APPENDIX B
EARLY INTERVENTION SERVICES
REQUEST TO EXCEED MEDICAID LIMITATIONS FORM

<table>
<tr><td colspan="4">I. GENERAL INFORMATION (to be completed by the provider)</td></tr>
<tr><td>Recipient Medicaid Number (10-digits)</td><td>Last Name</td><td>First Name</td><td>Date of Birth</td></tr>
<tr><td colspan="2">Diagnosis Codes and Descriptions</td><td>Procedure Code</td><td>Procedure Description</td></tr>
<tr><td colspan="2">Units of Services Requested</td><td colspan="2">Services Dates for Additional Services

FROM: _____ TO: _____</td></tr>
<tr><td colspan="4">Explanation of Necessity (Attach copy of Individualized Family Support Plan and Plan of Care)</td></tr>
<tr><td colspan="2">Individual or Group Provider Medicaid Number</td><td colspan="2">Individual or Group Provider Name</td></tr>
<tr><td colspan="2">Treating Provider Medicaid Number</td><td colspan="2">Treating Provider Name</td></tr>
<tr><td colspan="2">Individual or Group Provider Address and Phone</td><td colspan="2">Signature and Date

_____ _____
Signature Date</td></tr>
</table>

AHCA-Med Serv Form 019, August 2007 (incorporated by reference in 59G-4.085, F.A.C.)

Request to Exceed Medicaid Limitations Form, continued

II. EARLY INTERVENTION PROGRAM CONCURRENCE (to be completed by the EIP Director)
I Concur_____ **Recommended:** **Units of Services** _____ **Dates of Service FROM:**_____ **TO:** _____
I Do Not Concur_____
Reason for Not Concurring
Signature of EIP Director: _____ _____ **Signature** **Date**

III. MEDICAID AUTHORIZATION (to be completed by Medicaid)
Approved_____ **Units of Service** _____ **Dates of Service FROM:**_____ **TO:** _____
Denied_____
Reason for Denying
Authorized by: _____ _____ **Signature** **Date**

AHCA-Med Serv Form 019, August 2007 (incorporated by reference in 59G-4.085, F.A.C.)

Instructions for the Request to Exceed Medicaid Limitations Form

I. General information to be completed by the provider:	
ITEM TITLE	**ACTION**
Recipient Medicaid Number	Enter the Medicaid eligible child's I.D. Number.
Last Name	Enter the child's last name as it appears on the Medicaid identification card.
First Name	Enter the child's first name as it appears on the Medicaid identification card.
Date of Birth	Enter the child's date of birth.
Diagnosis	Enter both the ICD-9 code and description. List the diagnosis(es) that is most relevant to the child's need for additional services.
Procedure Code	Enter the procedure code for which you are requesting authorization.
Procedure Description	Enter a description of the procedure for which you are requesting authorization.
Units of Service	Enter the total number of units of services that you are requesting. For example, if you are requesting one additional individual session per week from June 1 through July 31, enter 9 units of service.
Service Dates	Enter the FROM and TO dates for the additional services that you are requesting. Note: There is a three-month maximum.
Explanation of Necessity	Attach a copy of the Medicaid eligible child's Individualized Family Support Plan and Plan of Care.
Individual or Group Provider Medicaid Number	Enter the individual or group provider's Medicaid number.
Individual or Group Provider Name	Enter the individual or group provider's name.
Treating Provider Medicaid Number	Enter the treating provider's Medicaid number.
Treating Provider's Name	Enter the treating provider's name.
Individual or Group Provider's Phone Number, Address, Signature, Date	Enter the individual or group provider's address, phone number, signature and date.

AHCA-Med Serv Form 019, August 2007 (incorporated by reference in 59G-4.085, F.A.C.)

***Instructions for the Request to Exceed Medicaid Limitations Form*,** continued

III. Medicaid Authorization -- To be completed by Medicaid	
ITEM TITLE	**ACTION**
Approved	The authorizing person checks if the request is approved and enters the number of additional units of services and the dates of service that have been approved.
Denied	The authorizing person checks if the services are denied and gives the reason for the denial.
Reviewed by	The authorizing person signs and dates the form.

AHCA-Med Serv Form 019, August 2007 (incorporated by reference in 59G-4.085, F.A.C.)