TEXAS Health and Human Services | Texas Department of State Health Services

NEWBORN SCREENING BENEFITS WAIVER OF INELIGIBILITY FORM

According to *Texas Administrative Code, Title 25, §37.61*; an individual is not eligible to receive the benefits described in §37.60 of this title if the individual or the parent, managing conservator, or legal guardian is eligible for some other benefit, such as Medicaid, CSHCN Services Program, CHIP, or private insurance, that would pay for all or part of the services in question.

Individuals who are covered **by Medicaid, CHIP, CSHCN or Private Health Insurance** may apply for a waiver of ineligibility if the other medical program denies coverage for a benefit or service that may be otherwise covered by NBS Benefits. The contractor must first confirm the denial by the other programs. Only after the coverage is denied can the individual apply for the waiver.

Identify the applicant's current coverage:

Applicant Name:_____ DOB:_____

Medicaid/Medicare: ☐ YES ☐ NO If yes, list ID #_____

CHIP: ☐ YES ☐ NO If yes, list ID #_____

CSHCN: ☐ YES ☐ NO ☐ Wait list If yes, list ID #_____

Private Insurance? ☐ YES ☐ NO Name of Insurance:_____

Provide a brief statement indicating the above program's response in regards to the product(s)/service(s) that are not covered. (Include any written response from client's current coverage provider if applicable.)

_____

List the prescribed item(s)/service(s) denied by the above programs/private insurance:

_____

This waiver is being requested after finding that the insurance carrier/benefits program listed above does not cover or has denied coverage of the products/services listed. This has been verified by reviewing the formulary provided on the carrier/program website or by the prescription being denied by the carrier. The formulary does not provide an acceptable alternative for these products, per the medical provider. I declare these statements to be true to the best of my knowledge.

Contracted Provider Dietitian's Printed Name:_____

Above Dietitian's Signature:_____ Date:_____

This form must be submitted with the completed
NBS Benefits PRESCRIPTION REQUEST FORM. Fax or e-mail to NBS Benefits:
Fax: (512) 776-7593 E-mail: NBSBenefits@dshs.texas.gov
Attn: NBS Program Benefits