Michigan Department of Health and Human Services

Health Services

**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 |
|  | | |  |  |
| Organization Name (If applicable) | | | Organization NPI Number |  |
|  | | |  |  |
| Business Address | | | Are you the PCP? | |
|  | | | **YES**   **NO** | |
| City | State | ZIP Code | Telephone Number | Fax Number |
|  |  |  |  |  |

**SECTION 4 – Referred Provider Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Provider Name | | | Individual NPI Number | Specialty |
|  | | |  |  |
| Organization Name (If applicable) | | | Organization NPI Number |  |
|  | | |  |  |
| Business Address | | | Telephone Number | Fax Number |
|  | | |  |  |
| City | State | ZIP Code | Anticipated Duration of Need | |
|  |  |  | Acute/Short-Term | Chronic/Long-Term |

**SECTION 5 – Drugs Subject to Abuse**

|  |
| --- |
| MDHHS 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)**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| 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 MDHHS website.

MDHHS 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 MDHHS 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 MDHHS review. When using this form to communicate a discharge from practice, include a copy of the communication from your office to the patient for MDHHS records. |

**Copy Distribution**

* Original – Referring Provider File
* Copy – Referred Provider
* Copy – Michigan Department of Health and Human Services (MDHHS), Health Services, 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:

**MDHHS – Health Services**

**Benefits Monitoring Program**

**PO Box 30170**

**Lansing, MI 48909**

**Fax Number: (517) 335-0075**

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

|  |
| --- |
| **AUTHORITY:**  Title XIX of the Social Security Act.  **COMPLETION:** Is Voluntary, but is required if Medical Assistance program payment is desired. |
| The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy. |

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