

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:		<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 needs an extension to the benefit Describe what progress has been made to date and what progress is expected		
Services being requested:					
Number of Services or units requested:					