Benefit Exceptions Request Form

Home State Health • 1-855-694-4663 • Fax: 855-286-1811
Show Me Healthy Kids • Phone: 1-877-236-1020 • Fax: 1-833-924-2511

home state health | Show Me Healthy Kids
MANAGED BY 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 agency making skilled nurse visits? ☐ YES ☐ NO		
If YES, list agency name:	If YES, list agency phone number:	
Diagnosis Code:		
List all appropriate alternative covered services attempted and found ineffective for the above diagnosis:		

Requests for exceptions to non-covered benefits must demonstrate at least one of the following:

☐ Item or service is required to sustain life
☐ Item or service would substantially improve the quality of life for a terminally ill patient
☐ Item or service is necessary as a replacement due to an act occasioned by violent nature without human intervention such as a tornado, flood, etc.
☐ Item or service is necessary to prevent a higher level of care

CPT Code (REQUIRED)	Place of Service	Description	Number of units (including daily quantity)	Duration of need

SERVICING PROVIDER (PROVIDE WHO WILL DISPENSE AND BILL FOR SERVICES)				
Provider Name:				
Address:				
Provider Phone:	Provider Fax:	Servicing Provider ID#:	NPI	TIN:

REFERRING PROVIDER (PRIMARY CARE PROVIDER / SPECIALIST)		
Referring Provider Name:	Referring Provider Address:	
Contact Person's Name:	Contact Phone Number:	Contact Fax Number:
Referring Provider ID#:	NPI:	TIN:

► All clinical information to support requested services is required to be submitted with this form ◄

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