

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, and FS 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: _____