Exception Request for SED Waiver Services Which Exceed the Limits of Initial Authorization

Member Name: _____ Date of Birth: _____
Last First Middle mm/dd/yy

Medicaid Number: _____ Social Security Number: _____

Provider Agency: _____

Check the box corresponding to the service for which the initial authorization limits have been met.

Service	Units Requested	Service	Units Requested
☐ SED Short Term Respite Care		☐ SED Professional Family Resource Care	

Timeframe of Request: Start Date: _____ (mm/dd/yy) End Date: _____ (mm/dd/yy)

Provide in detail the reason for this request (i.e., why are additional units medically necessary?)

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Completed By: _____ Date: _____ (mm/dd/yy)
Please Print Name

Contact Number: _____

Phone: 1-877-642-9283
Fax: 1-785-232-2610