

MO HealthNet
Authorization Determination
Date:

Request No:

Receipt Date:

****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.****

Service
Provider:
Participant:

DOB
Sex PT

Proc	Mod				Auth. Dates	Units			Dollars			Sta- tus	Reason
	M1	M2	M3	M4		Req	/	Auth	/	Used	Req		

Comments:

To request changes to any authorized service(s) listed above, please make appropriate corrections and return this letter with any related documentation. Include all appropriate modifiers. To request reconsideration of a DENIED service, you must complete a new prior authorization request form.

Physician/Provider Signature _____ Date _____