



EIP EXCEPTION REQUEST

For eligibility, medication, and insurance premium exception requests.

(For exceptions for payment of medical procedures, medical or dental claims, please use **Benefit Exception**

Request form <http://www.doh.wa.gov/Portals/1/Documents/Pubs/410-060-ExceptionRequest.docx>)

If the Early Intervention Program (EIP) approves the request, payment is still subject to all general conditions of the program.

CLIENT INFORMATION

Client Name <i>Leave this blank if you plan to email this form back to EIP</i>	
EIP ID Number	
Date of Birth	

REQUESTOR

Name <i>Leave this blank if you are the client and you plan to email this form back to EIP</i>	
Agency (If applicable)	
Date of Request	

EXCEPTION REQUEST

Reason for Request	
Description	

Does insurance cover this (if applicable)?	
Have you requested an exception to policy from the insurance plan if insurance does not cover?	
Other resources (e.g., charity care, patient assistance program) that client has applied for	

Please provide all supporting documents.

Requestor Signature: _____ **Date:** _____

I certify that the information provided on this form is true, accurate, and complete to the best of my knowledge.

CLIENT SERVICES USE ONLY
PROVIDER: DO NOT COMPLETE THIS PORTION

Reviewer Decision:	Approve Deny	Cost:	
Start Date		End Date	
Signature		Date	