*Insert Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  is requesting an approval for an exception to/special handling of the requirement that a claim containing waiver-funded services must be submitted within 180 days from the date on which the service was rendered (ODP Announcement 37-17).

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| --- | --- | --- | --- |
| **Individual’s Name** |  | **Recipient Identification Number (RID)** also known as MCI or MAID number |  |
| **MPI: 9-digit** |  | **4-digit Service Location Code** |  |
| **Please explain the issue that prevented you from submitting your claim within the 180-calendar day submission time limit:** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Internal Control Number, ICN** | **Claim Detail Line #** | **FROM Dates of Service** | **TO****Dates of Service** | **Procedure Code** | **Modifier** | **Modifier** | **Modifier** | **Modifier** | **Units of Service** | **DETAIL LINE** **Billed Amount** | **FOR INTERNAL USE ONLY****Determination Decision** |
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| **Signature of the Provider Representative :** |  |  **Date:** |  |

**Email address for Provider Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**If you need more space, please use a separate form and indicate in your email request that additional pages were needed.**

This request has been reviewed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and has been determined to be **eligible / not eligible** as a(n) **Exception / Special Handling**.

The review has determined that there was an issue with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (AE, SC, County MH/MR, Regional Office, etc.) that caused the provider to be unable to bill within 180 days, as required.

Recommendation for special handling case: **APPROVE / DENY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization from Regional Program Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

5/5/2017