Exception to Rule Request Form



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 o	☐ Ordering provider is PCP					Ordering provider is Specialist				
			PCP's Clinic Name:				Specialty:			
PATIENT INFORMATION										
First Name:			Last Name:				MI:	/II: Date of Birth:		
CHPW Member ID:										
SERVICE PROVIDED BY										
First Name: Last Name:					Address:					
☐ Participating	Tax ID:			Specialty:		Cor	ntact Pho	one #:	Contact Fax #:	
☐ Non-Participating										
Facility Name:										
racility Name.	Address:									
Participating	Tax ID:					Contact Phone #:		one #:	Contact Fax #:	
☐ Non-Participating	Non-Participating									
Denial reference #: Date of Denial:										
Diagnosis: Primary: Code () Description:						To be completed by ordering provider:				
Secondary: Code () Description:						Describe why this patient is so clinically/medically unique from others with a similar condition that the Exception to Rule should be granted.				
Services being requested:										
							Describe what alternative treatments have been tried and the outcome.			