

Exception Review Request

To:	California Choice Exception Review Team	Phone:	800-558-8003
		Fax:	714-347-3899
		Email:	customerservice@calchoice.com

Group Name:		Phone#:	
Group#*:		Fax#:	

*Required fields must be completed for review

Our group is requesting the following exception for review for the following employee(s) *:

1. _____ 2. _____ 3. _____

Indicate type of Exception Request*	Submit Applicable Supporting Documentation with this Request*
<input type="radio"/> Loss of Coverage	<ul style="list-style-type: none"> • Employee Application and one of the following: <ul style="list-style-type: none"> ○ Copy of ID card for all participants or carrier bill listing all participants enrolling due to loss of coverage accompanied with a written letter from the member stating when the loss of coverage occurred and that it was beyond their control ○ Cobra offering paperwork (must include names of all previously covered participants requesting to enroll). ○ HIPAA Certificates or letters from a carrier of all previously covered participants requesting to enroll
<input type="radio"/> Addition of an Employee	<ul style="list-style-type: none"> • Employee Application
<input type="radio"/> Gaining or becoming a Dependent	<ul style="list-style-type: none"> • Employee Change Request Form AND one of the following: <ul style="list-style-type: none"> ○ Birth Certificate or Letter from medical center showing proof of birth ○ Adoption papers or Proof of Placement for adoption ○ Evidence of proof from a court, department of Social Services, or other agency that you have the legal right to make medical decisions for a child in foster care. ○ Marriage License or Proof of Domestic Partnership
<input type="radio"/> Plan Correction	<ul style="list-style-type: none"> • Employee Change Request Form • Proof of loss of Primary Care Physician
<input type="radio"/> Correction of Employee Date of Hire	<ul style="list-style-type: none"> • Complete Payroll ledgers from previous date of hire to new date of hire
<input type="radio"/> Termination of an Employee	<ul style="list-style-type: none"> • Employee Termination form

Please provide a brief explanation for why the request was not submitted to California Choice within the policy guidelines: *

We understand and attest to the following:

- The exception request and supporting documentation is subject to review by California Choice and/or the carrier and is not guaranteed to be approved.
- The group is responsible and liable for any retroactive premiums and/or claims that may be incurred as a result of the change being requested should it be approved.
- Additional support documentation may be required based on documents received above.
- If approved, the effective date of the request will be based on the initial eligibility enrollment date unless otherwise stated in the approval.

Print Authorized Contact Name*

Signature*

Date*