MEDICAL REFERRAL AND AUTHORIZATION

PURPOSE: To provide a uniform cover letter for the IM-60A, Medical report including Physician's Certification/Disability Evaluation, or for the release of medical information to the Family Support Division (FSD).

NUMBER OF COPIES AND DISPOSITION: Make an original and one copy. Attach the original to the IM-60, if appropriate, and mail it to the physician, hospital, laboratory, etc. File the copy in the Medical section of the case record.

MANUAL REFERENCE:

0105.025.15.25 Medical Assistance Program
0105.025.15.40 Supplemental Nursing Care
0205.050.20 Physical and Mental Incapacity

INSTRUCTIONS FOR COMPLETION: Type or complete legibly in ink. Use this form to accompany the IM-60A.

FROM:

COUNTY OFFICE: Enter the name of the county office.

TELEPHONE NUMBER: Enter the telephone number of the county office.

DATE: Enter the date the form is mailed.

ADDRESS: Enter the street address of the county office.

CITY, STATE, ZIP CODE: Enter the city and zip code of the county office. The State is already entered.

TO:

NAME: Enter the name of the physician, hospital, or laboratory to whom the letter is sent.

ADDRESS: Enter the address of the physician, hospital or laboratory to whom the letter is sent.

CITY, STATE, ZIP CODE: Enter the city and zip code of the county office. The State is already entered.

RE:

CASE NAME: Enter the first, middle, and last name of the individual.

CASE DCN: Enter the type of assistance, and DCN (Departmental Client Number) for the case name.

PATIENT NAME: Enter the first, middle, and last name of the individual for whom the medical information is being requested.

BIRTHDATE: Enter the month, day, and year of the individual's birthdate.

INDIVIDUAL DCN: Enter the patient's DCN, if applicable.

In the space provided in the first paragraph, enter the type of assistance the individual is requesting and:

- check the box to the left of "permanently and totally disabled" to request medical information and/or reports for the purpose of determining PTD.

- check the box to the left of "unable to work because of a physical/mental disability" to request medical information and/or reports for the purpose of establishing unemployability for Medicaid or incapacity for Temporary Assistance.

- check the box to the left of "pregnant" to request medical information and/or reports to verify pregnancy for the Medicaid for Pregnant Women program.

In the next section, mark one of the following boxes to designate the type of medical information requested.

1. If the Eligibility Specialist is requesting information from the individual's physician, check the first box.

2. If the individual was hospitalized, check the second box and enter the date of discharge.

3. If the individual has not seen his/her physician in the last 6-12 months, or does not have his/her own physician, the Eligibility Specialist schedules an appointment with an agency designated physician (except in those counties where the local Medical Review Team schedules these examinations). Check the third box to indicate the date and time of the examination. Do not check this box if you are only requesting a determination of pregnancy; use box five instead. If requesting a determination of pregnancy and unemployability/incapacity, check boxes three and five.

4. If the individual is currently being seen on an outpatient basis, check the fourth box.

5. When requesting a determination of pregnancy and the individual has not seen or does not have her own physician, the Eligibility Specialist would have scheduled an appointment with an agency designated physician (except in those

counties where the local Medical Review Team schedules these examinations). Also check box three and indicate the date and time of the examination.

ELIGIBILITY SPECIALIST NAME: The Eligibility Specialist enters his/her name.

LOAD NUMBER: The Eligibility Specialist enters his/her caseload number.

AUTHORIZATION:

INDIVIDUAL NAME: Enter the individual's first, middle, and last name.

NAME OF PERSON OR INSTITUTION AUTHORIZED: Enter the individual's physician or institution's (hospital, clinic, etc.) name. Include the specific name of a drug and alcohol treatment center or clinic.

If appropriate, check the box to the left of "drug and alcohol abuse", "psychiatric care", or Acquired Immune Deficiency Syndrome (AIDS)" to request information about the individual's treatment for such medical problems.

THIS CONSENT (UNLESS EXPRESSLY WITHDRAWN) EXPIRES ON: Enter the month, day, and year (not to exceed thirty days), from the date the individual signs the form. Although the form must be mailed and received by the physician or institution before the consent expires, the medical information does not have to be returned by the physician or institution before the consent expires. Any IM-60 received before the expiration should be honored by the physician or institution.

NOTE: *Continue to use the MO 650-2616 Authorization for Disclosure of Consumer Medical/Health Information (HIPAA form) and send it with the IM-60 to the appropriate provider.*

SIGNATURE SECTION:

The individual (guardian or conservator) must sign and date the form. If the individual is unable to sign his/her name, the signature should be made by his/her mark. The signature and address of two witnesses must be entered whenever a signature by a mark is made.

The correct procedure for a signature by mark is illustrated below:

			his	
/s/ Jane Doe	02/14/06		Edward J. (x) Lee	02/14/06
Witness	Date		mark Individual	Date

100 N. Main Street, Your Town, MO 611111
Address

/s/ John Smith 02/14/06
Witness Date

1000 First Street, Your Town, MO 64111
Address

NOTICE FROM THE PROVIDER TO THE FAMILY SUPPORT DIVISION: This notice is included because some medical providers will not release information unless the consent statement includes this re-disclosure notice.