Carelon Behavioral Health
150 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 150 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 150 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:** _____