# Carelon Behavioral Health
# 120 Day Waiver Request Form
# (Medicaid ONLY)

I. Demographic Information

**Provider Name:** _____

**NPI #:Member** _____

**Name:Member** _____

**ID #: Contact** _____

**Person:** _____

**Telephone #:** _____

II. Reason(s) For Waiver

**Valid reasons for requesting a 120 Day Waiver are indicated below. Copy of claim required. Please check all that apply.**

- ☐ **Provider retroactively eligible for reimbursement**
- ☐ **Member retroactively enrolled**
- ☐ **Third party coverage (Copy of EOB required – Please attach)**
- ☐ **Member retroactively authorized for service**

**I am requesting a waiver of the 120 day timely filing deadline for the above reason(s). I hereby certify that the above claim is true and correct. I further understand and agree that Carelon Behavioral Health's billing policies and procedures apply to this claim.**

**Provider Signature:** _____

**Date:** _____

III. For Carelon Behavioral Health Use Only

**Status**: **Approve** Deny **Return to Provider**

**Processor Name:** _____ **Date:** _____