MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

EXCEPTION REQUEST
UROLOGICAL 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 SERVICE(S) REQUESTED)

HCPCS CODE(S) FOR REQUESTED ITEM(S):

IS THIS REQUEST	
☐ INITIAL ☐ RENEWAL	☐ Intermittent ☐ Indwelling ☐ External

SPECIFY QUANTITY PER DAY BEING REQESTED:

IF A4352 INTERMITTENT URINARY CATHETER, COUDE (CURVED TIP, OR A4353 INTERMITTENT URINARY CATHETER WITH INSERTION SUPPLIES, PLEASE PROVIDE THE MEDICAL REASON THE PARTICIPANT REQUIRES THIS TYPE OF CATHETER?

CATHETER SCHEDULE (I.E. TIMES PER DAY)

WHO IS PERFORMING THE CATHETERIZATIONS?

TECHNIQUE USED FOR CATHETERIZATIONS:	
☐ Sterile ☐ Clean	If sterile technique, please provide the specific medical reason sterile technique is required for this participant.

HAS THE PARTICIPANT HAD FREQUENT UTI'S DURING THE LAST YEAR? IF YES, PLEASE PROVIDE THE DATES AND TREATMENT:

IF INDWELLING CATHETER, PLACE OF SERVICE WHERE THE CATHETER IS REPLACED?

WHAT IS THE FREQUENCY FOR INDWELLING REPLACEMENT?

1x/month _____; 2x/month _____; Other (specify) _____

IS THE PARTICIPANT RECEIVING SKILLED NURSING HOME VISITS? ☐ Yes ☐ 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
MO HEALTHNET PROVIDER ID	PHYSCIAN NPI	PHYSCIAN TAXONOMY CODE
DOCTOR'S OR APN'S ORIGINAL SIGATURE AND TITLE		DATE