MoHealthNet

PRIOR AUTHORIZATION REQUEST

RETURN TO: WIPRO INFOCROSSING
PO BOX 5700
JEFFERSON CITY, MO 65102

Authorization approves the medical necessity of the requested service. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The participant must be MO HealthNet eligible on the date of service or date the equipment or prosthesis is received by the participant. See reverse side for instructions.

Section I – General Information

1. Choose One ☐ Initial Prior Authorization ☐ Reauthorization	2. Participant Last Name	First Name	Middle Initial	3. Date of Birth
4. Street Address		City	State	Zip Code
5. MO HealthNet ID Number	6. Prognosis		7. Diagnosis Code	
8. Diagnosis Description		9. Name of Facility Where Services Are to be Rendered if Other than Home or Office		
10. Street Address of Facility		City	State	Zip Code

Section II – HCY (EPSDT) Service Request (May Require Plan of Care)

11. Date of HCY Screen	12. Screening ☐ Full ☐ Inter-periodic ☐ Partial	13. Type of Partial HCY Screen
14. Screening Provider Name	15. Provider NPI	16. Telephone Number

Section III – Service Information

17	18	19	20	21	22	23	24	For State Use Only		
Ref No	Proc Code	Modifiers	From	Through	Description of Service/Item	Qty or Limits	Amount to be Charged	Appr	Denied	Amount Allowed if Priced by Report
(1)								☐	☐	
(2)								☐	☐	
(3)								☐	☐	
(4)								☐	☐	
(5)								☐	☐	
(6)								☐	☐	
(7)								☐	☐	
(8)								☐	☐	
(9)								☐	☐	
(10)								☐	☐	
(11)								☐	☐	
(12)								☐	☐	

25. Detailed Explanation of Medical Necessity for Services/Equipment/Procedure/Prosthesis (Attach additional pages if necessary)

Section IV - Provider

26. Provider Name	27. Provider Street Address	City	State	Zip Code
28. Provider NPI	29. Signature			Date

Provider V – Prescribing/Performing Practitioner			
30. Prescribing/Performing Practitioner Name		31.Telephone Number	
32. Prescribing/Performing Practitioner Street Address	City	State	Zip Code
33. Date Disability Began	34. Period of Medical Need in Months	35. NPI	Taxonomy
36. Prescribing/Performing Practitioner Signature			Date

Section VI – For State Use Only		
Denial Reason(s); Refer to Field 17 Above by Reference Numbers		
If approved, Services Authorized to Begin	Reviewed By Signature	Date

Instructions for Completion

Section I – General Information			
1	Type of authorization for services requested	7	Diagnosis Code(s)
2	Participant Name – As it appears on MO HealthNet ID Card	8	Diagnosis Description – All diagnosis appropriate to services being requested
3	Participant date of birth		
4	Participant Address	9	Name of facility where services are to be rendered if service is to be provided other than home or office
5	8-digit MO HealthNet ID Number	10	Address of facility where services are to be rendered if service is to be provided other than home or office
6	Participant prognosis		

Section II – Healthy Children and Youth (HCY) Service Request (Plan of Care may be required, see Provider Manual)			
11	Date HCY Screen was done	14	Provider's name who performed screening
12	Check Full, Inter-Periodic or Partial Screen	15	Provider's NPI who performed screening
13	Type of partial HCY Screen performed (e.g., Vision, Hearing, etc)	16	Provider's telephone number

Section III – Service Information			
17	Identifies each separate line on the request	22	Specific description of service/item being requested
18	Procedure code(s) for services being requested	23	Quantity or units of service/item being requested
19	Modifier(s) for services being requested	24	Amount to be charged for the service
20	From date services will begin if authorization approved (mm/dd/yy)	25	Detailed explanation of medical necessity of the service/equipment/procedure/prosthesis, etc. Attach additional pages if necessary. **Do not use another PA form.**
21	Through date services will terminate is approved (mm/dd/yy)		

Section IV – Provider Requesting Prior Authorization			
26	Providers Name making the request; if clinic/group, also complete section V	28	Providers NPI and taxonomy code (if applicable)
27	Complete mailing address	29	Provider signature and date; check Provider Manual to determine if this field is required

Section V – Prescribing/Performing Practitioner			
This section must be completed for services which require a prescription such as durable medical equipment, physical therapy or for services which will be prescribed by a physician/practitioner that require Prior Authorization, or when the provider in Section IV is a clinic or group practice. Review Provider Manual for additional instructions.			
30	Name of prescribing/performing practitioner	34	Estimated number of months participant will need the equipment/services
31	Prescribing/performing practitioner telephone number	35	Provider's NPI and taxonomy code (if applicable)
32	Prescribing/performing practitioner address	36	Prescribing/performing practitioner signature; signature stamps are not acceptable
33	Date disability began (e.g., originated at birth, enter date of birth)		

Section VI – For State Use Only
Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing. At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.