IM-60A Instructions

MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

Purpose:
To provide a method of obtaining medical information and certification as to the incapacity or employability of the person being examined.

Form Processing:
The completed form is to be returned to the Family Support Division (FSD) office by the examining physician and is to be filed in the electronic record.

Manual References:
1060.005.05 Obtaining Medical Evidence For Medical Review Team
0205.050.20 Physical and Mental Incapacity

Instructions for FSD Staff Use:

Staff should complete the designated sections before sending it to the provider. Before using this form for the first time with any physician, clinic, hospital, or other medical professional, FSD staff must discuss the form, the reasons the medical information is needed, and the procedures relating to appointments, invoices, payment, and return of the completed form with the provider. Attach form MO 650-2616 to the IM-60A and send it to the physician/clinic/hospital. Provide directions for the physician/clinic/hospital to return the form and other appropriate medical records.

Individual's First Name: Enter the individual's first name.

Middle Initial: Enter the individual's middle initial. If none, leave this field blank.

Last: Enter the individual's last name.

Individual DCN: Enter the individual's DCN.

Date of Birth: Enter the numeric date of birth, month, and day and 4-digit year of the individual's birth.

NOTE: This information must also be entered at the top of page 2.

Date of App/Review: Enter the date of application, reapplication, or review on which the individual applied for assistance.

Date Submitted to MRT: Enter the date the form and all the supporting documentation is sent to the Medical Review Team for eligibility determination.

TO THE EXAMINING PHYSICIAN:

This contains instructions for the medical professional to complete the form.

Physician's Name: Enter the name of the examining physician.

Specialty: Enter the type of specialty the examining physician practices, (i.e. orthopedic, psychologist, psychiatrist, Internal Medicine, etc.)

Scheduled Appointment: The first field should be the date and time of the scheduled evaluation (ex: December 21, 2020). The second field should be the type of exam that was scheduled (Mental Health Evaluation).

To Be Completed by the Medical Professional Examining the Above Named Patient:

The remainder of the form fields should ONLY be completed by the medical professional. No additional notes or comments should be made by FSD staff on the remainder of the form.