Benefit Exception Inquiry Form Instructions

General Instructions:
Medica allows flexibility in benefits provided for Special Needs Products. It is our policy to administer these benefits equitably. Use the Benefit Exception Inquiry (BEI) form to:

- Request a service/item outside of the standard benefit set covered by the product (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]).
- Request to exceed Department of Human Services (DHS) case mix cap for MSHO/MSC+ Elderly Waiver (EW) members

Please fax completed form to 952-992-2589 along with all supporting documentation (ie: therapy evaluations, physician documentation, EW case mix cap tool, etc.). A reply will be given in 14 calendar days via email or phone. If BEI does not include sufficient information, it will be returned to the care coordinator (CC) or rejected for “lack of information”.

Note: If the request is to see an out of network provider, the provider must follow the prior authorization process available on Medica.com; using the Provider tab and clicking on “Policies and Guidelines”, then selecting “UM Policies and Prior Authorizations”. The "Prior Authorization Request Form for Out of Network Provider" will be found under the “Prior Authorizations” link.

Urgent Requests: Urgent request can be submitted when they relate to immediate health and safety concerns of the member. If the member is experiencing a medical emergency, please call 911. Transportation requests are not considered urgent. Also not considered urgent is a BEI that was not sent in timely.

Section 1 Member & Care Coordinator Information:

1. Date of inquiry: THIS IS DAY ONE of 14 – please fax in ASAP)
   a. This area should be completed for all BEI Requests
2. Member Name: member’s legal first and last name
3. DOB: member date of birth in MM/DD/YYYY format
4. Current ID#: Medica’s 16 digit ID number to be entered
5. Product: indicate by checking the box next to the appropriate product
6. MSHO/MSC+ EW Case Mix: Please provide current cased mix and cap
7. AccessAbility/SNBC Waiver Status: Please provide type of waiver member is utilizing, or date member applied and was denied or if member wait listed
8. Entity providing care coordination: List the name of the county/agency or care system member is currently managed by
9. Care Coordinator: fill in full name of CC
10. Phone: enter 10 digit phone number (include extension if applicable)
11. Care Coordinator e-mail address: fill in full CC email address
12. Primary PCP: fill in the name of the members Primary Care Physician (PCP)
13. Clinic Name: provide the name of the clinic the PCP practices from
14. Clinic Phone: provide the PCP clinic phone number
Section 2: Service information:

1. **Item/Service for Consideration**: Indicate the service being requested:
2. **Name of Provider of the Requested Item/Service**: Indicate who will be providing the service/item
3. **Frequency & duration of item**: indicate the frequency and duration of the service/item being requested.
4. **Cost**: please indicate the cost of the service/item, or if request is to exceed cap the additional cost.
5. **Primary Diagnosis**: Please include description, not just codes
6. **Diagnosis related to need**: Please include description, not just codes
7. **Rationale to support requested item/service**: If the BEI does not include sufficient information, it will be returned to the care coordinator or rejected for “lack of information”.
8. **Alternative resources CC has researched/attempted (ex. loan closets, private funds, etc.)**: Please list alternative resources
9. **Current services member receives**: please list or attach a copy of the current service agreement/care plan

Section 3: Additional Documentation:

1. **MSHO/MSC+ EW Members Budget Cap**: Indicate If on EW does the request fit within the members DHS case mix cap
2. **AccessAbility/SNBC Members Waiver Screening**: Date the member will be, or was last screened for the waiver
   a. Requests for waivered service will not be considered without a screening date & notes
3. **Documents attached to support need**: Please check all that apply
   a. Note: A script from a physician is not sufficient documentation without supporting physician notes

After this request has been reviewed by the BEI team at Medica, the care coordinator will receive a communication back regarding the status of the request.

- If approved, a referral will be entered into Medica’s system and the care coordinator can proceed.
- If the request has not been approved the care coordinators next step will be to speak with the member regarding the inquiry. If member accepts the decision, no DTR (Denial/Termination/Reduction) is needed. If member does not accept the decision, the care coordinator is to complete the DTR form immediately and send into Medica using the DTR fax cover sheet. Both the DTR form and DTR fax cover sheet are found on the Medica.com care coordinator site.

For the most current and up to date information and forms, please visit [www.medica.com/carecoordination](http://www.medica.com/carecoordination)