180 Day Waiver Request Form

I. DEMOGRAPHIC INFORMATION

Provider Name: _____

NPI #: _____

Member Name: _____

Member ID #: _____

Contact Person: _____

Telephone #: _____

II. REASON(S) FOR WAIVER

Valid reasons for requesting a 180 Day Waiver are indicated below. Copy of claim required. Please check all that apply.

- ☐ Provider retroactively eligible for reimbursement
- ☐ Member retroactively enrolled
- ☐ Third party coverage **(Copy of EOB required – Please attach)**
- ☐ Member retroactively authorized for service

> I am requesting a waiver of the 180 day timely filing deadline for the above reason(s). I hereby certify that the above claim for services is true and correct. I further understand and agree that CHIPA billing policies and procedures apply to this claim.

Provider Signature: _____

Date: _____

III. FOR CHIPA USE ONLY

Status: ☐ Approve ☐ Deny ☐ Return to Provider

Processor Name: _____

Date: _____

Note: Please make a copy of this form for your records.