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 (Copy of admission order is required)

Request for Reconsideration of Medically Denied Days **Psychiatric Residential Treatment Facility**

Date of Medicare Part A exhaustion (if applicable) ________/________/________

Requestor's name: ____Date: ____________________________

Requestor's phone number/extension :(_____)_________________________ Fax #: (_______)___________________________

Participant name: ____D.O.B______/___ ___/________

Mo HealthNet ID # (DCN): ______________________ If DCN is unknown, provide SSN: _________-______-_________

Facility:__________________ Facility NPI (required) _______________ Taxonomy code (PRTF only)________________

Attending Physician:_____________________________ Physician NPI number __________________________________

Physician Address: ____

Physician Phone Number: __________________________ Physician State License Number: ______________________________

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 (circle one): Y N U W If POA indicator = **N**, enter Date of Diagnosis:_______________

Other Diagnosis: ____ Diagnosis code:____________________

Present on admission (circle one): Y N U W If POA indicator = **N**, enter Date of Diagnosis:_______________

Procedure: ____ Procedure code: ____________________

Clinical Notes: ____

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____.

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 (does not apply for PRTF 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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