



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF FAMILY SERVICES
QUALIFIED MEDICARE BENEFICIARY AUTHORIZATION

FROM	CASEWORKER NAME	TELEPHONE NUMBER	DATE
	COUNTY OFFICE ADDRESS (STREET, CITY, STATE, ZIP CODE)		
TO	NAME		
	ADDRESS (STREET OR P.O. BOX NO.)		
	CITY	STATE	
RE	CASE NAME	CASE NUMBER	

This is to certify that the following person is eligible for Qualified Medicare Beneficiary (QMB) benefits for the period shown below:

NAME (LAST, FIRST, MIDDLE)	QMB NO.	PERIOD OF COVERAGE	
		FROM	TO

ATTENTION MEDICAL PROVIDERS

LIMITATION OF SERVICES: This claimant is not eligible for payment of any covered Medicaid Services except services covered as Medicare/Medicaid crossover claims. Total payment will consist of co-insurance and deductible amounts, as determined by the Medicare program. No other services will be paid.

THIRD PARTY LIABILITY	
NAME:	
INS. CO.:	INS. CODE:
NAME:	
INS. CO.:	INS. CODE:
NAME:	
INS. CO.:	INS. CODE:
NAME:	
INS. CO.:	INS. CODE:

CASEWORKER SIGNATURE