



## HRSA Exception to Rule Request\* Bathroom Equipment

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, bathroom equipment 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 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
<b>Clinical Provider Information</b>		
CLINICAL PROVIDER'S NAME		PROVIDER NPI NUMBER
PHONE NUMBER (AND AREA CODE)		FAX NUMBER (AND AREA CODE)
<b>Vendor Information</b>		
VENDOR'S NAME		PROVIDER NPI NUMBER
PHONE NUMBER (AND AREA CODE)		FAX NUMBER (AND AREA CODE)
<b>Service Request Information</b>		
PRODUCT REQUESTED. ATTACH THE 1500 FORM AND HRSA PRESCRIPTION FORM		QUANTITY REQUESTED
<b>Provide all applicable diagnoses (ICD-9 codes and description)</b>	ICD-9	DESCRIPTION
	ICD-9	DESCRIPTION
<b>To be completed by Prescribing Provider</b>		
* 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 bathroom equipment?		
* What other alternatives/less costly treatments <u>have been tried</u> ? (DSHS does not pay for products available at a store over-the-counter.)		
* What was the outcome?		
PHYSICIAN (OR PRESCRIBING PROVIDER) PRINTED NAME		
PHYSICIAN (OR PRESCRIBING PROVIDER) SIGNATURE (INCLUDE CREDENTIALS)		DATE