MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

EXCEPTION REQUEST
NEGATIVE PRESSURE WOUND THERAPY PUMP

RETURN TO: ATTN EXCEPTIONS UNIT
MO HEALTHNET DIVISION
PO BOX 6500
JEFFERSON CITY, MO 65102-6500
FAX NO: 573-522-3061

PLEASE TYPE OR PRINT. ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL NOT BE PROCESSED

PARTICIPANT NAME	DOB	PARTICIPANT MO HEALTHNET NUMBER (DCN)

PARTICIPANT DIAGNOSES (MUST RELATE TO ITEM(S) OR SERVICE(S) REQUESTED)	HCPCS CODE AND DESCRIPTION
REQUESTED SERVICE DATES	ESTIMATED DURATION OF NEED

Please list the primary wound type: (i.e. Arterial ulcer, Diabetic Ulcer, Necrotizing fascilitis, amputation - diabetic, amputation - traumatic, burns, dihesced, post-op flap or graph, pressure ulcer state III or IV, Surgical non dehisced, trauma-orthopedic or soft tissue open, venous stasis ulcer etc.)

WOUND INFORMATION:

Surgical Wound _____________ If Yes, type of surgery _____________ Date of Surgery _______________________ Date of Dehiscence __________________________

Neuropathic Wound _________ If Yes; on a comprehensive diabetic management program _______________________ Blood sugars controlled? ______________________

Venous Stasis Ulcer ________ If Yes, are compression bandages/garments consistently applied? _________________ Are leg(s) elevated? _________________________

Pressure Ulcer ______________ If Yes; is a Support Surface being used? ________________ Kind/name being used ____

Is participant's nutritional status adequate for healing? ☐ Yes ☐ No If No, what nutritional measures have been taken?

Have wound dressings been applied to maintain a moist wound environment? ☐ Yes ☐ No If No, why?

Is untreated osteomyelitis present within the vicinity of the wound?
☐ Yes ☐ No

Is cancer present in the wound?
☐ Yes ☐ No

Is there a fistula to an organ or body cavity within the vicinity of the wound? ☐ Yes ☐ No
If yes, specify location/proximity to wound:

Was NPWT initiated in an inpatient facility? ___________________ Facility Name ______________________________ Date NPWT initiated _________________________

What is the medical necessity for accelerate formation of granulation tissue which cannot be achieved by other available topical wound treatments? ________________________

List all treatments/dressing tried prior to NPTW: ____

Please provide current wound(s) information below:

Evaluation Date	Location	Stage	Size in centimeters L x W x D	Description

MO HEALTHNET PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER)

NAME	TELEPHONE NUMBER
ADDRESS	FAX NUMBER

MO HEALTHNET PROVIDER ID	PROVIDER NPI	PROVIDER TAXONOMY CODE

DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE	TELEPHONE NUMBER

DOCTOR'S ADDRESS OR APN'S ADDRESS	FAX NUMBER

MO HEALTHNET PROVIDER ID	PHYSICIAN NPI	PHYSICIAN TAXONOMY CODE

DOCTOR'S OR APN'S ORIGINAL SIGNATURE AND TITLE	DATE