

**WHA Medical/Benefit Policy Interpretation Inquiry
(Attachment A)**

Expedited Request

Requested Service: _____ Date of Request: _____

Reason for Inquiry: (e.g., appears not to be a benefit, possible experimental, EOC language is silent, etc.) _____

References: (EOC, policy manual, etc.) _____

Current Policy: (Site sources and attach copies if available) _____

Inquirer's Comments: _____

Submitted by: _____ Phone Number: _____

WHA's Response: _____

Source used for response: _____

Date of Action: _____ Signature: _____

Distribution: Delegated Medical Groups () Permanent Files () Date: _____

[Internal Use Only]

Benefit Matrix update () Modify policy () Create a new policy () Effective date: _____