Pennsylvania
Department of Human Services

Medical Assistance BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
June 25, 2025	July 25, 2025	08-25-40, 27-25-40

SUBJECT

Implementation of Updated Dental Benefit Limit Exception Form

BY

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Deputy Secretary
Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.pa.gov/en/agencies/dhs/resources/for-providers/promise/promise-provider-enrollment.html

PURPOSE:

The purpose of this bulletin is to advise dental providers that the Department of Human Services (Department) is issuing a revised MA 549 form to use for dental benefit limit exception (BLE) requests.

SCOPE:

This bulletin applies to Medical Assistance (MA) enrolled dental providers who render services to MA beneficiaries in the MA Program's fee-for-service delivery system. Providers rendering services to MA beneficiaries in the managed care delivery system should refer to Managed Care Operations Memorandum MCS-06-2025-008 (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/managed-care-operations-memos/mcs-06-2025-008.pdf) and contact the appropriate managed care organization (MCO) with billing or other questions.

BACKGROUND / DISCUSSION:

On September 26, 2011, the Department issued MA Bulletin 27-11-47 titled, "Medical Assistance Dental Benefit Changes," to inform providers of the dental benefit limits that were being implemented for adult MA beneficiaries and the criteria and procedure to request an exception to the limits (https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/d_005794.pdf).

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-service provider service center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
https://www.pa.gov/agencies/dhs/departments-offices/omap-info.html

As set forth in MA Bulletin 27-11-47, the Department developed a dental BLE process along with a "Dental Benefit Limit Exception Request Form" (MA 549) for submission of dental BLE requests.

On April 15, 2021, the Department issued MA Bulletin 27-21-01 titled, "Dental BLE Process Update," that advised providers of operational changes to the dental BLE process (https://palegalaid.net/sites/default/files/2024-08/Dental%20BLE%20MA%20Bulletin%202021%2004.pdf). Under these changes, the Department reviews dental BLE requests without requiring supporting medical record documentation for certain medical conditions if the condition has been identified in the beneficiary's claims history. These conditions are:

1. Diabetes.

2. Coronary Artery Disease or risk factors for the disease.

3. Cancer of the Face, Neck and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin).

4. Intellectual Disability.

5. Current Pregnancy including postpartum period.

The Department has updated the dental BLE form to include these five conditions that were identified in MA Bulletin 27-21-01 to better assist providers in identifying when supporting medical documentation of the beneficiary's condition is not needed for a dental BLE request.

PROCEDURE:

Effective with the issuance of this bulletin, dental providers are to use the updated version of the "Dental Benefit Limit Exception Request Form" (MA 549) to request a dental BLE.

The updated form is available on the Department's website at: https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/documents/ma-response-forms/Dental%20Benefit%20Limit%20Exception%20Request%20Form.pdf. The MA MCOs may require the use of the "Dental Benefit Limit Exception Request Form" (MA 549), or another form approved by the Department, and providers should refer to their MCO contracts or contact MCOs for information.

Providers are to refer to the attachment and links within this MA bulletin, as well as the Department's website, for PROMISe™ Provider Handbook or Billing Guide at: https://www.pa.gov/en/agencies/dhs/resources/for-providers/promise/promise-provider-handbooks-guides.html.

ATTACHMENTS:

Dental Benefit Limit Exception Request Form (MA 549)

Dental Benefit Limit Exception Request Form

Failure to legibly complete all fields will result in this form being returned. This form must be attached to a completed ADA dental claim form and accompanied by documentation supporting the need for the service, including but not limited to chart documentation, diagnostic study results, radiographs (if applicable), and dental history, as well as any applicable medical records that document the existence of conditions meeting benefit limit criteria. If you check one of the five health conditions below, you do not need to submit supporting documentation from a physician as the Department will review the beneficiary's claim history for verification of the condition.

Please Print:

Beneficiary Last Name: _____ Beneficiary First Name: _____

Beneficiary 10-digit MA ID#: _____ Beneficiary Date of Birth: _____

Provider Last Name: _____ Provider First Name: _____

Provider MA 13-digit ID#: _____ Provider NPI #: _____

Provider Telephone Number: Area Code _____ Phone: _____

Benefit Limit Exception Request Type: ☐ Prospective ☐ Retrospective - Dates of Service: _____

Does the beneficiary have any of the following conditions? (Check all that apply):

- ☐ Diabetes
- ☐ Coronary Artery Disease or risk factors for the disease
- ☐ Cancer of the Face, Neck, and Throat (not including Stage 0 or 1 non-invasive sarcoma or basal cell cancers of the skin)
- ☐ Intellectual Disability
- ☐ Current Pregnancy including post-partum period
- ☐ Other: _____

If you checked **other** above and indicate a condition that is not listed, then explain below why the beneficiary meets the criteria for a benefit limit exception. The request explanation should be in narrative form and include a comprehensive justification as well as any supporting documentation from a physician verifying the condition. (attach additional pages as necessary).

_____

_____

_____

☐ This Benefit Limit Exception request meets one or more of the following criteria:

1. Beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the beneficiary.

2. Beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the beneficiary.

3. Granting the exception is a cost-effective alternative for the MA Program.

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

The Department will notify the provider and beneficiary of its decision within 21 days after receiving a prospective benefit limit exception request, or within 30 days after receipt of a retrospective benefit limit exception request. A retrospective request for an exception must be submitted no later than 60 days from the date the Department rejects the claim because the service is over the benefit limit. Retrospective exception requests made after 60 days from the claim rejection date will be denied.

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: _____

Email: ra-ffs_dental@pa.gov
Fax: 717-265-8287

Mail to: DHS/Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs
Dental Benefit Limit Exception Review
P.O. Box 8187
Harrisburg, PA 17105-8187