EXCEPTION TO COVERAGE REQUEST FORM

Requesting provider contact information:

Name:

Address:

Phone:

Fax:

Colorado Medicaid Provider ID#:

1. Client information (name of adults and/or children):

NAME: Last, First MI	BIRTH DATE	CLIENT MEDICAID ID / ELIGIBILITY TYPE

2. MEDICAID RULE (identify rule, standard, policy, or documentation describing current coverage):

3. Specific nature of request:

4. Justification for request conforming with 10 CCR 2505-10 section 8.016.3 et seq.
Attach additional information as needed, including documentation of FDA-approved IND for Stiripentol or Clobazam requests:

5. Alternative treatment(s) explored:

6. Probable course of treatment if coverage is denied:

7. Previous coverage of this treatment for patient:

Any known previous requests for coverage of this treatment? ☐ YES ☐ NO Date: ____

What was previously requested?

Disposition: ☐ APPROVED ☐ DENIED

8. Dates for which this exceptional coverage is being requested:

☐ ONE-TIME: Begin Date: ____ End Date: _____

☐ CONTINUING: Begin Date: _____ End Date: _____

9. Additional cost of exceptional coverage:
For medical exception requests, specify the estimated total cost of exceptional coverage.

☐ MONTHLY AMOUNT $_____ or ☐ ONE-TIME AMOUNT $_____ or ☐ TOTAL AMOUNT $_____

10. TO BE COMPLETED BY CHIEF MEDICAL OFFICER OR DESIGNEE

☐ APPROVED ☐ DENIED Signature: ____ Date: _____________

Comments on determination:

11. STATE OFFICE ACTION

Decision communicated to Requestor and Benefits Management Section: Date __________________________________

Signature: ____ Date: _________________________________
(staff reporting decision to provider)

Pursuant to 10 CCR 2505-10, sections 8.050 and 8.016.4.A, determinations of exceptional coverage are subject to appeal. A denied request for exceptional coverage is an adverse action. The information in Section 11 above is the reason for the determination.