



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

BENEFIT EXCEPTION REQUEST

Client Services
Early Intervention Program (EIP)
PO Box 47841
Olympia WA 98504-7841

The Early Intervention Program reviews requests for benefit exceptions on the basis of medical necessity only. If Client Services approves the request, payment is still subject to all general conditions of the Early Intervention Program, including current member eligibility, other insurance, and program restrictions. Client Services will notify the provider and client of the decision.

CLIENT INFORMATION

Client Name	
Client EIP Number	
Client Telephone Number	
Client Date of Birth	

PROVIDER INFORMATION

Provider Name	
Date Requested	
Provider/Requestor Contact Phone:	
Provider/Requestor Contact Email:	
Provider Tax ID Number	
Primary Care Provider	Yes No

Explanation of why this service is medically necessary. Include the diagnosis, place of service, and description of the proposed treatment. Attach supporting document as necessary.

Primary Diagnosis:		Secondary Diagnosis:	
Place of service:			
Description of Treatment:			
List all alternative services attempted and found ineffective:			



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SERVICES REQUESTED

CPT/ADA CODE	CODE DESCRIPTION	NO. OF UNITS	ESTIMATED COST

Please include additional pages if more room is needed.

Provider Signature: _____ **Date:** _____

I certify that I am the provider identified on this form. I certify that the information provided on this form and on any attachments, including medical necessity information is true, accurate, and complete to the best of my knowledge.

Attachments (circle one): **Yes** **No**

Please submit all documentation via mail or fax to:

Department of Health HIV Client Services
Attn: Krystal Sterling
PO BOX 47841 Olympia, WA 98504
Fax: 360-664-2216

CLIENT SERVICES USE ONLY
PROVIDER: DO NOT COMPLETE THIS PORTION

Reviewer Decision:	Approve Deny	Projected cost:	
Authorized effective date:		Authorization end date:	
Consultant Signature		Date:	