

**ABH ~ Project SAFE
Special Exception Request**

Date of Request: _____

Provider Name: _____

Person Requesting Exception: _____

Client Name: _____

Client ABH#: _____

Client DOB: _____

Client SSN: _____ - _____ - _____

Client's Insurance: _____

Reason for Exception:

- Project SAFE Provider does not participate in client's insurance plan – Out of Network
- Client's insurance changed to out of network
- Clinician is out of network with client's insurance
- In-network service does not have childcare
- Services not covered by client's insurance plan
- No transportation to in-network provider
- Client's State/Private/Medicare will not authorize services (PHP,IOP,OP-IND,GROUP)

Reason: _____

(The following two categories are being collected for tracking purposes only at this time.)

- Private Insurance has high deductible: **Amount of Deductible-** \$ _____
- Spend down – **Reason/Amount of Spend down:** \$ _____

Type of Treatment Requested:

- Individual
of sessions: _____ Start date: _____ End date: _____
- Group
of sessions: _____ Start date: _____ End date: _____
- Family
of sessions: _____ Start date: _____ End date: _____

Special Exceptions for IOP & PHP Services

- IOP ****Please fax OTR with this form for clinical review**
- PHP ****Please fax OTR with this form for clinical review**

Clinician Signature: _____