DDAP-EFM-1303 Rev. 1-19

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

Request for Liability Reduction or Elimination Form

One Penn Center, 5th Floor
2601 N. 3rd Street
Harrisburg, PA 17110
Email: RA-DA_GAMBLING@pa.gov
Ph: 717-783-8200 Fax: 717-787-6285

Provider/Agency Name: _____

Client ID#: _____ Date: _____

PART 1. INSURANCE INFORMATION

Do you have insurance (private and/or public) coverage? ☐ Yes ☐ No

If insurance denied payment, indicate the date and reason for denial:

If client has a deductible or is unable to pay their copay please complete the following information:

Insurance Company	Insured Person (self or other)	Group/ ID #	Copay Amount	Deductible (Medical Expenses Already Applied)

PART 2. CLIENT ATTESTATION OF INSURANCE DEDUCTIBLE FOR MEDICAL EXPENSES

Please Note: You MUST Redact Client Signature Prior to Submission

I am requesting an adjustment to my liability for the following reason(s):

_____ _____

Client Signature Date

PART 3. AGENCY REQUEST

I request that the liability be: ☐ Abated in Full

☐ Modified to: Client responsibility: DDAP responsibility:

The abatement is being requested due to: ☐ Clinical Reasons ☐ Substantial Financial Hardship

Description of reason (be specific):

☐ I certify that to the best of my knowledge and belief, the imposition of the assessed liability would likely negate the effectiveness of treatment, or prohibit the client's access to, or continuation of, treatment and failure to provide such treatment would result in serious harm to the client's access to, or continuation of, treatment and failure to provide such treatment would result in serious harm to the client's welfare or greater cost to the Commonwealth due to deterioration in the client's condition.

_____ _____

Provider Signature Date

DEPARTMENT OF DRUG & ALCOHOL PROGRAMS USE ONLY

☐ Approved

☐ Denied

_____ _____

DDAP Authorized Signature Effective Date

_____ _____

DDAP Authorized Signature Effective Date