MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

EXCEPTION REQUEST - 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)

REQUESTED THERAPY TYPE

☐ Physical Therapy ☐ Occupation Therapy ☐ Speech Therapy (CPT Code 92507 Only) for Training in use of Artificial Larynx

APPROPRIATE CPT CODE(S) FOR THE REQUESTED THERAPY WITH TOTAL NUMBER OF UNITS FOR EACH TREATMENT MODALITY (NOTE 1 UNIT = 15 MINUTES OF THERAPY)

REQUESTED FREQUENCY OF VISITS

☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ Other (specify)

NUMBER OF PREVIOUSLY APPROVED UNITS REMAINING PER CPT CODE

POTENTIAL FOR REHABILITATION?	DURATION OF NEED FOR THE REQUESTED THERAPY
☐ Good ☐ Fair ☐ Poor	

PARTICIPANTS CURRENT SPECIFIC FUNCTIONAL LIMITATIONS

PARTICIPANTS INDIVIDUALIZED PLAN OF CARE

SPECIFIC GOALS OF THERAPY FOR THE PARTICIPANT

DATE OF SURGERY	HAS THE PARTICIPANT BEEN INSTRUCTED IN HOME EXERCISE PROGRAM ☐ YES ☐ NO IF NO, PLEASE EXPLAIN

IF HOME HEALTH THERAPY:

CPT CODE G0151 PT_____ AND/OR G0152 OT _____

TOTAL NUMBER OF PT/OT HOME HEALTH VISITS	DURATION OF EACH VISIT BY PT/OT ☐ 15 min ☐ 30 min ☐ 45 min ☐ Other (specify) _____

Note: Please submit the following documents, as applicable. Inpatient rehabilitation discharge summary, physician and therapy notes. Therapy evaluation, if completed. Physician office/clinic notes that document history of present illness, including date of onset and any pertinent x-rays, MRI and/or CT reports. If post-surgical, please submit operative report.

THE PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES
NOTE: "01" HOSPITAL PROVIDER OR "58" HOME HEALTH PROVIDER ARE THE ONLY PROVIDERS FOR PT, OT OR ST.

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