SKYGEN/Pennsylvania Plans Dental Benefit Limit Exception (BLE) Request Form

Failure to complete this form in its entirety will result in this form being returned unprocessed. This form must be attached to a completed ADA dental claim form and mailed to:
SKYGEN Attention: UPMC Health Plan BLE Authorizations, *P.O. Box 351 Milwaukee WI 53201*

Member Last Name_____ First Name_____

Member ID Number_____ Member Date of Birth_____

Provider Last Name_____ First Name _____

Provider NPI #_____ Provider Telephone (___)_____

Benefit Request Type ☐ Prospective ☐ Retrospective - Date(s) of Service _____

Benefit Limit Criteria to be reviewed (check all that apply):

☐ Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member.

☐ Member has a serious chronic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the Member.

☐ Granting the exception is a cost - effective alternative for Plan.

☐ Granting the exception is necessary in order to comply with Federal law.

This request must include documentation supporting the need for the service, including but not limited to chart documentation to include a treatment plan, radiographs (if applicable), and medical and dental history.

Explain why the Member meets criteria for a benefit limit exception in the space below. The explanation should be in narrative form and include a comprehensive justification (attach additional pages as necessary).

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SKYGEN will notify the Provider and Member of its decision **within 2 business days of receiving the request or within 2 business days of receiving additional information if requested by Skygen.**

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_____