**MSHO/MSC+ Benefit Exception Inquiry**

Instructions: Use this inquiry form when requesting an exception to a service or item outside the standard benefit set or when the service plan will exceed the case mix budget cap. Be as specific as possible to avoid a return request for additional information.

Complete one Benefit Exception Inquiry form per service or item. All sections must be completed. Return via email at: [hp\_mshomsc\_cc@HealthPartners.Com](mailto:hp_mshomsc_cc@HealthPartners.Com)or fax at 952-883-9764. Requests for waivered services will not be considered without screening dates & notes.

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| **Member & Care Coordinator Information**  Date of Request (MM/DD/YY):       (If this is Day 1 or 14 – please fax in ASAP)  HealthPartners Member ID:  Member Last Name:  Member First Name:  DOB: (MM/DD/YY):  Program:  MSHO Rate Cell A  MSHO Rate Cell B  MSC+ Rate Cell A  MSC+ Rate Cell B  Entity Providing Care Coordination:  Care Coordinator (CC) Name:  CC Phone:  CC Email:  Primary Care Physician:  Clinic Name:  Clinic Phone:  Case Mix & Cap (or attach current budget worksheet): |
| **Service Information**  Item/Service for Consideration:  Service Request Type:  Ongoing Service Request  New Service Request  Authorization Expiration Date (MM/DD/YY):  Service Provider Name:  Tax ID:  Phone #:  Fax #:  Amount of Units:  Frequency:  Duration of item:  HPCP Code:  Total Cost:  Requested Start Date: |
| **Service Information Continued**  Primary Diagnosis (include description and ICD-10 code(s):  Rationale to support requested item/service:  Alternative resources CC has researched/attempted:  Quasi formal services:  Informal services:  Other:  List current services member receives (or attach current budget worksheet with all services listed): |
| **Additional Documentation**  Member’s waiver screening date (MM/DD/YY)  *(Date the member will be, or last was, screened for the waiver)*  Notes:  *(Requests for waivered services will not be considered without screening dates & notes.)*  Documents attached to support need (check all that apply):  Current finding from HRA  Physical/Occupational/Speech/Respiratory Therapy Notes  Durable Medical Equipment (DME) Description of Item  Physician Notes  Other  Note: A prescription from a physician is not sufficient documentation without supporting physician notes. |
| **Outcome**  Service Approved  Start Date (MM/DD/YY):       End Date (MM/DD/YY):  Service Not Approved  Member in Agreement – No need to return form to HealthPartners  Member in Disagreement – Return to HealthPartners for issuance of DTR |
| Date:  Care Coordinator Signature        Date:  HealthPartners MSHO/MSC+ Supervisor Signature |