MoHealthNet BEHAVIORAL HEALTH SERVICES REQUEST FOR PRECERTIFICATION

Refer to the instructions on the second page of this form. Precertification requests may be called in to (866) 771-3350, faxed to (573) 635-6516 or mailed to Wipro InfoCrossing, PO Box 4800, Jefferson City, MO 65102.
An approved precertification approves only the medical necessity of the service and does not guarantee payment.

Participant Information

Participant Name	Date of Birth	Participant MO HealthNet Number

Billing Provider Information

Billing Provider Name		Billing Provider NPI
Taxonomy Code (If required)	**Phone Number**	**Fax Number**

Current Precertification Information

Number of Hours Used on Current Precertification (If multiple current precertification's, list therapy type and number of hours used)

Choose One If Applicable:
☐ Continued Therapy ☐ Clinical Exception

Requested Service Information* (If requesting Family Therapy, See Reminder in Instructions)

Requested Service	Hours	Precertification Start Date
☐ Testing (ages 0-2)		
☐ Individual Therapy		
☐ Group Therapy		
☐ Family Therapy without Patient Present		
☐ Family Therapy		

Complete This Section Only If Request is for Testing (ages 0-2):

Indicate the Referral Source:	Indicate the Reason for the Referral:	Indicate Which Test(s) You Are Performing:
☐ Physician ☐ Parent/Guardian self-referral ☐ Children's Division referral ☐ Court Ordered service ☐ School referral (Parents as Teachers, IFSP, Head Start, etc.) ☐ Other	☐ Evaluation for feeding and/or eating disorder ☐ Evaluation for Autism Spectrum Disorders ☐ Evaluation ADD/ADHD ☐ Evaluation for Developmental Delay ☐ Evaluation for Trauma ☐ Other	☐ Bayley Scales of Infant Development III ☐ Vineland Adaptive Behavior Scales ☐ AAMR Adaptive Behavior Scale 2nd Edition ☐ None of the above

For Family Therapy, list all family members, relationship to patient and DCN (If available)

Is This Request For:	If So, Have You Been Appropriately Trained/Certified?	If age is less than five, will services provided be developmentally appropriate?
☐ PCIT ☐ PMT ☐ TF-CBT ☐ DBT	☐ Yes ☐ No	☐ Yes ☐ No
Has the patient/guardian agreed to their treatment plan? ☐ Yes ☐ No	**Is the therapy court ordered?** ☐ Yes ☐ No	**Have you communicated with other involved therapist/health care practitioner about treatment?** ☐ Yes ☐ No
Is therapy the result of an EPSDT screen? ☐ Yes ☐ No		**If Yes, Date of Screen**
Is the child in state custody? ☐ Yes ☐ No	**If child in state custody, have you provided a copy of the treatment plan to:** Children's Division ☐ Yes ☐ No Contracted Case Manager ☐ Yes ☐ No	
Case Manager Name (If applicable)		**Date Provided (If applicable)**

Behavioral Health Diagnostic Codes			
Diagnostic Code (Primary)	Diagnostic Code	Diagnostic Code	Diagnostic Code

Is there evidence of substance use disorder?
☐ Yes ☐ No

General Medical Conditions			
Does the patient have a current general medical condition that is potentially relevant to the understanding or management of the behavioral health condition(s)? ☐ Yes ☐ No		If yes, List Condition	
Diagnostic Code (Primary)	Diagnostic Code	Diagnostic Code	Diagnostic Code

Performing Provider Information	
Performing Provider Name (Printed)	NPI
Performing Provider Signature	Date

Instructions for Completion	
Participant Name	Enter the participant's name as it appears on the MO HealthNet ID card.
Participant MO HealthNet Number	Enter the participant's number as it appears on the MO HealthNet ID card.
Date of Birth	Enter the participant's date of birth as it appears on the MO HealthNet ID card.
Billing Provider Name	Enter the billing provider name.
Billing Provider NPI	Enter the National Provider Identifier (NPI) that will be used for billing services to MO HealthNet. If this is a clinic/group setting the clinic number should be entered here.
Taxonomy Code	Enter the provider taxonomy code if the NPI is associated with multiple provider types.
Provider Phone Number	Enter current phone number of the provider making the request.
Provider Fax Number	Enter the fax number of the provider making the request.
Number of Hours Used on Current Precertification	List the number of hours used on current precertification. If there is more than one current certification, list the therapy type along with the number of hours used.
Continued Therapy/Clinical Exception	Check the appropriate box if request is for Continued Therapy (services beyond the initial precertification request) or Clinical Exception. Clinical documentation must be submitted including assessment, treatment plan and most recent three progress notes if available. Provide specific exception request and clinical rationale for clinical exceptions.
Requested Service Information*	
The Requested Service Information section must be completed for services requested.	
Testing (ages 0-2)	Complete referral source and testing instruments only for Testing for under age 3.
Family Therapy	When requesting family therapy, please list all members of the family. Only one precertification will be approved and open at a time for family therapy unless a clinical exception is requested and approved. If there is more than one eligible child and no child is exclusively identified as the primary patient of treatment, then the oldest child's DCN **must** be used for precertification and billing purposes. Each child may not be seen separately with parents and billed as family therapy.
Precertification Start Date	Please indicate the date you would like for your precertification to begin. The authorized start is the date of receipt or noted subsequent date.
Court Ordered Therapy	If therapy is the result of a court order a copy should be kept in the patient's record.
Diagnostic Codes	
Enter current version ICD code for behavioral health diagnosis. List general medical conditions diagnostic codes only if applicable.	
Performing Provider Information	
Signature	The provider of services must sign the request and indicate the date the form was completed.
Performing Provider Identifier	Enter the performing provider identifier (NPI).
Date	The provider of services must indicate the date the form was completed