Washington State Department of Health

DOH 150-099 November 2017

PrEP DAP BENEFIT EXCEPTION REQUEST

PrEP DAP reviews requests for benefit exceptions on the basis of medical necessity only. If PrEP DAP approves the request, payment is still subject to all general conditions of PrEP DAP, including current member eligibility, insurance, and program restrictions. PrEP DAP will notify the provider and participant of the decision.

PrEP DAP ENROLLEE INFORMATION

Name	
PrEP DAP ID:	
Phone Number	
Date of Birth	

PROVIDER INFORMATION

Provider Name		**Date Requested**	
Tax ID number		**Primary Care Provider**	**Yes No**
Requestor Contact Email:		**Requestor Contact Phone:**	

Explanation why this service is medically necessary. Include the diagnosis, place of service, and description of the proposed treatment. Attach supporting document as necessary.

Primary Diagnosis:		**Secondary Diagnosis:**	
Place of service:			
Description of Treatment:			
List all alternative services attempted and found ineffective:			
How is service/treatment related to PrEP? *Please explain and/or attach supporting documentation*			

continued on page 2

PrEP DAP BENEFIT EXCEPTION REQUEST

SERVICES REQUESTED

CPT/ADA CODE	CODE DESCRIPTION	NO. OF UNITS	ESTIMATED COST

Please include additional pages if more room is needed.

Provider Signature: _____ **Date:** _____

I certify that the information provided on this form and on any attachments, including medical necessity information is true, accurate, and complete to the best of my knowledge.

Attachments (*circle one***): Yes No**

Please submit all documentation via mail or fax to:

Department of Health – PrEP DAP
Attn: Lori Delaney
PO BOX 47840, Olympia WA 98504-7840
Fax: 360-664-2216

DO NOT WRITE BELOW THIS LINE - PrEP DAP USE ONLY

PROVIDER: DO NOT COMPLETE THIS PORTION

Reviewer Decision:	**Approve Deny**	**Projected cost:**	
Authorized effective date:		**Authorization end date:**	
Consultant Signature		**Date:**	