## Home State Health

**Exceptions & Out of Network Request Form**

**Phone:** 1-855-694-4663

**Fax:** 855-286-1811

home state health

| **Date of Request:** |
|---|

## Member Information

| **Member's First Name:** | **Member's Last Name** | **Member's Middle Initial:** |
|---|---|---|
| **Member's Medicaid ID:** | **Date of Birth:** | **Phone #:** |

| **Other Insurance Carrier (if applicable):** | **Policy # (if known):** |
|---|---|
| **Is a home health agency making skilled nurse visits?**<br>☐ YES ☐ NO | |
| **If YES, list agency name:** | **if YES, list agency phone number:** |

| **List all appropriate alternative covered services attempted and found ineffective for the above diagnosis:** |
|---|

| CPT Code: (required) | Place of Service: | Description: | Number of units:<br>(including daily quantity) | Duration of need: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Servicing Provider (provider who will dispense and bill for services)

| **Provider Name:** |
|---|
| **Address:** |

| **Provider Phone:** | **Provider Fax:** | **Servicing Provider ID#:** | **NPI:** | **TIN:** |
|---|---|---|---|---|

## Referring Provider

| **Referring Provider Name:** | **Referring Provider Address:** |
|---|---|

| **Contact Person's Name:** | | | **Contact Phone Number:** | **Contact Fax Number:** |
|---|---|---|---|---|
| **Referring Provider ID#:** | **NPI:** | **TIN:** | | |
| **Doctor's Original Signature (no stamps or photocopies):** | | | | |

**** ALL CLINICAL INFORMATION TO SUPPORT REQUESTED SERVICES IS REQUIRED TO BE SUBMITTED WITH THIS FORM ****

Revised: 2/2020