

Exception to Rule Request Form



COMMUNITY HEALTH PLAN
of Washington™

Exception To Rule requests may be faxed to:
(206) 652-7078

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:	<input type="checkbox"/> Ordering provider is PCP PCP's Clinic Name:		<input type="checkbox"/> 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:		
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating	Tax ID:	Specialty:	Contact Phone #:	Contact Fax #:
Facility Name:		Address:		
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating	Tax ID:	Contact Phone #:	Contact Fax #:	
Denial reference #:		Date of Denial:		
Diagnosis: Primary: Code (_____) Description: Secondary: Code (_____) Description:		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.		
Services being requested:				