RATE CONSIDERATION REQUEST

This form is to be used when a provider would like Alliance Health to consider a change to an Individual specific rate for the service previously approved. This form is to be used in conjunction with the enhanced Rate Budget form listed on our website at http://www.alliancebhc.org/providers/finance-and-claims-forms. Please email this form along with the Enhanced Rate Budget form* to the Rate Request address RRequest@alliancebhc.org and CC the Care Coordinator. *please keep form in excel format

Request Type (Please check one)

☐ 1:1 staffing ☐ 2:1 staffing

☐ Higher Credential ☐ Other

Funding Source (Please check applicable)

☐ Medicaid ☐ Non-Medicaid

Disability (Please check applicable)

☐ Mental Health ☐ Intellectual/Developmental Disabilities ☐ Substance Use ☐ Traumatic Brain Injury

Reason for request

☐ Behavioral Support

☐ Behavioral Support Plan ☐ Physical Aggression ☐ Self Injurious Behaviors ☐ Eloping/ Running Away

☐ Sexual Inappropriateness ☐ Restrictive Interventions ☐ Recently Discharged from Facility ☐ Pica

☐ Suicidal/ Homicidal Ideation ☐ Property Destruction ☐ Sleep Disturbances ☐ Recent Medication Change

☐ Medical Support

☐ Oxygen Treatment ☐ Injections ☐ Wound Care ☐ Turning/ Positioning ☐ Sleep Disturbances

☐ Incontinence ☐ Ambulation Support ☐ Frequent Seizure Care ☐ Feeding Tube/ Dietary Support

☐ Recently Discharged from Facility ☐ Recent Medication Change ☐ Lifts/ Transfers

☐ Higher credential/ Enhanced training

☐ RN ☐ LPN ☐ QP ☐ RBT ☐ CBIS ☐ Licensed Mental Health Professional

☐ Other (if your needs cannot be captured above, please describe below)

Is the individual authorized for the service? ☐ Yes ☐ No

Are there other services or funding sources that can fund the support requested (Medicare, private insurance, etc.)?
☐ Yes ☐ No

Provider Name:	
Service Address:	
Contact Name and Title:	
Contact Number:	
Contact Email Address:	
Service\Code for review:	
Consumer Name and DOB	
Rate request ($ amount):	
Effective dates:	Begin Date: _____End Date: _____

*Programmatic rate requests are not being accepted at this time

_____ _____ _____
Signature Printed Name Date

For Internal Use Only ☐ Approved* ☐ Denied
Approved Decision/Reason for Denial:

☐ • Additional/enhanced good or service proposed to be funded by non-standard rate conflicts with definition or requirements of service and/or funding source (e.g. Medicaid).
☐ • Description of member and current circumstances are inconsistent with information in the Alliance medical record for this member.
☐ • Additional/enhanced good or service proposed to be funded by non-standard rate is/are potentially available through another service or funding source for which the member is eligible.

Signature: _____ Date: _____

If your request for a non-standard rate was denied and you feel the member you support has needs that could potentially be met through another service or funding source, we recommend speaking with the member's care coordinator or Alliance Utilization Management Department.

Copy: Requestor, IDD Clinical Director, Director of UM, and Care Coordinator
**This request may be subject to a contract amendment*

If you disagree with our decision, you may file a grievance with us. Please direct the grievance to:

Alliance Health
Attn: Access Department
5200 W. Paramount Pkwy, Suite 200
Morrisville, NC 27560
(800) 510-9132

You may file a grievance by phone, in person or in writing. For more information on the grievance process, please contact (800) 510-9132.