STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

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BEHAVIORAL HEALTH SERVICES REQUEST FOR PRECERTIFICATION

PARTICIPANT NAME (LAST, FIRST, MI)		PROVIDER NAME
PARTICIPANT NUMBER	BILLING PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE (IF REQUIRED)
DATE OF BIRTH	PROVIDER FAX NUMBER	PROVIDER PHONE NUMBER
PROVIDER SIGNATURE		DATE
NUMBER OF HOURS USED ON CURRENT PRECERTIFICATION (IF MULTIPLE CURRENT PRECERTIFICATIONS, PLEASE LIST TYPE)		

1. Service Requested (if requesting Family Therapy please see reminder in instructions)

☐ Testing (ages 0-2) Hours _____ Precertification Start Date _____

☐ Individual Therapy Hours _____ Precertification Start Date _____

☐ Family Therapy* Hours _____ Precertification Start Date _____

☐ Group Therapy Hours _____ Precertification Start Date _____

☐ Family Therapy without patient present Hours _____ Precertification Start Date _____

*If requesting Family Therapy, please list all members of the family, relationship to patient and DCN if available.

Is this request for ☐ PCIT ☐ PMT ☐ TF-CBT or ☐ DBT? If so, have you been appropriately trained/certified? ☐ Yes ☐ No
If age is less than 5, will services provided be developmentally appropriate? ☐ Yes ☐ No

2. Has the patient/guardian agreed to his/her treatment plan? ☐ Yes ☐ No

3. Is the therapy court ordered? ☐ Yes ☐ No

4. Have you communicated with other involved therapist/health care practitioners about treatment? ☐ Yes ☐ No

5. If child is in state custody, have you provided a copy of the treatment plan to the Children's Division case manager or contracted case manager? If yes, date _____ ☐ Yes ☐ No

Case manager name _____ ☐ Child not in state custody

6. Is therapy the result of an EPSDT screen? If yes, date of screen _____

BEHAVIORAL HEALTH DIAGNOSTIC CODE

DIAGNOSTIC CODE (PRIMARY)	DIAGNOSTIC CODE
DIAGNOSTIC CODE	DIAGNOSTIC CODE

IS THERE EVIDENCE OF SUBSTANCE ABUSE?
☐ 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 ABOVE DIAGNOSTIC CODE(S)?

☐ Yes ☐ No If yes, list condition:

DIAGNOSTIC CODE (PRIMARY)	DIAGNOSTIC CODE
DIAGNOSTIC CODE	DIAGNOSTIC CODE

***PLEASE SEE INSTRUCTIONS ON REVERSE SIDE OF FORM**

INSTRUCTIONS FOR COMPLETION

HEADER INFORMATION

Participant Name - Enter the participant's name as it appears on the MO HealthNet ID card.

Participant 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.

Provider Name - Enter the provider name.

Billing Provider Identifier - Enter the 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.

Provider Fax Number - Enter the fax number of the provider making the request.

Provider Taxonomy Code - Enter the provider taxonomy code (if required).

Provider Phone Number - Enter current phone number of the provider making the request.

Signature/Date - The provider of services must sign the request and indicate the date the form was completed.

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.

QUESTIONS 1 THROUGH 6 MUST BE COMPLETED FOR THERAPIES REQUESTED.

***REMINDER:** When requesting family therapy, please list all members of the family. Only one (1) precertification will be approved and open at a time for family therapy. 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. **PROVIDERS SHOULD NOT REQUEST MORE THAN ONE (1) FAMILY THERAPY PRECERTIFICATION PER FAMILY.** 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. NOTE: The authorized start is the date of receipt or noted subsequent date.

If therapy is the result of a court order a copy should be kept in the patient's file.

DIAGNOSTIC CODES

Enter current version ICD code for behavioral health diagnosis. List general medical conditions diagnostic codes only if applicable.

Precertification requests may be phoned, faxed or mailed into the call center (see below)

Wipro InfoCrossing
P.O. Box 4800
Jefferson City, MO 65102
Phone (toll free): 866-771-3350
FAX: 573-635-6516

AN APPROVED PRECERTIFICATION APPROVES ONLY THE MEDICAL NECESSITY OF THE SERVICE AND DOES NOT GUARANTEE PAYMENT.