## **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 Date of Birth:  First Name:
Recipient 10-digit MA ID#:Provider Last Name:	
Provider Telephone Number: Area Code Phone: _	
Benefit Exception Request Type: Prospective Retrospective	ve - Dates of Service:
Benefit Limit Criteria to be reviewed (Check all that apply):	
Patient has a serious chronic systemic illness or other serious h the life of the recipient.	ealth condition and denial of the exception will jeopardize
Patient has a serious chronic systemic illness or other serious he serious deterioration of the health of the recipient.	alth condition and denial of the exception will result in the
Granting the exception is a cost-effective alternative for the MA F	Program.
Granting the exception is necessary in order to comply with Fede	ral law.
This request must include documentation supporting the need for the diagnostic study results, radiographs (if applicable), medical and den	
Explain below why the patient meets the criteria for a benefit limit exinclude a comprehensive justification (attach additional pages as necessary)	
The department will notify the provider and recipient of its decision within 30 days after receipt of a retrospective BLE request. A retrospethan 60 days from the date the Department rejects the claim because trequests made after 60 days from the claim rejection date will be deni	ective request for an exception must be submitted no later the service is over the benefit limit. Retrospective exception
I attest that the information provided and statements made herein are and I understand that any falsification, omission, or concealment of	
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