Centene Dental Mississippi Medicaid MSCAN Benefit Limit Exception (BLE) Form

Mississippi Division of Medicaid defines a limit on Medicaid dental services payable per member per state fiscal year (July 1 - June 30) of $2,500 ($4,620 per lifetime for orthodontia services). Requests to exceed this payable limit for medically necessary dental treatment must be authorized prior to treatment being rendered* and submitted to Centene Dental outside routine authorization submission procedures.

When submitting a BLE Authorization Request, please provide the following additional information:

- ☐ 2012 or newer ADA Claim Form **(required)**
- ☐ Radiographs
- ☐ Additional Dental Needs/History
- ☐ Periodontal Charting
- ☐ This BLE Form **(required)**
- ☐ Narrative of Medical Necessity
- ☐ Treatment Plan
- ☐ Photographs

BLE Reminders/Tips:

- Submit ALL documentation so your BLE request is processed timely.
- For paper submissions, please write "**MSCAN BLE Request**" at the top of your ADA claim form for efficient processing; **e-mail submission is preferred**.
- *Retrospective requests will be considered for emergency situations only (planned facility-based treatment is not considered emergency).
- For retrospective requests, a BLE authorization must be submitted and approved PRIOR to a claim being filed; claims filed without BLE authorization will deny for exceeding benefit maximum and will require claim appeal for payment.
- If Centene Dental has not responded within 30 days, please call Provider Services for a status inquiry.
- A BLE request approval is **NOT** a guarantee of payment; members and providers must be eligible at the time of service and other service benefit limitations will still apply to care rendered.
- Once a BLE authorization is approved, claims for approved services may be filed by normal submission routes.

BLE requests will receive a response, or a request for additional information, within 30 calendar days of receipt of the request. When the required additional information is received, the exception request will be approved or denied within 30 calendar days after receipt of all information necessary to make a decision.

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 _____

Please send information by email or mail to the following:

Email: DentalBLE@Centene.com
Mail: Centene Dental, MississippiCAN BLE Authorizations, P.O. Box 25255, Tampa, FL 33622-5255

Questions? Call Centene Dental Provider Services at 844-464-5636

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