

**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