

Unison MedPLUS Benefit Limit Exception Form

Prospective Review (prior to the service)

Retrospective Review (service rendered)

| | | |
|---------------------------|----------------------------|-------------|
| Member ID # | Last Name | First Name |
| Ordering Practitioner | Practitioner ID # | Telephone # |
| Servicing Practitioner | Servicing Practitioner ID# | Telephone # |
| Address: (City/State/Zip) | | |

Request Type: (Exception requests are only considered for the following services)

Inpatient Acute Hospital Admission

Outpatient Visits:

Specialists

Podiatrist

PCP

Chiropractor

Home Health

Inpatient Hospital Admission for Rehabilitation

| | |
|--|-------|
| Number of visits requested | _____ |
| Recipient Principal Diagnosis / Secondary Diagnosis (ICD-9) | 1) |
| | 2) |

Please check any/all of the reasons below that apply to why you are asking for an exception:

Patient has a serious chronic illness or other serious health condition and without the additional service his/her life would be in danger.

Patient has a serious chronic illness or other serious health condition and without the additional service his/her health will get much worse.

Patient would need more costly services if the exception is not granted.

Patient would have to go into a nursing home or institution if the exception is not granted.

Please check box below if decision requires **expedited review** (sooner than 21 days) and indicate the reason for expedited review: Expedited reviews will be reviewed within 48 hours of receiving the completed form.

Reason for expedited request: _____

| | | |
|-----------------------------------|---------------------------|-------|
| * Ordering Physician's Signature: | Physician's return Fax #: | Date: |
|-----------------------------------|---------------------------|-------|

Please submit a complete summarization of the medical necessity (attach additional information) to support the reason(s) checked below. Your request will be processed within 21 business days for a prospective request and 30 business days for a retrospective request, from receipt of complete information.

***Please Note: A form not properly completed and signed will be procedurally denied.**

| Internal use only | |
|--|-----------------------|
| Medical Director: | Authorization Number: |
| Expiration Date for Benefit Limit Exception: | |

Mail to:

Unison

Unison Plaza

Benefit Limit Exception Request

1001 Brinton Road

OR Fax to: 412-457-1338

Authorization does not guarantee payment, which is affected by other factors, such as eligibility, benefit limitations, exclusions and other coverage issues.

Fax completed form to: 412-457-1338

Pittsburgh, PA 15221

Physicians may call Provider Services at 800-600-9007 for further assistance.

11/1/2005