*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 21-046 Reissue).

|  |  |  |  |
| --- | --- | --- | --- |
| **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:** | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  |  |  |  |  | |  | |  |
| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_