

BENEFITS MONITORING PROGRAM REFERRAL

SECTION 1 – Purpose of Submission

PCP Designation Specialty Referral Discharge from Practice

SECTION 2 – Beneficiary Information

Beneficiary Name (Last, First, Middle)			mihealth Card Number
Street Address			Home Telephone Number
City	State	ZIP Code	Work or Other Telephone Number

SECTION 3 – Referring Provider Information

Provider Name			Individual NPI Number	Specialty
Group Name (If applicable)			Group NPI Number	
Business Address			Are you the PCP? <input type="checkbox"/> YES <input type="checkbox"/> NO	
City	State	ZIP Code	Telephone Number	Fax Number

SECTION 4 – Referred Provider Information

Provider Name			Individual NPI Number	Specialty
Group Name (If applicable)			Group NPI Number	
Business Address			Telephone Number	Fax Number
City	State	ZIP Code	Anticipated Duration of Need <input type="checkbox"/> Acute/Short-Term <input type="checkbox"/> Chronic/Long-Term	

SECTION 5 – Drugs Subject to Abuse

MDCH must authorize all prescribers of drugs subject to abuse for BMP-enrolled beneficiaries. Do you anticipate a need for the referred provider to prescribe medications in these classes?

YES NO Unable to determine

Include the beneficiary's current medication list with form submission.

SECTION 6 – Additional Information/Comments (including diagnoses)

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Provider Signature	Date of Authorization
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Benefits Monitoring Program Referral (MSA-1302) Instructions for Completion and Submission

General Instructions

This form should ONLY be used for beneficiaries enrolled in the Benefits Monitoring Program (BMP).^{*} Enrollment may be verified through the CHAMPS Eligibility Inquiry response as additional information. The form is to be completed by the beneficiary's BMP Authorized Provider(s). For additional program information, refer to the Michigan Medicaid Provider Manual (Beneficiary Eligibility Chapter, Benefits Monitoring Program Section) available on the MDCH website.

MDCH requests that the MSA-1302 be typewritten to facilitate processing.

Form Completion

Section 1	Check the appropriate box to communicate purpose of the submission.
Section 2	Beneficiary Information.
Section 3	Referring (or Primary Care) Provider Information.
Section 4	Referred Provider Information. Note: This section may be left blank when making a PCP designation only.
Section 5	Check the appropriate box to communicate the anticipated need for MDCH to authorize the referred provider to write prescriptions for drugs subject to abuse for this beneficiary. Include the beneficiary's current list of medications with form submission.
Section 6	Fill in the reason for referral, including diagnosis. Include any additional information that would assist in MDCH review. When using this form to communicate a discharge from practice, include a copy of the communication from your office to the patient for MDCH records.

Copy Distribution

- Original – Referring Provider File
- Copy – Referred Provider
- Copy – Michigan Department of Community Health (MDCH), Medical Services Administration, Benefits Monitoring Program

Form Submission

The MSA-1302 and any supplemental information (e.g. medication list, medical records, forged prescriptions, etc.) must be mailed or faxed to:

**MDCH – Medical Services Administration
Benefits Monitoring Program
PO Box 30170
Lansing, MI 48909**

Fax Number: (517) 335-0075

The MDCH Program Review Division may be reached via telephone at (800) 622-0276.

^{*} Previously known as Beneficiary Monitoring Program.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

AUTHORITY: Title XIX of the Social Security Act.

COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.