

BENEFIT EXCEPTION REQUEST

Client Services

Client Services reviews requests for benefit exceptions on the basis of medical necessity only. If Client Services approves the request, payment is still subject to all general conditions of our program, including current member eligibility, insurance, and program restrictions. Client Services will notify the provider and client of the decision.

**CLIENT INFORMATION**

|  |  |
| --- | --- |
| **Client Name** | Click here to enter text. |
| **Client EIP Number** | Click here to enter text. |
| **Client Date of Birth** | Click here to enter text. |
| **Client’s Case Manager** | Click here to enter text. |

**PROVIDER INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider Name** | Click here to enter text. | **Date Requested** | Click to enter text. |
| **Tax ID number** | Click here to enter text. | **Primary Care Provider** | [ ] **Yes** [ ]  **No** |
| **Requestor Contact Email:** | Click here to enter text. | **Requestor Contact Phone:** | Click to enter text. |

**Explanation why this service is medically necessary. Include the diagnosis, place of service, and description of the proposed treatment. Attach supporting document as necessary.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Diagnosis:** | Click to enter. | **Secondary Diagnosis:** | Click to enter text. |
| **Place of service:** | Click to enter. |
| **Description of Treatment:** |  |  |
| Click here to enter text. |
| **List all alternative services attempted and found ineffective:** | Click here to enter text. |
| **How is service/treatment related to the client’s HIV status?** *Please explain and/or attach supporting documentation* | Click here to enter text. |

*continued on page 2*



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**SERVICES REQUESTED**

|  |  |  |  |
| --- | --- | --- | --- |
| **CPT/ADA CODE** | **CODE DESCRIPTION** | **NO. OF UNITS** | **ESTIMATED COST** |
| Click to enter. | Click to enter. | Click to enter. | Click to enter. |
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*Please include additional pages if more room is needed.*

**Provider Signature: Date:**

*I certify that the information provided on this form and on any attachments, including medical necessity information is true, accurate, and complete to the best of my knowledge.*

**Attachments (***check one***): Yes** [ ]  **No** [ ]

Please submit all documentation via secure email (*you may request a secure email from us by reaching out to* EIP.ClaimsPayments@doh.wa.gov *and you may reply to it with the completed form attached*), mail or fax to:

Department of Health Client Services

Attn: Claims

PO BOX 47841

Olympia, WA 98504

Fax: 360-664-2216

Email: EIP.ClaimsPayments@doh.wa.gov