MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

EXCEPTION REQUEST
LIFE VEST

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 COD AND DESCRIPTIONS

REQUEST TYPE:	DURATION OF NEED FOR LIFE VEST:
☐ INITIAL ☐ RENEWAL	

Does the participant have a documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia? ☐ Yes ☐ No

Does the participant have a condition with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy? ☐ Yes ☐ No

Does the participant have either prior MI (Myocardial Infarction) or Dilated/Nonischemic Cardiomyopathy AND a measured left ventricular ejection fraction < than or = to 0.35? ☐ Yes ☐ No

If Yes, what is the current Left Ventricular Ejection Fraction (LVEF) result?

Is the Life Vest due to a previously implanted defibrillator now requiring explantation? ☐ Yes ☐ No

If Yes, provide the medical necessity for the explanation of the defibrillator.

How long will the Life Vest be required before the defibrillator can be re-implanted? _____

Hospital discharge date: _____. Was the participant discharged wearing the Life Vest? ☐ Yes ☐ No

If No, what date was the Life Vest dispensed to participant? _____

Has an AICD been implanted? ☐ Yes ☐ No

If Yes, what date was the AICD implanted? _____

IF RENEWAL, PLEASE SUBMIT THE FOLLOWING INFORMATION:
The Wear Time & Histogram reports beginning with date the Life Vest was dispensed to the current date. (Available to the prescriber in LifeVest Network)
The Wear Time & Histogram reports must indicate the participant is wearing the Life Vest as they agreed to at time of fitting, wearing the LifeVest at all times, except to bathe, shower or change the garment. Doctor direction to wear for a different timeframe must be specified in progress notes.

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