Dental Benefit Limit Exception (BLE) Request Form

This form must be attached to a completed ADA dental claim form. All fields must be legibly completed, and all required documentation provided.

AmeriHealth Caritas Pennsylvania

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 or do not check any boxes if none 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.

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).

AmeriHealth Caritas Pennsylvania will notify the provider and recipient of its decision within 21 days of our receipt of the request or within 30 days after receipt of a retrospective 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 AmeriHealth Caritas Pennsylvania rejects the claim because the service is over the benefit limit. 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
c/o DentaQuest — Authorizations
P.O. Box 2906
Milwaukee, WI 53201-2906