MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MO HEALTHNET SPEND DOWN PROVIDER

Provider Instructions: Please fill out this form when you have a patient who has qualified for spend down, and an actual bill is not yet available. By completing this form, you (or an authorized employee) are verifying that your patient has incurred, and personally owes payment for, medical expenses you provided. If you have questions about filling in this form, see the other side.

You must fill out **all** fields below. If you leave any fields empty, attach separate papers that give information for those fields. (Please print)

PATIENT NAME	MO HEALTHNET NUMBER

PROVIDER NAME

CHECK ONE
☐ Doctor ☐ Pharmacy ☐ Other:

HOSPITAL
☐ In-patient ☐ Out-patient

Date of Service (use a separate row for each date)	Description of Service	Procedure Code	Name of liable third party/parties	Total amount of charge	Third party payment	Write off or other discount (such as Indigent Waiver)	Total amount patient is responsible to pay for each date of service	Total amount billable to DMH and DHSS contracts
Example: 08/01/2015	***CT Scan Abdomen***	***72192***	***Medicare***	***$2000.00***	***$300.00***	***$1360.00***	***$340.00***	***$0.00***

Verify: By completing and signing this document, you verify that you have provided accurate information and that you will bill the patient for the amount due. Also, if you filled in the "Total amount patient is responsible to pay" column above with a good faith estimate, INITIAL HERE: _____

AUTHORIZED EMPLOYEE COMPLETING FORM (PLEASE PRINT)

NAME

TITLE	DATE

ADDRESS	TELEPHONE

SIGNATURE OF PERSON COMPLETING FORM

This form is not considered acceptable verification of allowable spend down expenses unless you completed the required fields and sign it. This form does not replace your responsibility to bill the patient or submit a claim to MO HealthNet.

ADDED INSTRUCTIONS FOR FILLING OUT THIS FORM

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

Grid (boxed) section:

- **MO HealthNet Number:** Fill in the patient's MO HealthNet number or DCN, as shown on their MO HealthNet card.
- **Provider name:** Fill in your name as it appears on your contract with MO HealthNet Division (MHD). If you have not contracted with MHD, list your name as it appears on income tax documents.
- **Date of service:** Use a separate row for each date you provided services. If you performed more than one service on the same date, you can combine them in the row for that date.
- **Description of service:** See RSMO Section 208.152 if you need definitions for medically necessary services. If the patient has Medicare, we will accept Medicare's determination of medical necessity.
- **Procedure code:** See http://manuals.momed.com/manuals for procedure codes used to submit claims to MO HealthNet.
- * **Name of liable third party/parties (TPL):** Fill in the name of any third party payers or insurance that you know may pay for the patient's medical expenses. If there are multiple TPLs, list each one separately. If there is no known TPL, enter "N/A".
- **Total amount of charge:** Fill in the **TOTAL** amount of charges incurred by the patient on each date.
- **Third party payment:** Fill in the amount a TPL will pay or has paid. If a TPL has not yet paid and you know what the amount will be, fill it in and be sure to verify it by signing your initials in the "Verify" section. If no TPL, enter "$0" or "N/A".
- **Write off or other discount:** Fill in the amount of incurred expenses written off or any discounts given that will not be billed to the patient. If no write offs or discounts are given, enter "$0".
- **Total amount patient is responsible to pay for each date of service:** To get this amount, take the "Total amount of charge" minus any third party payment and write off/discounts.
  - If you provided services to the patient on more than one date, fill out a separate row for each date.
  - If you are not billing any amount to the patient, enter "$0".
- **Total amount billable to DMH (Department of Mental Health), DHSS (Department of Health & Senior Services) contracts:** Fill in "N/A" unless the amount will be paid by state-only funding (through DMH or DHSS). Do not enter any state funds that are intermingled with federal funds. If no state-only funds will be paid, enter "$0".

"Verify" section:
If you are filling in the "Total Expenses Patient is Responsible to Pay" field with a good faith estimate, sign your initials to verify that it is based on third party liability and discount information available at the time you are completing this form.

"Authorized employee completing form" section:
The person who filled in the form must type or print their information. By completing the Provider Form, you are attesting to the accuracy of the information and must be able to verify the amount you billed to the patient, upon request. You may sign the signature field with a signature or signature stamp of the authorized employee completing the form A typed signature can only be accepted if the form is accompanied by a letter on company letterhead that includes identifiable contact information which states that the typed signature is an authentic signature from the company.

How to submit this form:
When the form is completed, please send it along with any separate verifying documents to the Family Support Division Spend Down Unit. Send forms and documents for each patient separately, not with multiple patients in one fax, scan, or email.

Email: **SESD@ip.sp.mo.gov** or fax: **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**