HRSA Exception to Rule Request*
Compression Garments

HRSA Authorization Unit
Division of Eligibility and Service Delivery – Authorization Services 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 August 1, 2009, compression garments are 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 medical needs cannot be met by less costly alternatives.

Please note that all fields are required to be completed or request cannot be appropriately evaluated. Fax this completed form and supporting clinical notes to the HRSA DME Authorization Unit to the fax number above.

To be completed by vendor or clinician:

CLIENT'S NAME	CLIENT ID

Clinical Provider Information	
CLINICAL PROVIDER'S NAME	PROVIDER NPI NUMBER
PHONE NUMBER (AND AREA CODE)	FAX NUMBER (AND AREA CODE)

Vendor Information	
VENDOR'S NAME	PROVIDER NPI NUMBER
PHONE NUMBER (AND AREA CODE)	FAX NUMBER (AND AREA CODE)

Service Request Information		
PRODUCT REQUESTED. ATTACH THE 1500 FORM AND HRSA PRESCRIPTION FORM		QUANTITY REQUESTED
Provide all applicable diagnoses (ICD-9 codes and description)	ICD-9	DESCRIPTION

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 for compression garments?		
* Medical justification: What medical conditions exist for this client that requires the use of compression garments? What are the short and long-term treatment goals (Include supporting clinical documentation specifying the affected area(s) and the treatment plan)?		
* What other alternatives/less costly treatments have been tried? (DSHS does not pay for products available at a store over-the-counter.)		
* What was the outcome?		
MEASUREMENTS OF THE AFFECTED AREAS		DATE
PHYSICIAN (OR PRESCRIBING PROVIDER) NAME	PHONE NUMBER (AND AREA CODE)	MEDICAID PROVIDER NUMBER
PHYSICIAN (OR PRESCRIBING PROVIDER) SIGNATURE		DATE