

Benefit Exception Inquiry (BEI) form

Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO), Medica Choice CareSM (Minnesota Senior Care Plus, or MSC+) and Medica AccessAbility Solution® (Special Needs Basic Care, or SNBC/SNBC Enhanced)

Please fax completed forms and supporting documentation to: **952-992-2589**

**Section 1 Member & care coordinator Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **1. Date of member inquiry:** (Date of inquiry starts the 14-day turn-around timeline. If resubmitting, please update the inquiry date) | | | | | |
| **2. Member name:** |  | | | **3. Member DOB:** |  |
| **4. Member address:** |  | | | **5. Member Medica ID Number:** |  |
| **6. Product:** | MSHO  MSC+  SNBC   SNBC Enhanced | | | | |
| **7. If MSHO/MSC+: wavier and case mix information:** | EW non-EW CADI  other Case mix:       Case mix cap: | | | | |
| **8. If AccessAbility SNBC, waiver status:** | NA, not on waiver program OR CADI BI CAC DD  Date the member will be or was last screened for the waiver.  Notes: | | | | |
| **9. Name of care coordinator (CC)** |  | | | **10. Delegate Name:** |  |
| **11. CC phone number:** |  | | **12. CC email:** |  | |
| **13. CC fax number:** |  | | **14. PCA Out of Network (OON) Requests – OON PCA agency email address and NPI or TIN #** | | |
| **15. BEI reviewed with Supervisor:** | **Y** | **16. Supervisor’s email:** |  | | |
| **17. Primary Care Physician:** |  | | | | |
| **18. Primary Care Clinic name:** |  | | | | |
| **19. Primary Care Clinic address:** |  | | | | |
| **20. Primary Care Clinic Fax:** |  | | | | |

**Section 2 Service information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Service/item description/code | 2. Provider name/address/phone/fax number | 3. Units (hrs./days/weeks/months) | 4. Duration of service span  (start date/end date) | 5. Cost |
|  |  |  |  |  |
|  |  |  |  |  |

**6. Primary diagnosis related to request (include code description):**

**7**. **Rationale to support the need for requested item/service (do not refer to documents, provide a summary of the need):**

**8. Alternative resources CC has researched/attempted (be descriptive: ex. loan closets, private funds, friend/family, non-profit community organizations, informal supports** **etc):**

**9. If member has been receiving the service or item requested, how has this been provided and/or paid for?**

**Section 3 Additional Documentation:**

**1. Required Documents attached to support need/request (check all that apply):**

EW case mix cost cap tool *(required if member is on EW)*

Current service plan – *(required for all requests)*

Physical/Occupational/Speech therapy notes if applicable

Durable Medical Equipment (DME) description of item if applicable

Eye Kraft Cost Sheet (*required if submitting BEI for eyewear)*

Physician notes – *(****A prescription alone, cannot be submitted as documentation)***

Other

**NOTE: When submitting supporting documentation please refrain from sending in numerous pages of documentation not relevant to the request and/or highlight/call out the areas within the documentation that support the need requested.**

Suggested Resources:

Customer service, DME grid, DME provider, waiver worker, MHCP Manual, CBSM Manual, CMS – medicare.gov, mnhelp.info

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