Washington State Health Care Authority

Exception to Rule Request*
Compression Garments

Health Care Authority (HCA)
Durable Medical Equipment (DME)Program Management Unit
PO Box 45535 Olympia, WA 98504-5535
FAX: 1-866-668-1214

This is confidential information intended only for the person to whom it is faxed.

* Effective for dates of service on or after August 1, 2009, compression garments are not covered for adults 21 and older. In order to request an exception to rule (WAC 182-501-0160), complete the following form in its entirety. Please fill out this form only if the client's medical needs cannot be met by less-costly alternatives.

HCA requires all fields to be completed so we can appropriately evaluate the request. Fax this completed form and supporting clinical notes to the HCA DME Authorization Unit at 1-866-668-1214.

To be completed by vendor or clinician		
CLIENT'S NAME	CLIENT ID	
Clinical Provider Information		
CLINICAL PROVIDER'S NAME	PROVIDER NPI NUMBER	
PHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)	
Vendor Information		
VENDOR'S NAME	PROVIDER NPI NUMBER	
PHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)	
Service Request Information		
PRODUCT REQUESTED. (ATTACH THE HCA PRESCRIPTION FORM)	QUANTITY REQUESTED	
Provide all applicable diagnoses (ICD-9 codes and description)	ICD-9	DESCRIPTION
To be completed by prescribing provider		
* Explain why this client is clinically/medically unique from others with a similar condition (diagnosis) to the extent that the agency should grant an exception to the rule for compression garments.		
* Medical justification: What medical conditions exist for this client requiring the use of compression garments? What are the short- and long-term treatment goals? Include supporting clinical documentation specifying the affected area(s) and the treatment plan.		
* What other alternatives/less-costly treatments have been tried? (HCA does not pay for products available at a store over-the-counter.)		
* What was the outcome?		
MEASUREMENTS OF THE AFFECTED AREAS		DATE
PHYSICIAN (OR PRESCRIBING PROVIDER) NAME	PHONE NUMBER (WITH AREA CODE)	MEDICAID PROVIDER NUMBER
PHYSICIAN (OR PRESCRIBING PROVIDER) SIGNATURE		DATE