Wellpoint

FCS Exception to Rule/Limited Extension Request Form

This form is a request for additional supported employment or supportive housing units above the initial units authorized during a current period of authorization. Email this request form to FCSTPA@amerigroup.com or fax to **844-470-8859**.

For questions, call Foundational Community Supports (FCS) at **844-451-2828**.

Select one: ☐ Supportive housing ☐ Supported employment

* Indicates a required field

Enrollee information
First name*:
Last name*:
DOB*:
ProviderOne ID:
Address:
City, State, ZIP*:
Phone:
Email:
Provider contact information
Provider first name*:
Provider last name*:
Provider address:
Provider city, state, ZIP*:
Provider phone*:
Provider email*:

Exception to rule request information
Request date:
Number of units requested*:
Number of units used*:
Authorization start date*:
Authorization end date*:

Please provide the following supporting documents and explanations on a separate attachment:

☐ Progress notes (from authorization start date to current)

☐ A description of why this enrollee is clinically unique from others with a similar condition

☐ A description of alternatives that have been tried and their outcomes

☐ The enrollee's person-centered care plan for employment/housing

☐ A description of the additional services that will be needed

☐ The level of improvement the client has shown to date related to FCS services and what improvements could be reasonably expected if FCS services are extended

☐ How an enrollee's condition might worsen if FCS benefits are not extended

☐ Completed and signed *FCS TPA Single Case Agreement Form* (See below.)

FCS TPA Single Case Agreement

This form is required to be completed along with any *Exception to the Rule (ETR) Forms*. All fields must be completed in order to be considered.

This *Single Case Agreement* is made by and between Wellpoint Washington, Inc. ("Wellpoint") and the undersigned Provider ("Provider").

This *Single Case Agreement* confirms that Wellpoint authorizes/the Provider identified below to provide services required by the Wellpoint foundational community supports third party administrator enrollee identified below pursuant to the terms and conditions set forth below for the specific episode of care:

Enrollee name:
Enrollee DOB:
Enrollee ProviderOne ID:
Provider name:
Provider/group tax ID:
Provider NPI number:
Authorization period:
Service type (SE/SH):
Units requested:

It is understood that Provider will accept the above payment less the amount of any applicable cost sharing responsibilities as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the member in excess of the amount of applicable cost sharing responsibilities.

In witness whereof, the duly authorized officers of Wellpoint and Provider hereby execute this *Single Case Agreement*.

Wellpoint Washington, Inc.: (to be completed by FCS staff)	**Provider:** (to be completed by provider staff)
By:	By:
Title:	Title:
Date:	Date: