Dental Benefit Limit Exception Request Form – Instructions for Completion

To avoid returned forms:
- ✓ All fields must be completed (including the narrative section)
- ✓ Provide all supporting required documentation
- ✓ Attach a completed ADA dental claim form
- ✓ Sign and date

Documentation required:
- ✓ **The request must include documentation from the patient's primary care or specialty care physician supporting the need for the exception, e.g., medical/dental history, chart documentation, diagnostic study results, radiographs (if applicable), etc.**

Mail to:
Request for Benefit Limit Exception
Keystone First
PO Box 2083
Milwaukee, WI 53201

Questions:
- ✓ Contact Provider Services at 1-877-408-0878

Dental Benefit Limit Exception Request Form

Failure to legibly complete all fields <u>and</u> provide required documentation will result in this form being returned.
This form must be attached to a completed ADA dental claim form.

<u>**Please Print**</u>:

Member Last Name: _____   First Name: _____

Member KMHP ID#: _____   Recipient Date of Birth: _____

Provider Last Name: _____   First Name: _____

Provider KMHP 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 Plan.

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

Benefit Limit Exception Request for Periodontal Services Only
☐ Patient is pregnant, has diabetes or has coronary artery disease and meets clinical dental criteria for ***periodontal services*** included in the Plan's benefit program.

> **This request must include documentation from the patient's primary care or specialty care physician 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).

_____

_____

_____

A BLE requested before the dental service begins, will receive an answer, or a request for additional information to be provided, within 21 business days of receipt of the request. When additional information is required and received, the exception request will be approved or denied within 21 business days after receipt of the information.   BLE retrospective requests must be submitted no later than 60 days from the date the claim was rejected and will be answered within 30 days. 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, Keystone First, PO Box 2083, Milwaukee, WI 53201   04/2013