



PRE-SERVICE REQUESTS ONLY

Benefit Exception Request

FAX TO: 1-866-610-7215

Phone: 1-877-447-4384

REQUEST MUST COME FROM ATTENDING HEALTH CARE PROVIDER OR CARE MANAGER FOR WAIVER SERVICE. DO NOT USE THIS FORM FOR MEMBER REIMBURSEMENT OF NON-COVERED SERVICES OR ITEMS.

Date of Request: _____

Member Name: _____ **UCare ID #:** _____

Requestor's Information

Name: _____ **Company:** _____

Phone Number: _____ **Fax Number:** _____

Service/Item Request: _____

Diagnosis: _____ **HCPC/CPT Code:** _____

Why is it a benefit exception?

- Experimental Not in benefit (medical or home and community services)
- Exceeds Benefit

Please submit the following information (if known):

Planned Date (s) of Service: _____ **Number of visits:** _____

Provider of Service: _____

Place of Service (location): _____

Provide member specific clinical information and/or a cost benefit analysis that supports the request.

(Please attach additional documents if needed. Request will be denied for lack of information if this section is not completed)

Please state what other options have been explored for coverage of this service for this member

(Family or Social Services, Community Resources, etc., request will be denied for lack of information if this section is not complete)

Attending Health Care Provider/Case Mgr signature

Date