365 Day Waiver Request Form

I. Demographic Information

Provider Name: _____

Carelon Provider ID #: _____

Member Name: _____

Member ID #: _____

Contact Person: _____

Telephone #: _____

II. Reason(s) For Waiver

- Valid reasons for requesting a 365 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 365 day timely filing deadline for the above reason(s). I hereby certify that the above claim for services is true and correct. I further understand and agree that Carelon'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:** _____