



**Warning: claims which result in overpayment under Medicare may result in civil and/or criminal penalties**

**Payor of Last Resort Waiver Request Form**

TO: BCMHARSB Waiver Request

From: Provider Agency: \_\_\_\_\_

(Secure Fax: 513-860-1125)

Staff Name: \_\_\_\_\_

ATTN: Executive Director

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Secure Fax: \_\_\_\_\_

RE: Client Name/UCI Number: \_\_\_\_\_

DATE SUBMITTED: \_\_\_\_\_

New Client  Existing Client *If existing client, how long has the current clinician?* \_\_\_\_\_

Which payor source are we being asked to waive?

Medicare  3<sup>rd</sup> Party Insurance, *Name of 3<sup>rd</sup> Party* \_\_\_\_\_

Is a credentialed paneled provider available? Yes  No

If yes, must submit bill to Medicare/3<sup>rd</sup> Party Insurance. If no, a waiver is needed.

Are you requesting a waiver for a Medicare/3<sup>rd</sup> Party reimbursable service? If so, please list the services below:

\_\_\_\_\_

Please note any special circumstances or situations that apply to this waiver request below:

\_\_\_\_\_

BCMHARS appropriate supported services:

Did you review Attachment # 1 in the BCMHARS Fee for Service Contract to confirm that services were supported for this fiscal year?  Yes  No

Client meets financial determination based on BCMHARS Board sliding fee scale (Form 100)?  Yes  No

**Section below to be completed by BCMHARS Executive Director or designee:**

	Approved		Denied	<b>Approval Expires One Year from Date Submitted</b>
<i>Approval is contingent upon available contractual funding. If contractual funding is exhausted, services may not be paid based on this approval.</i>				
Signature: _____ Date: _____				

\*Approval Form must be kept on file in client's chart and available upon request. \*

\*\*Diagnostic assessments will be paid by the Board for one hour/one session per year without needing to be waived based on Form 100 results\*\*

\*\*\*Updated waiver forms are required one year from submitted date \*\*\*

Approved waivers must be uploaded into the GOSH Enrollment screen within 30 days for review and endorsement prior to any payment.

Revised \ Effective 6.14.24