Limitation Extension (LE)

COMMUNITY HEALTH PLAN of Washington™

Limitation Extension 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 Limited Extension

Apple Health and FIMC

CHPW considers the following in evaluating a request for a limited extension:
· The level of improvement the client has shown to date related to the requested health care service and the reasonability/calculated probability of continued improvement if the requested health care service is extended AND
·The reasonability/calculated probability the client's condition will worsen if the requested health care services are not extended.

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:

Number of Services or units requested:

To be completed by ordering provider:

Describe why this patient needs an extension to the benefit

Describe what progress has been made to date and what progress is expected