Private Insurance Exemption Request

Please complete this form and send in a HIPAA secure format to Eligibility@rmhumanservices.org prior to invoicing RMHS. Billing will not be processed if an exemption is submitted after invoicing, and resubmission may be needed. Exemptions will only be considered for commercial insurance plans.Exemptions cannot be granted when there is secondary Med/DHMC/CHP+ coverage. Exemptions must be renewed at each annual review, if there is a policy change, or for change in providers. Further details about insurance exemptions can be found in the Provider Manual.

Patient Name:

DOB:

Date Form Completed:

Provider Agency:

Provider Name(s):

Insurance Carrier:

Member ID:

Secondary Coverage:
(If applicable)

Annual IFSP Date:
*Exemptions can only be approved through the Annual IFSP date

Provider Network Status:

IFSP Service	Exemption Reason	Requested Start Date	Justification for Retro Start Date (If Applicable)

Insurance Benefit Verification Details: Please verify and record the private insurance benefits that correspond with the exemption reason you are seeking. Benefits should be verified according to your in or out-of-network status. You can use this form as a guide for the type of information to obtain when contacting insurance companies.

High Deductible Plan

Individual Amount: Expected to be met?

Individual Remaining:

Family Amount:

Family Remaining:

Unable to Obtain Prior Auth

Is Prior Authorization Required?:

Are you Able to Obtain Prior Authorization?:

No Out of Network Benefits/ Non-Covered Services

Are Services Covered?:

Note: Services not covered due to the child's condition/diagnosis would be considered Non-Covered Services. Ex: Some policies do not cover therapies unless there is an injury/stroke. It may help to ask the insurance company if the child's diagnosis is covered.

Untimely Response

Date of Submission to Insurance:

Payment Issued to Family

Who Will Payment be Issued To?:

Any Additional Details to Justify Request?:

Required

Date Benefits Verified:

Call Reference Number:
(Or Attach Online Verification)

To Be Completed By RMHS:

Insurance Exemption:

Denial Reason:

Insurance Exemption Date Range:

Review Date:

Review Staff Initials: