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MO HEALTHNET DIVISION
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PROGRAM INTEGRITY UNIT
MEDICAL REFERRAL FORM OF RESTRICTED PARTICIPANTS

PARTICIPANT NAME: (Last) (First) (Middle)

PARTICIPANT IDENTIFICATION NUMBER:

AUTHORIZED PROVIDER MAKING REFERRAL:

PROVIDER VENDOR NUMBER:

TAXONOMY CODE : (If applicable)

AUTHORIZED PROVIDER'S SIGNATURE:

DATE OF SIGNATURE:

DATE OF SERVICE:

REASON FOR REFERRAL:

REFERRING TO: (Provider's Name)

ADDRESS: PHONE:

PROVIDER VENDOR NUMBER:

TAXONOMY CODE : (If applicable)

This form is to be completed and signed by the authorized lock-in provider when a referral to another provider is medically necessary.

This referral form should NOT be attached to the claim form. You may either send it to Infocrossing Healthcare Services, Inc., P.O. Box 5900, Jefferson City, MO 65102 or submit via Internet. The website for these submissions is www.emomed.com. A referral form is needed for each claim in which services are rendered to a Missouri restricted participant in order for the provider performing the service to receive payment for his or her claim.

THIS REFERRAL IS GOOD ONLY FOR 30 DAYS FROM THE DATE OF SERVICE.

PI 118 - Revised 09/08