MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

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

NUMBER OF COPIES AND DISPOSITION: One copy is returned to the Family Support Division (FSD) office by the examining physician and filed in the medical section of the case record. In case an appeal is filed, the original accompanies the appeal summary. Make a copy for filing in the medical section of the case record.

MANUAL REFERENCE:

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

INSTRUCTIONS FOR COMPLETION: Complete this form online. Before using this form for the first time with any physician, clinic, or hospital, the Eligibility Specialist or County Manager discusses 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. Inform the provider to send a bill in triplicate attached to the completed form to the county office. Attach form MO 650-2616 to the IM-60A and mail it to the physician/clinic/hospital. Enclose a self-addressed envelope with the form.

INDIVIDUAL NAME (FIRST): Enter the individual's first name.

MIDDLE: Enter the individual's middle name or 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.

COUNTY: Enter the name of the county in which the case is carried.

ELIGIBILITY SPECIALIST: Enter the name of the Eligibility Specialist responsible for sending the form.

FAMIS USER ID: Enter the FAMIS User ID of the Eligibility Specialist responsible for sending the form.

LOAD: Enter the caseload number of the Eligibility Specialist sending the form.

DATE OF APP/REAPP/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: The examining physician completes the rest of 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)