Dental Benefit Limit Exception (BLE) Request Form

AmeriHealth Caritas Pennsylvania

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

Please print

Member information
Last name:
First name:
Date of birth (mm/dd/yyyy):
Member ID number:
Phone:

Provider information
Last name:
First name:
NPI number:
AmeriHealth Caritas ID number:
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 patient.

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

☐ Granting the exception is a cost-effective alternative for AmeriHealth Caritas Pennsylvania.

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

☐ Patient does not meet any of the benefit limit exception criteria.

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 AmeriHealth Caritas Pennsylvania's benefit program.

This request must include documentation from the patient's primary care practitioner or specialty care physician supporting the need for the service, including but not limited to chart documentation, diagnostic study results, radiographs (if applicable), and 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 if necessary).

_____

_____

A BLE requested before the dental service begins will receive an answer, or receive a request for additional information, within 21 business days of our receipt of the request. When additional information is required and received, the exception request will be approved or denied within 21 business days after our 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 on or after the 61st day 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
P.O. Box 654
Milwaukee, WI 53201