Dental Benefit Limit Exception Request Form

Failure to legibly complete all fields will result in this form being returned.
This form must be attached to a completed ADA dental claim form.

Please Print:

Recipient Last Name: _____ First Name: _____

Recipient 10-digit MA ID#: _____ Recipient Date of Birth: _____

Provider Last Name: _____ First Name: _____

Provider MA 13-digit ID#: _____ NPI #: _____

Provider Telephone Number: Area Code _____ Phone: _____

Benefit Exception Request Type: ☐ Prospective ☐ Retrospective - Dates of Service: _____

Benefit Limit Criteria to be reviewed (Check all that apply):

☐ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the recipient.

☐ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the recipient.

☐ Granting the exception is a cost-effective alternative for the MA Program.

☐ Granting the exception is necessary in order to comply with Federal law.

This request must include documentation supporting the need for the service, including but not limited to chart documentation, diagnostic study results, radiographs (if applicable), medical and dental history.

Explain below why the patient meets the criteria for a benefit limit exception. The explanation should be in narrative form and include a comprehensive justification (attach additional pages as necessary).

_____

_____

_____

_____

The department will notify the provider and recipient of its decision within 21 days after receiving a prospective BLE request, or within 30 days after receipt of a retrospective BLE request. A retrospective request for an exception must be submitted no later than 60 days from the date the Department rejects the claim because the service is over the benefit limit. Retrospective exception requests made after 60 days from the claim rejection date will be denied.

I attest that the information provided and statements made herein are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider Signature: _____ Date: _____

Mail to: DHS/Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs
Dental Benefit Exception Review
P.O. Box 8187
Harrisburg, PA 17105-8187