Washington State Health Care Authority

Maternity Support Services (MSS) and Infant Case Management (ICM)

Limitation Extension Request

Please see instructions for completing this form on next page.

Client information	
1. Mother's name	2. Mother's EDD
3. Infant's name	4. Infant's DOB
Background information	
5. How many MSS or ICM units have been used to date?	
6. List other programs, agencies, and/or community resources this family is currently involved with (WIC, HeadStart, medical care, home visiting services, etc.):	
7. Additional risk factors or issues we should be aware of when reviewing this request:	
8. Describe interventions provided and/or actions taken through MSS or ICM services to date to address identified risk factors and client needs:	
9. Describe changes in client status or condition related to risk factor(s) since beginning services:	
10. What interventions and/or actions will be taken if additional units are approved? How will this move the client toward the goal of a healthy birth outcome if MSS, or improved welfare of the infant if ICM?	

A **typed** and completed General Authorization for Information form (HCA 13-835) must be attached as the first page of your request, along with this form, complete chart notes, care plan(s), and screening tool(s) in order to be processed by the Health Care Authority.

Fax to: **1-866-668-1214** Or mail to: Health Care Authority
P.O. Box 45535
Olympia WA 98504-5535

For inquiries, please call the Medical Assistance Customer Service Center at **1-800-562-3022** or **360-725-1293**.

Completing this form

- Make sure all boxes on page one of this form are completed and legible.
- You must submit the appropriate screening tool(s), good quality supporting documentation - including chart notes and the client's care plan with your faxed request. The person reviewing this document does not know the circumstances surrounding the client. Create a compelling reason for the reviewer to approve the request for additional units.
- If more space is needed to complete any section on page one, submit on a separate sheet of paper. Clearly identify which question you are answering.
- What outcomes are you and the client working toward? What interventions and/or actions will be taken with the additional units requested to move in that direction?
- If the department does not receive adequate information to make a determination, additional information will be requested. This will increase the amount of time it takes to process the decision.

Instructions for completing this form: The following is additional information for each box on this form:

1. Self explanatory.
2. Enter mother's Estimated Delivery Date (EDD).
3. Complete only if this is for an ICM limitation extension request.
4. If infant is born, enter Date of Birth (DOB).
5. Depending on which program additional units are needed, enter in the total number of MSS or ICM units used to date.
6. If you need additional space, use a separate sheet of paper.
7. Use this space to state risk factors not listed on the screening tool. List additional issues that will help justify approval of this request.
8. This box should contain details of actions taken to reduce the negative impact of identified risk factors by the MSS/ICM agency throughout the time the agency provided MSS/ICM services.
9. If status or condition improved, tell how. If condition remained the same, explain why you think it didn't improve. If the status or condition worsened, please tell why you believe this happened.
10. Actions and/or interventions by both the MSS/ICM provider and client should be listed here. Use additional paper if more space is needed.

WAC 182-501-0169 Healthcare coverage – Limitation extension