



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
MO HEALTHNET FORMS REQUEST

DATE

PROVIDER IDENTIFIER (OR AFFIX PROVIDER LABEL HERE)		ATTACHMENTS		QUANTITY
PROVIDER NAME		J. HCY Medical Screening Tool (All Pages)		
PROVIDER PHONE		HCY Screening Forms by Age Group		
PROVIDER TAXONOMY CODE		2. Newborn - 1 month/2-3 months		
QUANTITY PREPRINTED BLANK		3. 4-5 months/6-8 months		
		4. 9-11 months/12-14 months		
A. Pharmacy		5. 15-17 months/18-23 months		
B. Dental		6. 24 months/3 years		
C. CMS 1500		7. 4 years/5 years		
D. CMS 1450 Inpatient/Outpatient/Home Health		8. 6-7 years/8-9 years		
F. Prior Authorization		9. 10-11 years/12-13 years		
If provider labels are needed with blank Claim Forms (A-F), check box. If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels. If provider labels are not needed and you are not ordering Forms A-F, indicate the quantity _____.		*. 14-15 years/16-17 years		
		&. 18-19 years/20 years		
SPECIAL MAILING INSTRUCTIONS		L. Sterilization Consent		
		M. Acknowledge Hysterectomy		
NAME		O. Hearing Aid Evaluation		
ATTN		P. Medical Necessity		
STREET ADDRESS (NOT PO BOX)		Q. Adjustment Request		
CITY		R. Medical Necessity Long Term HPN		
STATE		S. Second Surgical Opinion		
ZIP		T. Medical Necessity - Abortion		
ADDRESS CHANGE/CORRECTION		U. Hospice Election Statement		
		V. Oxygen - Respiratory Justification		
NAME		W. Notification of Termination of Hospice Benefits		
STREET ADDRESS (NOT PO BOX)		Y. Insurance Resource Report (TPL-4)		
CITY		Z. Accident Reporting Form (TPL-2P)		
STATE		1. Physician Certification of Terminal Illness		
ZIP		*PROVIDER SIGNATURE (MUST BE PROVIDER'S ORIGINAL SIGNATURE)		
EFFECTIVE DATE OF CHANGE				

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Infocrossing Healthcare Services, Inc. are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating MO HealthNet Providers. They are intended solely for MO HealthNet claims filing. Please complete the above information and return it to Infocrossing Healthcare Services, Inc. via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Infocrossing Healthcare Services, Inc. at (573) 635-3559.

All MO HealthNet forms can be downloaded and printed from the Web site at <http://www.dss.mo.gov/mhd/providers/index.htm> and then choosing the "forms" option in the left column. They are also available at the MO HealthNet Billing Web site at www.emomed.com.