Exception to Rule Request Form

COMMUNITY HEALTH PLAN of Washington™

Exception To Rule requests may be faxed to:**(206) 613-8873**

Please call Customer Service to verify eligibility & benefits: **1-800-440-1561; Monday through Friday, 8 a.m. - 5 p.m.**

Request for a Non-covered Health Service

Apple Health and FIMC

·Requests must provide member specific information and documentation that demonstrates that there is no equally effective, less costly covered service or equipment that will meet the needs of the member.
·You may submit an ETR request without a denial for the non-covered service
·If you did receive a denial for the non-covered service, then the ETR request must be submitted in writing within 90 days.

ORDERING PROVIDER INFORMATION

First Name:	Last Name:	Contact Phone #:	Contact Fax #:
Contact Person at this office:	☐ Ordering provider is PCP PCP's Clinic Name:	☐ Ordering provider is Specialist Specialty:	

PATIENT INFORMATION

First Name:	Last Name:	MI:	Date of Birth:
CHPW Member ID:			

SERVICE PROVIDED BY

First Name:	Last Name:	Address:		
☐ Participating ☐ Non-Participating	Tax ID:	Specialty:	Contact Phone #:	Contact Fax #:
Facility Name:		Address:		
☐ Participating ☐ Non-Participating	Tax ID:		Contact Phone #:	Contact Fax #:

Denial reference #: Date of Denial:

Diagnosis: Primary: Code (_____) Description:

Secondary: Code (_____) Description:

Services being requested:

To be completed by ordering provider:

Describe why this patient is so clinically/medically unique from others with a similar condition that the Exception to Rule should be granted.

Describe what alternative treatments have been tried and the outcome.