State of California – Health and Human Services Agency | Department of Health Care Services

REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

Each area of the Request For Exemption From Plan Enrollment form must be completed.
If not, the medical exemption will be denied – **Please Print or Type (Ink Only)**

To Be Completed and Signed By Beneficiary
Part I

1. Name: (Please Print) Last Name First Name M.I.		2. Benefits Identification Card Number:
3. Date of Birth: __ __ / __ __ / __ __ Month Day Year	4. Check One: ☐ Female ☐ Male	5. Medi-Cal ID Number:
6a. Are you a member of a health Plan? ☐ Yes (go to box 6b) ☐ No (go to box 7a)	6b. Plan Name:	6c. Plan Membership Number:
7a. Is someone other than the beneficiary completing this section? ☐ Yes (go to box 7b) ☐ No (go to box 8)	7b. If yes, please provide the following information: Print Name Relationship Phone Number	

8. I am requesting that Dr. _____ send in a request for a Medi-Cal Managed Care **medical exemption** for me.
Name of Doctor

9. Beneficiary's Signature: Signature of beneficiary or Parent of beneficiary if a minor child	10. Date Signed: __ __ / __ __ / __ __ __ __ Month Day Year

This information is requested by the Department of Health Care Services, Medi-Cal Managed Care Division, under Title 22, California Code of Regulations, Sections 53887 or 53923.5, in order to comply with requirements of continuing with Fee-for-Service medical care. Completion of this form is mandatory for an exemption. Not completing this form could result in enrollment in a Managed Care health plan. **For help with this form, please call Health Care Options at (800) 430-4263. This call is free.**

Physician's Certification For Medical Exemption
Part II

The beneficiary's rendering physician MUST fill out AND SIGN this section.

For State Use Only:	
	Approved: ☐
	Denied: ☐ Initials: _____
	Deferred: ☐ Date: _____

11. Date you started treating beneficiary for one of the conditions listed below in box 13: __ __ / __ __ / __ __ Month Day Year	12. Estimated date of completion of treatment or therapy for condition requiring exemption: __ __ / __ __ / __ __ Month Day Year

For state use only:	13. Please check the following as appropriate (ICD-9-CM code must be included in column 14 at right, or the exemption will be considered incomplete and returned.)	14. ICD-9 Codes
P	❑ A. Pregnant and currently under your care for the pregnancy. Due Date _____	
F	❑ B. HIV+ or has been diagnosed with AIDS	1. 2.
D	❑ C. Receiving chronic renal dialysis treatment under your supervision	1. 2.
E	❑ D. Undergoing one of three transplant classifications (see item 13-D on page 4) Classification: _____ Medi-Cal designated transplant center: _____	1. 2.

PART II – To Be Completed and Signed By Beneficiary's Rendering Physician

Dear Medi-Cal Physician: If you are **currently** providing medical services to the Medi-Cal beneficiary identified in Part I and who has one of the conditions or reasons for a medical exemption listed in Box 13 of this page AND you are NOT affiliated with any Medi-Cal Managed Care health plans in the county of residence of the beneficiary, you may be able to continue providing services to the individual. The beneficiary must request a medical exemption, and you and the beneficiary must fill out this form, sign it, and mail or fax it (Part I and Part II) to the Health Care Options office (see mailing address and fax number at the bottom of Part II). Please refer to Title 22, California Code of Regulations, Sections 53887 or 53923.5, for additional information concerning requirements for medical exemptions.

This exemption is valid until the date you indicate the individual will be stabilized enough to allow enrollment in a Medi-Cal Managed Care health plan or the condition is resolved. An exemption can be requested for a maximum of 12 months. An extension may be requested at the end of 12 months by submitting a new exemption form.

Instructions for completing Boxes 13-D through 13-I (and 14):

Item 13-D

Please list on the line provided which of the following transplant situations is relevant. Please specify the Medi-Cal designated transplant center involved in the evaluation, transplant procedure or current follow-up. Please specify ICD-9 code for organ transplanted/to be transplanted and any codes for complications in box 14. *(Please note: this exemption does not apply to beneficiaries who are medically stable on post-transplant therapy.)*

Transplant classifications:

- Beneficiary is under active evaluation for the need for an organ transplant
- Beneficiary has been approved for and is awaiting an organ transplant
- Beneficiary has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant performed.

Item 13-E

The type of therapy must be described on the line provided, and both the start date and the expected duration of therapy must be listed in boxes 11 and 12. *Beneficiaries in long-term remission without signs of disease or who are classified as "cured" are not eligible for medical exemption.*

Cancer classifications:

- Beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer
- Beneficiary has been approved for such therapy and is awaiting initiation of approved therapy

Item 13-F

Please check this item if beneficiary has been approved for and is awaiting a major surgical procedure, **including surgery for cancer.**

List both ICD-9 (in box 14) and appropriate CPT code(s) for pending procedure(s) on the line provided. If beneficiary is immediately post-operative, estimate duration of time necessary for recovery under your supervision in box 12.

Item 13-I (and all box 14 ICD codes)

The ICD-9 code must be listed in box 14, and the treatment must be stated on the line provided.
Please check this item if beneficiary has a complex and/or progressive disorder not covered above which requires ongoing medical supervision, such as:

- Cardiomyopathy
- Amyotrophic lateral sclerosis and/or has been approved for or is receiving ongoing complex medical treatment for the disorder, the administration of which cannot be interrupted

Part II Continued

For state use only		14. ICD-9 Codes
C	❑ E. Undergoing one of two cancer classifications (see item 13-E on the reverse side). Classification: _____ Type of Therapy: _____	1. 2.
G	❑ F. Has been approved for and is awaiting a major surgical procedure (see item 13-F on the reverse side). CPT code(s) for pending procedure(s): _____	1. 2.
A	❑ G. Has a complex neurological disorder, such as multiple sclerosis	1. 2.
B	❑ H. Has a complex hematological disorder, such as hemophilia or sickle cell disease	1. 2.
M	❑ I. Has other complex and/or progressive disorder not covered above which requires ongoing medical supervision (See item 13-I on the reverse side). Describe treatment: _____	1. 2.

Please note that chronic disorders, such as asthma and diabetes, do not generally constitute grounds for approval as a medical exemption. Providers who believe that the severity of such a condition, or any other condition or combination of conditions, is/are sufficient to require a medical exemption should attach to this form additional medical documentation to establish the necessity for an exemption. Please include the beneficiary's Medi-Cal identification number and Benefits Identification Card Number on each page of medical doumentation submitted.

15. Beneficiary's Benefits Identification Card Number

_____

16. Are you affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence?

☐ Yes _____
Print the name of health plan

☐ No

17. Physician National Provider Identication Number used to bill the Medi-Cal Program for this beneficiary:

_____

18. Medi-Cal Provider:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

19. Medi-Cal Billing Information: (If different from box 18 above.)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

I have read this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Care Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care health plan(s) and/or to determine whether the Medi-Cal beneficiary's listed medical condition constitutes grounds for a medical exemption.

20. Rendering Physician's Medical License Number:

21. If you are NOT affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence, you MUST complete this box. If you are affiliated with any Medi-Cal Managed Care health plan(s) in the beneficiary's county of residence, please make sure boxes 18 and 19 are complete.

Rendering Physician's Phone number: _____ FAX: _____

22. Signature: (No Stamp) _____
(Authorized Rendering Medical Physician)

23. Date Signed: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

MAIL COMPLETED FORM to: Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

or FAX this form to:
(916) 364-0287

INSTRUCTIONS FOR COMPLETING REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

PART I – To Be Completed and Signed By Beneficiary

Dear Medi-Cal Beneficiary: You and/or your family is now or may soon be required to receive your health care through a Medi-Cal Managed Care health plan. You may be seeing a doctor who is not part of a health plan. If you want to keep seeing this doctor, you may qualify for what is called a **medical exemption.** To receive a **medical exemption,** you must be seeing your doctor for something serious, and your doctor must NOT be a part of a health plan in the county where you live.

If you want to ask for a **medical exemption**, you must fill out Part I of this form. Please sign it and give it to your doctor. Your doctor will fill out and sign Part II of this form. If your request for a **medical exemption** is approved, you will NOT have to join a Medi-Cal Managed Care health plan for the time being. You can remain on regular Medi-Cal (non-managed care) and keep seeing your current doctor for up to 12 months. (In some cases, the exemption will be for fewer months. Your doctor will decide this). If you need another medical exemption after your exemption period is over, you and your doctor must fill out and sign a new exemption form.

All information in this medical exemption form will be kept confidential. This information will only be used by the Medi-Cal program, its employees, and contractors.

If you have any questions regarding this form, please call Health Care Options at (800) 430-4263.

INSTRUCCIONES PARA COMPLETAR LA CERTIFICACION DE EXENCION DE ATENCION MEDICA DE LOS PLANES ADMINISTRADOS DE MEDI-CAL

Primera Parte - Para Ser Completado y Firmado Por el Benificiario.

Estimado Benificiario de Medi-Cal : Usted o su familia estan ahora o pueden requerirse que pronto recivan su cuidado de salud a través de un plan de Medi-Cal por Managed Care. Usted puede estar viendo a un doctor que no es parte de un plan de salud. Si usted quiere seguir viendo a este doctor, usted puede calificar para lo que se llama una exención médica. Al recievir una exención médica, usted debe estar viendo a su doctor para algo serio, y su doctor no debe de participar en uno de los planes de Managed Care en el condado donde usted vive.

Si usted quiere pedir una exención médica, usted debe completar la primera parte de esta forma. Por favor fírmelo y déselo a su doctor. Su doctor completara la segunda parte de esta forma. Si su peticion para una exención médica es aprovada, usted no tendrá que afiliarse en un plan de Medi-Cal Managed Care por el momento. Usted puede permanecer en Medi-Cal regular (sin plan de salud) y seguir viendo a su actual doctor hasta por 12 meses. (En algunos casos, la exención sera por menos meses. Su doctor decidirá esto.) Si usted necesita otra exención médica después de que su periodo de la exención haya terminado, usted y su doctor deben completar y firmar una nueva forma de exención.

Nos gustaria informarle que toda la información en esta forma de la exención médica se mantendra confidencial. Esta información sólo será usada por el programa de Medi-Cal, sus empleados, y contratistas.

Para mas informacion por favor llame a Health Care Options al (800) 430-3003 esta llamada es completamente gratis.