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MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

EXCEPTION REQUEST
AIR FLUIDIZED/LOW AIR LOSS THERAPY

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(S):

PLEASE CHECK THE BOX THAT APPLIES:

☐ Air Fluidized ☐ Low Air Loss

For consideration of a low air loss mattress, the participant must have been on a comprehensive ulcer treatment program for at least the past month which has INCLUDED the use of an appropriate group 1 support surface.

Please list the name of the Group 1 Support Surface(s) tried and failed and the time period it was used:

Please explain in what way the Group 1 Support Surface did not meet the participant's needs?

Has the requested item been dispensed? ☐ YES ☐ NO

** If Yes, date item was dispensed. _____

Note: Please submit the IOC (Invoice of Cost) paid by the DME provider to the manufacturer and product description sheet that indicates the warranty information.

Date Skin Breakdown first noticed: _____.

How many hours per day is the participant out of bed up in wheelchair and will be off this therapy? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ 5+

Please provide the current Preventative Plan of Care.

Please provide current wound(s) information below:

Location	Stage	Size in centimeters LxWxD	Description

Please submit the assessment and progress notes supporting the medical necessity for the support surface requested.

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
PHYSICIAN OR ADVANCED PRACTICE NURSE'S NAME AND TITLE		TELEPHONE NUMBER
PHYSICIAN ADDRESS OR APN'S ADDRESS		FAX NUMBER
MO HEALTHNET PROVIDER ID	PHYSICIAN NPI	PHYSICIAN TAXONOMY CODE
PHYSICIAN OR APN'S ORIGINAL SIGNATURE AND TITLE		DATE