



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 SPECIAL HEALTH CARE NEEDS – MEDICALLY FRAGILE ADULT WAIVER (MFAW)  
**MFAW CONFIRMATION OF VERBAL SERVICE AUTHORIZATION**

PROVIDER NAME	ATTENTION
PROVIDER FAX NO.	PROVIDER TELEPHONE NO.

AUTHORIZING SERVICE COORDINATOR	FACILITATOR	
PHONE NO.	FAX NO.	DATE

PARTICIPANT NAME (LAST, FIRST, MI)	DCN
------------------------------------	-----

**SERVICES**

The following services have been verbally approved by the Special Health Care Needs Service Coordinator:

<input type="checkbox"/> Private Duty Nursing (PDN)	<input type="checkbox"/> Personal Care Aide/Waiver Attendant Care (inside the home)
<input type="checkbox"/> PDN may be provided outside the home during normal life activities.	<input type="checkbox"/> Waiver Attendant Care outside the home
<input type="checkbox"/> PDN may be provided during travel outside the home overnight as specified below.	<input type="checkbox"/> Advanced Personal Care
	<input type="checkbox"/> Authorized RN Visit
	<input type="checkbox"/> Specialized Medical Supplies

VISITS/HOURS AUTHORIZED	EFFECTIVE DATE
-------------------------	----------------

**Services to be delivered as authorized. Orders for discipline, amount, and frequency on the applicable form(s) as required in the MO HealthNet Provider Manual must match this authorization.**

**TERMS AND CONDITIONS**

Any variation to these services must be approved prior to initiation of changes, which includes but is not limited to:  
 Increase or decrease in authorized hours/visits  
 Change of residence/family status  
 Change in Medical Status or child admitted to hospital, etc.

This is not an official prior authorization. The plan of care, physician orders, and/or invoice of cost for specialized medical supplies must be submitted to Special Health Care Needs within 90 days for services to be approved for payment.

Please sign, date and return to the fax number indicated above. Questions and concerns may be directed to the Service Coordinator or Facilitator.

**STATEMENT OF UNDERSTANDING**

**I acknowledge that my signature indicates understanding and agreement with authorized services, terms and conditions above. Durable Medical Equipment providers acknowledge that the costs provided to BSHCN are wholesale costs.**

SIGNATURE	DATE
-----------	------

This facsimile transmission is from the Missouri Department of Health and Senior Services and is confidential, privileged and intended only for the use of the recipient named above. If you are not the intended recipient or the employee or agent responsible for delivering this information to the intended recipient, unauthorized disclosure, copying, distribution or use of the contents of this transmission is strictly prohibited. If you have received this message in error, please notify the sender immediately by calling the phone number listed above to arrange for return of the original document to the Missouri Department of Health and Senior Services.