MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

EXCEPTION REQUEST
HIGH FREQUENCY CHEST WALL OSCILLATION 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 and Description

Has this item been dispensed to the participant?

☐ Yes ☐ No **IF YES**, date dispensed? _____

What specific symptoms are currently being experienced by the participant that require this device?

Please list standard treatments to adequately mobilize retained secretions that have been tried and failed:

What is the participant's current pulmonary regime in the home, e.g. inhalers, nebulizers, O2 etc? Please list:

Has the participant had a daily productive cough for at least 6 continuous months or frequent (more than 2/year) exacerbation requiring antibiotic therapy?

☐ Yes ☐ No

IF YES, what was the frequency of these exacerbations in the past year? Provide dates, treatments, and outcomes for the exacerbations?

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	PHYSICIAN NPI	PHYSICIAN TAXONOMY CODE
DOCTOR'S OR APN'S ORIGINAL SIGNATURE AND TITLE		DATE