



Inpatient Certification Program  
 Post Office Box 105110  
 Jefferson City, MO 65110-5110  
 Phone 1.800.766.0686  
 Fax: 1.866.629.0737

**MO HealthNet Utilization Review (UR) Program  
 Inpatient Certification Request Form**

**Pre-certification      Initial Certification      Continued Stay      Retrospective (Post Discharge)**  
 Admit Date Change Request    From: \_\_\_/\_\_\_/\_\_\_    To: \_\_\_/\_\_\_/\_\_\_    (Copy of admission order is required)  
 Date of Medicare Part A exhaustion (if applicable) \_\_\_/\_\_\_/\_\_\_  
 Request for Reconsideration of Medically Denied Days

Requestor's name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 Requestor's phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Participant name: \_\_\_\_\_ D.O.B \_\_\_/\_\_\_/\_\_\_  
 MO HealthNet ID # (DCN): \_\_\_\_\_ If DCN is unknown, provide SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Facility: \_\_\_\_\_ Facility NPI number \_\_\_\_\_  
 Attending Physician: \_\_\_\_\_ Physician NPI number \_\_\_\_\_  
 Physician Address: \_\_\_\_\_  
 Physician Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Physician State License # \_\_\_\_\_

Date of admission or scheduled admission: \_\_\_/\_\_\_/\_\_\_ Date of scheduled surgery: \_\_\_/\_\_\_/\_\_\_  
 Requested number of days: \_\_\_\_\_ Requested date range: from \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_  
 Certification Number (if applicable): \_\_\_\_\_ Discharge Date: \_\_\_/\_\_\_/\_\_\_  
 Primary/Admitting diagnosis: \_\_\_\_\_ Diagnosis code: \_\_\_\_\_  
 Present on admission (check one):    Y    N    U    W    If POA indicator = N, enter date of diagnosis: \_\_\_/\_\_\_/\_\_\_  
 Other diagnosis: \_\_\_\_\_ Diagnosis code: \_\_\_\_\_  
 Present on admission (check one):    Y    N    U    W    If POA indicator = N, enter date of diagnosis: \_\_\_/\_\_\_/\_\_\_  
 Procedure: \_\_\_\_\_ Procedure code: \_\_\_\_\_

Clinical Notes:

Y=Present at time of admission, N=Not present at time of admission, U=Documentation insufficient, W=Provider unable to clinically determine

**Please attach a completed form with 10 pages or less of clinical synopsis for faxed in requests. Fax Number: 866-629-0737.  
 For retrospective and/or reconsiderations please mail entire medical record with completed inpatient request form.  
 Mailing Address: Conduent, P.O. Box 105110, Jefferson City, MO 65110. For Fed Ex and UPS: Conduent, 3425 West  
 Truman Blvd., Jefferson City, MO 65109.**

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