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MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

# PROVIDER ATTESTATION OF PHYSICIAN'S ORDER OF MEDICAL NECESSITY

**Instructions for home health care provider:** Please fill out this form to verify that there is a physician's order on record for a patient who has qualified for MO HealthNet spend down.

MO HealthNet must receive either this form or a Physician's Plan of Care before it can accept your patient's medical expenses to meet spend down. It must also be:

- Updated by the provider as needed, and
- Maintained in the patient's case record

Fill out **all** fields in Sections 1 and 2 below. If you have questions, see Added Instructions below. (Please print)

## SECTION 1: PATIENT AND PHYSICIAN INFORMATION

| PATIENT NAME | MO HEALTHNET NUMBER (DCN) |
|---|---|
| | |

| PROVIDER NAME |
|---|
| |

| CERTIFYING PHYSICIAN NAME | TELEPHONE |
|---|---|
| | |

| PHYSICIAN ADDRESS |
|---|
| |

| CARE PLAN BEGIN DATE | CARE PLAN END DATE |
|---|---|
| | |

## SECTION 2: PROVIDER INFORMATION AND SIGNATURE

By completing and signing this form, you verify that all services and supplies provided and billed for this patient:

- Are within the scope of the physician's order
- Are necessary to diagnose or treat the patient's medical condition, and
- Meet accepted standards of medical practice

You must be able to provide a copy of the physician's order to the Family Support Division (FSD) upon request. Anyone who knowingly and willfully makes, or causes to be made, a false statement or representation of this statement may be prosecuted under applicable federal or state laws.

**Provider or authorized employee completing this form** (please print)

| NAME | |
|---|---|
| | |

| TITLE | DATE |
|---|---|
| | |

| ADDRESS | TELEPHONE |
|---|---|
| | |

| SIGNATURE OF PERSON COMPLETING FORM |
|---|
| |

## ADDED INSTRUCTIONS FOR FILLING OUT THIS FORM

Here are instructions for some of the form fields that you may not be familiar with:

**Section 1: Patient and Physician Information**

- **Patient name:** Fill in the name of the patient who has incurred billable medical expenses.
- **MO HealthNet Number:** Fill in the patient's MO HealthNet number, also known as the Department Client Number (DCN). This appears on the patient's MO HealthNet card.
- **Provider name:** List your provider name as it appears on your contract with MO HealthNet Division (MHD). If you are not contracted with MHD, list your name as it appears on federal income tax documents.
- **Certifying physician name, phone, and address:** Fill in information for the physician who ordered the services to be provided.
- **Care plan begin date:** Enter the date the physician certified that services were needed by this patient.
- **Care plan end date:** Enter the date the current physician's order expires.

**Section 2: Provider Information and Signature**

- **Name and title of provider or authorized employee completing form:** Fill in the typed full name of the provider of the services or authorized employee. The person completing the Provider Form is attesting to the accuracy of the information and must be able to provide the physician's order, upon request.
- **Date:** Enter date you are completing and signing this form.
- **Address and phone:** Fill in information for the provider or authorized employee completing the form.
- **Signature:** You may fill in this field with a signature or signature stamp of the provider or authorized employee completing this form.

**How to submit this form:**
Please send it to the FSD Spend Down Unit: Email at SESD@ip.sp.mo.gov or fax at 1-855-600-3754

Questions about this form or about spend down? Call: 1-855-600-4412 or visit online:
**https://modss.uservoice.com/knowledgebase/topics/80263-spend-down-program**