missouricare℠

Continuation of Care Form
Page 1: Member Section

Date of Request: _____

This form is used to request ongoing care from your provider. Your provider is no longer working with Missouri Care. You may keep your provider if you are receiving care for circumstances such as:

- pregnancy
- a disability, life-threatening illness, an active stage of an illness, or a serious medical condition

1. Please fill out page one (for you).
2. The second page is for your provider to fill out.
3. Bring both pages of this form to your provider.
4. Ask your provider to fill out the second page. Send in both pages to Missouri Care.

Please fill out the following:

ID Number:		
Name:	Date of Birth:	☐ Male ☐ Female
Address:	Phone Number:	
City/State/Zip:		
PCP Name:	Specialist Name:	
PCP Phone:	Specialist Phone:	
Medical Conditions (list all):		
1. List all surgeries you have had in the past six months		
Surgery:	Provider:	Date:
2. List all surgeries that you plan to have in the next six months		
Surgery:	Provider:	Date:
3. Have you visited an ER in the past six months? ☐ Yes ☐ No		
Reason for Visit:	Name of Hospital:	Date:
4. Do you have any Specialist visits planned in the next six months? ☐ Yes ☐ No		
Specialist Name:	Reason for visit:	Date of appointment:
5. Are you pregnant? ☐ Yes ☐ No		
Due Date:	OB Name:	OB Phone:
6. Are you currently receiving behavioral health or alcohol and drug abuse services? ☐ Yes ☐ No		
Provider Name:	Provider Phone:	Date of next visit:
7. Are you currently receiving any of the following services? (Mark all that apply and enter provider name/phone)		
☐Home Health Nursing ☐Home Health Aide ☐Case Management ☐Speech Therapy ☐Physical Therapy ☐Occupational Therapy		
Provider Name:		Phone:
Provider Name:		Phone:
8. Are you currently using any of the following equipment or supplies? (Mark all that apply and enter provider name/phone)		
☐Wheelchair ☐Hospital Bed ☐Oxygen ☐Nebulizer ☐IV/Feeding pump ☐IV/Feeding Tubes ☐Ostomy supplies ☐Catheter ☐Other_____		
Provider Name:		Phone:

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Continuation of Care Form
Page 2: Provider Section

Date of Request: _____

Your patient is requesting continuity of treatment with you despite discontinuation of your contract for either
A) a disability, a life-threatening illness, an active stage of an illness, a serious medical condition, or,
B) prenancy
Please enter the requested information below and fax back to Missouri Care Prior Authorizations **866-946-2052.**

By submission of this document you acknowledge and accept:
A) The reimbursement rate of 100% of the Medicaid fee schedule.
B) Provider shall accept payment from Missouri Care as payment in full (no balance billing) and shall not collect payment from Members except for:

1) Applicable MO HealthNet cost sharing amounts; and
2) When services are not in the comprehensive benefit package and, prior to providing the services, Provider informed the Member that the services were not covered. Provider shall inform the Member of the non-covered service and have the member acknowledge the information. If the Member still requests the service, Provider shall obtain such acknowledgement in writing (a private pay agreement) prior to rendering the service. Regardless of any understanding worked out between Provider and the Member about private payment, once Provider bills Missouri Care for the service that has been provided, the prior arrangement with the Member becomes null and void.

A Missouri Care medical director will review this request and you will be notified promptly after a determination is made.

Requesting Provider:	**Contact Person:**	
Address:	**Phone:**	**Fax:**
Date of Appointment/Service:	**Number of Visits Required:**	
Problem/Diagnosis (ICD-9 Code(s) Required *see below):		
Service(s) Requested (CPT Code(s) Required *see below):		
Clinical Rationale (Please attach Clinical Notes, Lab reports, X-ray reports, etc.):		
Justification of why this cannot be done by a Missouri Care participating provider:		
Signature of Requesting Provider:	**Date:**	

***NOTE: <u>FAILURE TO INCLUDE CORRECT CPT AND ICD-9 CODES WILL RESULT IN DENIAL OF REQUESTED SERVICES</u>**

PLEASE SEND COMPLETED FORM TO:
Missouri Care Health Plan
2404 Forum Blvd.
Columbia, MO. 65203
Fax 866-946-2052

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