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:

Gateway Member's Last Name: _____ First Name: _____

Gateway ID# _____ Member's Date of Birth: _____

Provider Last Name: _____ First Name: _____

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

Provider Telephone Number: Area Code: _____ Phone: _____

Benefit 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.
☐ Patient has a pregnancy diagnosis.
☐ Granting the exception is a cost-effective alternative for the MA Program.
☐ Granting the exception is necessary in order to comply with Federal law.
☐ Patient does not meet any of the above criteria for exception.

This request must include documentation supporting the need for the service, including but not limited to chart documentation, pregnancy diagnosis (if applicable), 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).

_____

_____

_____

_____

Gateway 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 Gateway 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.
I have informed the patient to expect a denial if the shaded box above is selected. I further informed the patient that services will only be provided after the Gateway denial when the patient becomes financially liable for the service.

Provider Signature: _____ Date: _____

Gateway Health
A better way.℠

Mail to: Scion Dental
Benefit Limit Exception
P. O. Box 2190
Milwaukee, WI 53201