SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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Request for Rehabilitative Behavioral Health Services Limit Exception

Beneficiary Information	
Name:	
Address:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Provider Name:	
Provider NPI:	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	

Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/
Diagnosis - Code / Description:	/

Clinical Rationale for Request

Community Support Services (PRS, B-Mod, FS, TCC and CIS only)			
Procedure Code	**Service Name**	**# of Daily Units Currently Authorized**	**# of Daily Units Requested**

All Other Rehabilitative Behavioral Health Services			
Procedure Code	**Service Name**	**# of Units Requested**	**# of Encounters Requested**

LPHA Name: _____

Credentials: _____

Signature: _____

Date: _____