## CY2013 MEDICARE ADVANTAGE HSD EXCEPTION REQUEST TEMPLATE

(File naming convention: Contract ID_County Code_Specialty Code) – 15 characters

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| **CONTRACT ID:** | |
| **COUNTY CODE:** | |
| **SPECIALTY CODE:** | |

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| **JUSTIFICATION FOR EXCEPTION: (Select the *one* most relevant justification)** | ☐ Patterns of Care do not support the criteria<br>☐ RPPO |

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| **YOUR PLAN FOR ENSURING ACCESS TO SERVICES:** | *1.) Are there providers/facilities of the type that failed the ACC for this county, with which you have not contracted, located within the time/distance requirement? If yes, please provide their names and addresses (and telephone numbers, if available).*<br>*2.) What sources of information or research did you rely on to identify the providers/facilities (or lack thereof)? If published or Internet site, please provide the full citation and location of the specific information.*<br>*3.) If you answered yes to Question 1, explain in detail why you have not contracted with the providers/facilities you listed.*<br>*4.) Is there an unusual pattern of distribution of Medicare beneficiary residences in the specified county that you are able to document? If yes, as indicated in Question 2, please provide the sources for your information and explain how that pattern affects the local patterns of care for the county.*<br>*5.) Describe any unusual local pattern of care in the county for FFS Medicare beneficiaries when they seek and receive care and services normally offered by providers/facilities of the type that failed the ACC for this county. Support this description with data and provide sources of the data.*<br>*6.) Please describe how you will provide the services of the failed provider/facility type to beneficiaries who enroll in your plan(s) offered in the specified county.*<br>*7.) If you are proposing to use an "alternate" provider or facility to provide some, or all, of the Medicare covered services provided by the failed provider/facility type, please include a justification for using the alternate provider/facility. Please also include written assurance from the alternate provider/facility stating that it is currently providing services of the failed provider/facility type to Medicare beneficiaries, is willing to provide these services to your plan enrollees, and provides authorization to list it in your provider directory as offering the services in question. In addition, provide documentation that the alternate provider/facility meets all license, education, and experience requirements to meet your credentialing policies and procedures, and all State and Federal laws and requirements that apply to the specified services.* |

| **CONTRACTED PROVIDER(S) LISTED ON HSD TABLE THAT WILL ENSURE ACCESS** | |
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| **NAME FROM HSD TABLE:** | |
| **PROVIDER NPI:** | |
| **SPECIALTY TYPE:** | |
| **ADDRESS (street, city, state, zip code, and telephone number):** | |
| **DISTANCE FROM BENEFICIARIES (Based on Sample Beneficiary File in HPMS):** | |
| **NAME FROM HSD TABLE:** | |
| **PROVIDER NPI:** | |
| **SPECIALTY TYPE:** | |

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|---|---|
| **ADDRESS (street, city, state, zip code, and telephone number):** | |
| **DISTANCE FROM BENEFICIARIES (Based on Sample Beneficiary File in HPMS):** | |

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|---|---|
| **NAME FROM HSD TABLE:** | |
| **PROVIDER NPI:** | |
| **SPECIALTY TYPE:** | |
| **ADDRESS (street, city, state, zip code, and telephone number):** | |
| **DISTANCE FROM BENEFICIARIES (Based on Sample Beneficiary File in HPMS):** | |