4.0.1. Appendix I - Special Exemption Form for Title XXI and Title XIX

Request for Children's Medical Services Coverage of Medically Necessary Special Services for a Child Under Age 21

Patient Name: _____ Date of Birth: _____ Medicaid ID: _____

This section must be completed by a physician, licensed clinician, or other provider

Requested Provider Name: _____ National Provider ID: _____Telephone: _____ Fax: _____

Requesting Provider Name_____ National Provider ID: _____Telephone: _____ Fax: _____

Provider Type/Specialty: _____ This request is for a Product: ☐ Procedure: ☐ Service: ☐

CPT/HCPCS Code, *(if none, please describe)*: _____ Expected Frequency/Duration of Treatment:

_____

Is the request experimental or investigational? _____ Yes: ☐ No: ☐

(If yes, provide name and protocol)

_____

Is the request considered to be safe? _____ Yes: ☐ No: ☐

(If no, please explain why necessary)

_____

Is the request proved effective? _____ Yes: ☐ No: ☐

(If no, please explain why necessary)

_____

Is the request furnished in a manner primarily for the convenience of the provider, child, or parent/caregiver? Yes: ☐ No: ☐

(If yes, please explain why necessary) _____

_____

Please provide a description of how the requested procedure, product or service will correct or ameliorate the patient's defect, physical or mental illness, or condition. *(If more space is needed, please attach additional comments)*

_____

_____

Requester's Signature and Credentials: _____ License #: _____ Date: _____

Please attach <u>all related</u> medical records and evidence-based literature

This section must be completed by the Medical Consultant

Comments: Approved: ☐ Denied: ☐ Duration:

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

This section must be completed by the Utilization Manager

Program Assigned: _____ Name/Title: _____ Date: _____

CPT/HCPCS Code: _____ Provider Type: _____ Duration: _____

Comments: _____

_____