



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
**EXCEPTION REQUEST
DRESSING SUPPLIES**

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 SERVICES(S) REQUESTED)			
TYPE OF DRESSING HCPCS CODE, DESCRIPTION AND QUANTITY			
IS THIS REQUEST? <input type="checkbox"/> Initial Dressing <input type="checkbox"/> Renewal or Change to Current Approval			
SPECIFIC DRESSING CHANGE PROCEDURE			
WHO IS PERFORMING DRESSING CHANGES?		FREQUENCY OF THE DRESSING CHANGE	
PLEASE PROVIDE THE FOLLOWING CURRENT INFORMATION FOR EACH WOUND (Location, Stage, Size (in cm Length x Width x Depth) Drainage)			
Location	Stage	Size in Centimeters L x W x D	Description
DURATION OF NEED			
IS A HOME HEALTH AGENCY MAKING SKILLED NURSING VISITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, AGENCY NAME _____			
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
DOCTOR'S OR APN'S ORIGINAL SIGNATURE AND TITLE			DATE