

Request to Exceed Case Mix CAP Request MSHO/SecureBlue and MSC+/Blue Advantage

Send the completed form via secure email to Partner.Relations@bluecrossmn.com

CARE COORDINATION INFORMATION			
Date:	Care Coordinator:		Telephone:
	Agency:		Email address:
MEMBER INFORMATION			
Member Name:	Member ID:		Remaining Waiver Span Dates:
Case Mix:	Case Mix amount:		Amount Over Case Mix Being Requested:
Summary of Request:			
Cost-effective options considered to stay under the current case-mix cap (i.e., are all authorized services being used):			
ASSESSMENT INFORMATION			
Current Assessment Date:		Is a reassessment due within 60 days of this request? Yes No *If yes, please complete a reassessment and evaluate if a request is still needed.	
Was the assessment completed more than 60 days ago? ☐ Yes ☐ No		For an assessment completed more than 60 days ago, is a "Change in Condition" assessment warranted? Yes No	
Date Care Coordinator and Supervisor reviewed the request:		Date request was submitted to Blue Plus:	
REQUIRED DOCUMENTATION			
 □ Case notes for the previous 3 months if applicable □ MnCHOICES assessment (will review from R-MnCHOICES) □ Support Plan (will review from R-MnCHOICES) □ Rate tool (Completed and available for review in MnCHOICES) □ Other supporting documents deemed appropriate (bids, quotes, doctor's order, med records, EAA Assessment results, etc.) 			
BLUE PLUS PARTNER RELATIONS USE ONLY			
REQUEST TO EXCEED CASE MIX CAP/CONVERSION REQUEST DETERMINATION			
Date received:		Review/Determina	ation Date:
Determination: Approved		If APPROVED, total monthly amount:	
Denied, rational:		Start Date:	Span End Date:
☐ Void-returned to sender, rational:			
Comments:			
INTERNAL USE ONLY:			
Partner Relations Consultant Signature:		Date sent to Bridgeview Team and CC:	