



STATE OF WASHINGTON  
DEPARTMENT OF HEALTH

## EIP EXCEPTION REQUEST

For eligibility, medication, and insurance premium exception requests.

(For exceptions for payment of medical procedures, medical or dental claims, please use **Benefit Exception Request form** <http://www.doh.wa.gov/Portals/1/Documents/Pubs/410-060-ExceptionRequest.pdf>)

If the Early Intervention Program (EIP) approves the request, payment is still subject to all general conditions of the program.

### CLIENT INFORMATION

<b>Client Name</b> <i>Leave this blank if you plan to email this form back to EIP</i>	
<b>EIP ID Number</b>	
<b>Date of Birth</b>	

### REQUESTOR

<b>Name</b> <i>Leave this blank if you are the client and you plan to email this form back to EIP</i>	
<b>Agency (If applicable)</b>	
<b>Date of Request</b>	

### EXCEPTION REQUEST

<b>Reason for Request</b>	
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<b>Description</b>	
<b>Does insurance cover this (if applicable)?</b>	
<b>Have you requested an exception to policy from the insurance plan if insurance does not cover?</b>	
<b>Other resources (e.g., charity care, patient assistance program) that client has applied for</b>	

*Please provide all supporting documents.*

**Requestor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I certify that the information provided on this form is true, accurate, and complete to the best of my knowledge.*

**CLIENT SERVICES USE ONLY**  
**PROVIDER: DO NOT COMPLETE THIS PORTION**

<b>Reviewer Decision:</b>	<b>Approve    Deny</b>	<b>Cost:</b>	
<b>Start Date</b>		<b>End Date</b>	
<b>Signature</b>		<b>Date</b>	

**Client Services**  
**Early Intervention Program (EIP)**  
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