MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

HEALTHCARE INFORMATION REQUEST

TO: PHYSICIAN'S NAME:

ADDRESS:

ADDRESS:

CITY, STATE, ZIP:

Your patient below has requested Home and Community Based Services (HCBS). HCBS are authorized for reimbursement through Medicaid for participants who require nursing facility level of care. The services provide assistance with activities of daily living and/or instrumental activities of daily living as an alternative to nursing facility placement.

Your patient has authorized the Division to contact you to obtain information to assist in determining program eligibility. Please complete the below information within 10 days and fax this form to the staff listed at the bottom of this page. If you have additional information, please include that information in the space provided on the second page. Thank you.

PATIENT'S NAME:	DOB:	DCN:

Your Patient provided the information below regarding their eligibility for Medicaid HCBS.		**Is this information accurate according to your records?** IF NO, PLEASE EXPLAIN USING PAGE 2	
MEDICATIONS		☐ YES	☐ NO
TREATMENTS		☐ YES	☐ NO
REHABILITATIVE		☐ YES	☐ NO
COGNITIVE/ BEHAVIORAL		☐ YES	☐ NO
RESTORATIVE		☐ YES	☐ NO
MONITORING		☐ YES	☐ NO
PERSONAL CARE		☐ YES	☐ NO
DIETARY		☐ YES	☐ NO
MOBILITY		☐ YES	☐ NO

STAFF SIGNATURE	STAFF NAME (**PLEASE PRINT**)	DATE
ADDRESS		FAX NUMBER

MO 580-3211 (03-18)

DSDS STAFF COMMENTS

PHYSICIAN COMMENTS