

AmeriHealth Caritas Pennsylvania 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 and accompanied by documentation supporting the need for the service, including but not limited to chart documentation, diagnostic study results, radiographs (if applicable), and dental history, as well as any applicable medical records that document the existence of conditions meeting benefit limit criteria. If you check one of the five health conditions below, you do not need to submit supporting documentation from a physician as the Plan will review the beneficiary's claim history for verification of the condition. If no claim history exists for one of the five health conditions, you will receive a request from the MCO to supply documentation from the Beneficiary's physician for verification purposes.

Please Print:

Member Last Name: _____ Members First Name: _____
Member ID Number: _____ Member Date of Birth: _____
Provider Last Name: _____ Provider First Name: _____
Provider MA 13-digit ID#: _____ Provider NPI#: _____
Provider Telephone Number: Area Code: _____ Phone: _____

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

Does the beneficiary have any of the following conditions? (Check all that apply):

Diabetes

Coronary Artery Disease or risk factors for the disease

Cancer of the Face, Neck, and Throat (not including Stage 0 or 1 invasive sarcoma or basal cell cancers of the skin)

Intellectual Disability

Current Pregnancy including post-partum period

Other: _____

If you checked **other** above and indicate a condition that is not listed, then explain below why the beneficiary meets the criteria for a benefit limit exception. The request explanation should be in narrative form and include a comprehensive justification as well as any supporting documentation from a physician verifying the condition. (attach additional pages as necessary).

This Benefit Limit Exception request meets one or more of the following criteria:

1. Beneficiary has a serious chronic systemic illness or other serious health condition, and denial of the exception will jeopardize the life of the beneficiary.
2. Beneficiary 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 beneficiary.
3. Granting the exception is a cost-effective alternative for AmeriHealth Caritas Pennsylvania.
4. Granting the exception is necessary in order to comply with Federal law.

AmeriHealth Caritas Pennsylvania will notify the provider and beneficiary of its decision within 21 days after receiving a prospective benefit limit exception request, or within 30 days after receipt of a retrospective benefit limit exception request. A retrospective request for an exception must be submitted no later than 60 days from the date AmeriHealth Caritas Pennsylvania 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: Request for Benefit Limit Exception
AmeriHealth Caritas Pennsylvania c/o DentaQuest — Authorizations
P.O. Box 2906
Milwaukee, WI 53201-2906

