



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 FAMILY SUPPORT DIVISION
MEDICAL REFERRAL AND AUTHORIZATION

| | | | | | |
|-------------|----------------------------------|----------|--------|------------------------|----------------|
| FROM | COUNTY OFFICE | | | TELEPHONE NUMBER | DATE |
| | ADDRESS (STREET) | | | | |
| | CITY | | STATE | ZIP | |
| | COUNTY MANAGER | | | | |
| TO | NAME | | | | |
| | ADDRESS (STREET OR P.O. BOX NO.) | | | | |
| | CITY | | STATE | ZIP | |
| RE | CASE NAME (FIRST) | (MIDDLE) | (LAST) | | CASE DCN |
| | PATIENT NAME (FIRST) | (MIDDLE) | (LAST) | BIRTHDATE (MM/DD/YYYY) | INDIVIDUAL DCN |

We are determining if the above-named patient is eligible for _____. To make this determination, we must establish if the patient is:

- permanently and totally disabled
- unable to work because of a physical/mental disability
- pregnant

To help us, we would appreciate it if you would:

1. send us a copy or summary of your medical records and complete the certification section of the enclosed IM-60A or complete the entire IM-60A based on your medical records.
2. send us a copy of the hospital discharge summary. Date of discharge is _____.
3. do a general medical examination and complete the enclosed IM-60A. The examination may include test(s) which are indicated by the patient's complaints and are necessary before you can reach a decision on his/her employability. The examination is scheduled for _____ at _____.

The Family Support Division will honor a physician's usual and customary charges, up to but not exceeding our professional reimbursement schedule.

If, in your opinion, the patient must be hospitalized in order for you to complete this medical report, Prior Written Authorization by the State Medical Review Team must be given before payment will be made by the FSD.

4. send us a copy of your recent outpatient clinic records with the results of any special tests or examinations. If we have indicated above that we are trying to determine if the patient is pregnant, please include a statement indicating if pregnant and the estimated due date.
5. do a medical examination to determine pregnancy and the estimated due date and send us your findings.

This medical information could be presented as evidence in a hearing if denial or termination of benefits is recommended based on your report.

Please feel free to include any additional information you believe would be helpful.

A self-address envelope is enclosed for your use. Your prompt attention in this matter will be appreciated.

NOTE: In order to comply with Federal regulations, our agency is required to make a decision on this application within 28 days. We are unable to make this decision without your help and cooperation.

| | |
|-----------------------------|-------------|
| ELIGIBILITY SPECIALIST NAME | LOAD NUMBER |
|-----------------------------|-------------|

AUTHORIZATION

CLAIMANT NAME

I, THE ABOVE NAMED CLAIMANT, AUTHORIZE THE INDIVIDUAL OR INSTITUTION NAMED BELOW

NAME OF PERSON OR INSTITUTION AUTHORIZED

to release the Family Support Division office named in the letterhead on the reverse side of this form, sufficient medical information including, but not limited to, my diagnosis and ability to function from my medical records or from the results of the examination(s) or test(s) indicated on the reverse side of this form which can be used to determine whether I meet the Family Support Division's definition of permanently and totally disabled or inability to work because of a physical or mental disability.

This request for inpatient or outpatient records, completion of form(s), examination(s), summaries, or other information includes, but is not limited to, my treatment for:

- drug and alcohol abuse
 psychiatric care
 Acquired Immune Deficiency Syndrome (AIDS)

I understand that I may withdraw this consent at any time. However, if the Family Support Division has already requested medical information based on this consent before I withdraw it, that request must be honored.

THIS CONSENT (UNLESS EXPRESSLY WITHDRAWN) EXPIRES ON ►

MONTH

DAY

YEAR

CLAIMANT SIGNATURE

DATE

PARENT/GUARDIAN

RELATIONSHIP

DATE

WITNESS

DATE

ADDRESS

WITNESS

DATE

ADDRESS

NOTICE FROM THE PROVIDER TO FAMILY SUPPORT DIVISION

If medical information is supplied, the hospital, doctor, or provider notifies the Family Support Division that:

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.