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.

Patient Name:		MO HealthNet Number:	
Provider Name:			
Does the patient have Medicare or other Third-Party Insurance?	☐ Yes	☐ No	

Date of Service	Type of Service	Total Charge	Third Party Payment	Write-Off / Adjustment	Patient Responsibility
Example: 01/01/2024	X-RAY	$1000.00	$300.00	$500.00	$200.00

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 patient is responsible to pay" column with a good faith estimate, INITIAL HERE: _____

AUTHORIZED EMPLOYEE COMPLETING FORM (Please Print)

Name			
Phone		Date	
Signature of Person Completing the Form			

SUBMIT COMPLETED FORM TO: Email: SESD@IP.SP.MO.GOV FAX: 855-600-3754

A typed signature is allowed on this form only if the typed signature is accompanied with:

- A letter on company letterhead that includes verifiable contact information. The letter must state the letter constitutes a signature on the MO HealthNet Spend Down Provider form.
- An email including a signature block that includes verifiable contact information.