MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
EXCEPTION REQUEST
COUGH STIMULATION DEVICE

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(S) FOR REQUESTED ITEM(S):

HAS THE COUGH ASSIST DEVICE BEEN DESPENSED TO THE PARTICIPANT?

☐ Yes ☐ No

** If YES, date dispensed:

WHAT RESPIRATORY EQUIPMENT IS BEING USED IN THE HOME?

WHAT IS THE PARTICIPANT'S CURRENT SPECIFIC DAILY PULMONARY REGIME IN THE HOME?

PLEASE LIST ALL STANDARD TREATMENTS TRIED AND FAILED BY THE PARTICIPANT TO ADEQUATELY MOBILIZE RETAINED SECRETIONS.

EXPLAIN HOW EACH OF THE STANDARD TREATMENTS TO ADEQUATELY MOBILE SECRETIONS WERE INEFFECTIVE OR INAPPROPRIATE FOR THIS PARTICIPANT?

PLEASE PROVIDE AN EXPLANATION OF THE MEDICAL NECESSITY FOR THIS NON-COVERED ITEM:

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	PHYSCIAN NPI	PHYSCIAN TAXONOMY CODE
DOCTOR'S OR APN'S ORIGINAL SIGATURE AND TITLE		DATE