



HRSA Health & Recovery
Services Administration

HRSA Exception to Rule Request

HRSA MEDICAL ENTERAL AUTHORIZATION UNIT
Division of DESD – Authorization Service Office
PO Box 45535 Olympia WA 98504-5535
FAX 1-866-668-1214

This is confidential information only intended for to whom it is faxed.

Effective for dates of service on or after July 1, 2009, oral enteral nutrition is not covered for adults 21 and older. In order to request an exception to rule (WAC 388-501-0160), complete the following in its entirety. Please fill out this form only if the client's nutritional requirements cannot be met by food/products available in the store.

PLEASE NOTE THAT ALL FIELDS ARE REQUIRED TO BE COMPLETED OR REQUEST CANNOT BE APPROPRIATELY EVALUATED.

Fax this completed form supporting clinical notes and relevant lab results to HRSA Medical Enteral Authorization Unit.

To be completed by Vendor or Clinician

CLIENT INFORMATION

CLIENT NAME	CLIENT ID
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CLIENT RESIDENCE
 Private Home Adult Family Home or Boarding Home (e.g., ALF) Other state-funded living
 Other, please specify:

VENDOR INFORMATION

VENDOR NAME	PROVIDER NPI
VENDOR TELEPHONE NUMBER	FAX NUMBER

SERVICE REQUEST INFORMATION

NUTRITION PRODUCT REQUESTED	QUANTITY IN HCPCS UNITS PER DAY	LENGTH OF NEED	HCPCS CODE
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Provide all applicable diagnoses (ICD9 codes and description)

MEDICAL DIAGNOSIS	NUTRITIONAL DIAGNOSIS
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To be completed by Prescribing Provider

Explain why this client is so clinically/medically unique from others with a similar condition (diagnosis) that the department should grant an exception to rule.

Medical Justification: Does this client have a condition that affects his/her ability to break down, digest, or absorb nutrients? Yes No If "Yes" what is the condition?

What other alternatives/less costly nutrition sources have been tried? (DSHS does not pay for products available at a store or those that could be prepared in the residence by the client or others.)

What was the outcome?

WEIGHT	BMI	DATES AND WEIGHTS (OR PHYSICAL EXAM FINDINGS THAT SUPPORT SIGNIFICANT WEIGHT LOSS IF UNABLE TO WEIGH)
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LAB RESULTS TO SUPPORT DIAGNOSIS (E.G. Albumin, Pre-albumin to indicate malnutrition) – ATTACH RESULTS TO REQUEST

PHYSICIAN OR PRESCRIBING PROVIDER NAME	TELEPHONE NUMBER	PROVIDER NPI
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PHYSICIAN OR PRESCRIBING PROVIDER SIGNATURE	DATE
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