 1-800-221-1460

_____ _____
Employee Signature Date

For Office Use Only

This request is: Approved ☐ Denied ☐

_____ _____
Date Authorization Signature