Special Health Care Needs (SHCN)
Claims Submission Guidelines for CYSHCN Program

BILLING REMINDERS:

- The participant must be actively enrolled in the CYSHCN Program on the date of service.
- The provider must be an enrolled CYSHCN provider on the date of service.
- The provider must be in-network for the participant's private insurance, including MO HealthNet, for CYSHCN to consider reimbursement.
- The provider must submit claims on the appropriate billing form (CMS-1500, UB-04, or Dental Claim Form).
- A copy of the Explanation of Benefits (EOB) indicating the reimbursement received from insurance, a rejection statement, and/or the MO HealthNet Remittance Advice (RA) including an explanation and/or denial codes must be submitted with the claim.
- CYSHCN must receive provider claims within *90 calendar days* of the date of service or within *90 calendar days* of the EOB/RA process date but no longer than 6 months from the date of service.
  - Services delivered prior to June 30th must be submitted to CYSHCN no later than July 31st due to fiscal year limitations. CYSHCN is under no obligation to pay claims for dates of service in the prior fiscal year if these claims are submitted after July 31st.
- The provider must bill the Usual and Customary Rate (UCR) for all services, not the CYSHCN reimbursement amount.
- Claims must include a valid CPT, HCPCS, NDC, or CDT code.
- CYSHCN will consider the patient responsibility, up to the authorized reimbursement amount, after insurance has been exhausted.
- CYSHCN reimbursement for eligible services must be accepted as payment in full.
  - The provider cannot request payment for eligible services from CYSHCN participants or their families.
- Some services require prior authorization which must be obtained prior to delivery of services.
- CYSHCN will consider limited funding up to $25,000 annually per participant.
- CYSHCN is the payor of last resort.
- CYSHCN may request medical records to assist in determining if services will be covered.

PHARMACY CLAIMS:

- Health Insurance Claim Form (CMS-1500),
- NDC – National Drug Code
- Name of medication (generic or brand name),
- Insurance EOB/MO HealthNet RA or insurance payment amount, and
- Participant's/Family's financial responsibility.

HEARING AID CLAIMS:

- Health Insurance Claim Form (CMS-1500 or UB-04),
- Insurance EOB (if applicable),
- MO HealthNet RA (if applicable), and
- Hearing Aid Invoice (wholesale cost).

DURABLE MEDICAL EQUIPMENT (DME) CLAIMS:

- Health Insurance Claim Form (CMS-1500),
- HCPCS/CPT Code and UCR,
- Insurance EOB (if applicable), and
- MO HealthNet RA (if applicable).

DENTAL CLAIMS:

- Health Insurance Claim Form (CMS-1500) or Dental Claim Form,
- Insurance EOB (if applicable), and
- MO HealthNet RA (if applicable).

Reimbursement of charges will be denied or delayed if specified claim attachments are not received.

Provider Enrollment/Questions:
(573) 751-6246

Claims Questions:
(573) 751-6245

Claims and supporting documentation should be sent to:
Special Health Care Needs
PO Box 570
Jefferson City, MO 65102
OR
Claims Fax: (573) 522-2107
CYSHCNClaims@health.mo.gov

For CYSHCN provider information visit:
https://health.mo.gov/seniors/shcn/cshcnproviders.php

7/23/2025

PROVIDER APPEAL PROCESS:
Special Health Care Needs (SHCN) enrolled providers have the right to appeal decisions regarding denial of payment for services.

To appeal a decision made by SHCN, the provider must submit the following documentation to the Program Manager within *thirty (30) calendar days* of the SHCN warrant/voucher date:

- A letter describing the reason for the appeal;
- Documentation to support overturning the denial; and
- A copy of the claim being appealed.

The Program Manager will review the documentation and render a written decision to the provider within *thirty (30) business days* of the receipt of the appeal.

If the decision is unsatisfactory, the provider may submit a second appeal letter addressed to the Bureau Chief. The appeal and supporting documentation must be received by SHCN within *thirty (30) calendar days* of the Program Manager's written decision date. The Bureau Chief will review the documentation and render a written decision to the provider within *thirty (30) business days* of the receipt of the appeal.

If the decision is unsatisfactory, the provider may submit a final appeal letter to the Department Director, or designee. The appeal and supporting documentation must be received by SHCN within *thirty (30) calendar days* of the Bureau Chief's written decision date. The Department Director will make a final decision based on the evidence and documentation submitted with the appeal. A letter outlining the Director's decision will be mailed to the provider within *thirty (30) business days* of the receipt of the appeal.