**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.Comor 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 RequestAuthorization 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 ApprovedStart 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 |