



Request for Reimbursement from Billing Guidelines

Program: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Name/Discipline of person requesting waiver: \_\_\_\_\_

Child's name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Child's FULL registration #: \_\_\_/\_\_\_/\_\_\_/\_\_\_/\_\_\_ Prog. # Client ID # Referral #

Eligibility for EI (Check one):

- Established Diagnosis: \_\_\_\_\_ Developmental Delay(s)
At Risk Clinical Judgement

Services child & family currently receiving (including transportation) as listed on IFSP:
(Service type) (Frequency) (Duration) (Staff/Discipline)

Table with 4 columns: Service type, Frequency, Duration, Staff/Discipline. Contains 5 empty rows.

Code # Waiver Request

Explanation of extraordinary circumstances: \_\_\_\_\_

Anticipated date(s) of service: \_\_\_\_\_

Has this child ever received a previous waiver/permission for reimbursement of any type?

No Yes Authorization #: \_\_\_\_\_

Program Director's Signature: \_\_\_\_\_

This form should be filed in the child's record, available for both program and fiscal monitoring.

Box containing: (DPH use only) Approved Date: Authorization #: Denied Conditions: DPH Staff: