

# Chapter 12c: Discrimination—Treatment Protocol Supporting Documentation and Justification

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Please fill in the following information. Use one form for each deficiency identified in the Treatment Protocol Calculator review.

**Date:** \_\_\_\_\_

**Health Insurance Oversight System (HIOS) Issuer ID:** \_\_\_\_\_

**State:** \_\_\_\_\_

**HIOS Plan IDs:** \_\_\_\_\_

\_\_\_\_\_

**Medical Condition:** \_\_\_\_\_

**Justification for Benefit Design:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you do not have enough space here to list your justifications, print out another form to augment them as needed.