

Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
<http://DVHA.vermont.gov>

[Phone] 802-879-5900

Agency of Human Services

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide. Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć. Barua hii ni muhimu. Kama huielwi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi.

Dokumentigan ama qoraalkan waa muhiim. Haddii aadan fahmin, waxaad u qaadaa xafiiskaaga degaanka si aad caawimaad u hesho.

ဤစာရွက်စာတမ်းသည် အရေးကြီးပါသည်။ သင်နားမလည်လျှင်၊ သင်၏နယ်မြေရုံးခန်းသို့ အကူအညီရရန် ယူဆောင်သွားပါ။

यौ दस्तावेज महत्त्वपूर्ण छ। यदि तपाईंले यसलाई बुझ्नुभएन भने, मद्दतको लागि यसलाई आफ्नो स्थानीय कार्यालयमा लिएर जानुहोस्।

Dear Medicaid member:

Medicaid has rules about what medical services and items it will pay for. **Are you under age 21?** Your doctor or medical provider must ask before they treat you. Then Medicaid will tell them if it will pay.

Are you age 21 or older? Then you may ask Medicaid to pay for services or items not covered under the rules. You may ask Medicaid if it will pay **before** you get the services/items. If you don't, Medicaid will **not** pay for it.

To ask Medicaid to pay for something not covered you need 2 papers:

1. The **Beneficiary Request for Medicaid Coverage Exception**. You must fill it out and sign it.
AND
2. The **Request for Medicaid Coverage Exception - Medical Need**. Your doctor or medical provider must fill it out and sign it.

Both of these papers are with this letter. You should also send papers that show why you need the services/items. This can be:

- Medical records
- Letters from people you know saying why not getting the service/item will hurt you
- Other papers that show how the service/item meets the special Medicaid rules (Rule 7104)

We will look at your request as soon as we get both signed papers. We will make a decision within 30 days. Please send all information to:

**Commissioner, Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
ATTN: Exception Coordinator**

If you need help or have questions, please call **802-241-0454**.

Department of Vermont Health Access

Beneficiary Request for Medicaid Coverage Exception

(application form)

Are you age 21 or older? We need this signed paper to see if Medicaid will pay.

Are you under age 21? Don't send this paper unless we ask. Your doctor must ask Medicaid to pay first.

Please Print

Name:	
Address:	
City, state, zip code:	
Telephone number:	
Medicaid ID #:	DOB:
Medical provider's name:	Provider's phone number:

(Attach additional sheets if necessary.)

1. What is the service/item you want Medicaid to pay for?

2. How will you be harmed without the service/item?

I am asking Medicaid to pay for a service/item. By signing this paper, I am agreeing to release my medical records and information. My doctor/medical provider may give them to the Department of Vermont Health Access.

The information in this application is true and accurate as far as I know.

Beneficiary/Guardian's signature

Date

Print name

Relationship

Please send all information to: Commissioner, Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010 ATTN: Exception Coordinator

Department of Vermont Health Access

Request for Medicaid Coverage Exception - Medical Need Form

PROVIDER: Complete this form only for services/items **NOT** already covered by Medicaid.
If patient is under age 21, submit a prior authorization request for coverage of this service/item before using this form.

Please print

Provider Name:	<u>Medicaid Provider #:</u>
Address:	
City, state, zip code:	
Telephone number:	
Patient's Name:	Social Security Number:
Requested Service or CPT code:	

Please write legibly or type. (Attach additional sheets if necessary)

1. The above-named patient is requesting Medicaid coverage of a service/item not on the list of services/items that Vermont Medicaid covers. To get coverage, your patient must be approved for a Medicaid coverage exception. Please provide the clinical reasons that are the basis for your assessment that the service/item is medically necessary. **(Please submit the following information/records in support of this request: patient medical history; hospital discharge summary; emergency room report; operative, lab, x-ray and diagnostic reports; physical, occupational, speech, dental or mental health assessments; and a list of medications the patient is currently taking.)**

2. Describe the **unique** extenuating circumstances, if any, that can be *reasonably anticipated* to produce serious detrimental health consequences should the service or item not be provided to this individual. Please include a description of the **serious detrimental health consequences** that you anticipate. This information is critical for us to evaluate the request. Does **not** apply in this case.

Provider's signature

Date

Please return this form and all relevant supporting information to:

Commissioner, Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

ATTN: Exception Coordinator