



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
PRIOR AUTHORIZATION REQUEST

Return to: Infocrossing Healthcare Services, Inc.
PO Box 5700
Jefferson City, MO 65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The participant must be MO HealthNet Eligible on the date of service or date the equipment or prosthesis is received by the participant. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1.	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. MO HEALTHNET NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION
9. NAME AND ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE		

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING <input type="checkbox"/> FULL <input type="checkbox"/> INTERPERIODIC <input type="checkbox"/> PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME		14. PROVIDER IDENTIFIER
15. TELEPHONE NUMBER		

III. SERVICE INFORMATION

III. SERVICE INFORMATION								FOR STATE USE ONLY				
16. REF. NO	17. PROCEDURE CODE	18. MODIFIERS			19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
(11)												
(12)												

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)	
26. ADDRESS	FAX NUMBER
27. MO HEALTHNET PROVIDER IDENTIFIER	TAXONOMY
28. SIGNATURE	DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME	30. TELEPHONE
31. ADDRESS	
32. DATE DISABILITY BEGAN	33. PERIOD OF MEDICAL NEED IN MONTHS
I certify the information given in Sections I and III of this form is true, accurate, and complete.	
34. SIGNATURE OF PRESCRIBING PHYSICIAN/PRACTITIONER	DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin	DATE	REVIEWED BY SIGNATURE
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