Carelon Behavioral Health
95 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 95 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 other insurance explanation of benefits required**

☐ **Member retroactively authorized for service**

I am requesting a waiver of the 95 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 Behavioral Health's billing policies and procedures apply to this claim.

Provider Signature: _____

Date: _____