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MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

REQUEST FOR PARTICIPANT MO HEALTHNET REIMBURSEMENT

FSD OFFICE:	FSD STAFF:
OFFICE/UNIT NAME(EX. VENDOR UNIT)	NAME
ADDRESS	EMAIL
CITY, STATE ZIP CODE	PHONE NUMBER

WHEN TO USE THIS FORM

Use this form if retroactive coverage is authorized as part of resolving an incorrect action on behalf of the agency. The participant must first request reimbursement from the provider. If the provider refuses to bill MHN to reimburse the participant, use this form to request reimbursement for the participant from MHD.

PARTICIPANT'S NAME	DCN	PARTICIPANT'S SPOUSE	DCN

INSTRUCTIONS: COMPLETING AND SUBMITTING THIS FORM

This completed form and any provided verification must be sent to MO HealthNet Division.

If completed by FSD Staff with the participant by phone or in person:	FSD Staff may complete the participant information as it is reported by the participant. Document all conversations in the eligibility system.	Submit this form to: • Your local FSD office • By email to: MHD.PSUReferrals@dss.mo.gov • By mail to: MO HealthNet Division Participant Services Unit PO BOX 6500 Jefferson City, MO 65102
If mailed to the participant by FSD Staff:	Participants can complete Section A and submit the form to MO HealthNet Division. If you have questions, call FSD Information Center at 855-FSD-INFO (855-373-4636) or visit your local FSD office.	

SECTION A – PARTICIPANT TO COMPLETE

Did you, your spouse, or another member of your household (who is an eligible MO HealthNet participant) have any medical services during the following dates?

_____ TO _____ ☐ YES, CONTINUE WITH THIS FORM. ☐ NO. NOTHING ELSE IS REQUIRED. THANK YOU!

Did you pay out of pocket for any of those medical services?

☐ **No.** Contact the medical provider and tell them that you are covered by MO HealthNet and ask that your medical expenses be sent to MO HealthNet for payment. Keep this form until expenses are paid.

☐ **Yes.** Have you requested a refund from the medical provider?

☐ Yes. The provider will not reimburse me.
Sign and submit this form.
If you have receipts, bills, or invoices, please provide copies with this form.

☐ No. You **must** request refunds from your provider first. Reimbursements made by MHD will be made at the Medicaid rate and will likely be less than you actually paid.
Keep this form for your personal records.

PARTICIPANT'S SIGNATURE	DATE
SPOUSE'S SIGNATURE	DATE

SECTION B – FSD STAFF COMPLETE

Has the participant been determined eligible for the above period?

☐ Yes, **Move to Section C**.

☐ No. Nothing else is required. Put a copy in the participant's file.

SECTION C – FSD STAFF COMPLETE

Why did the participant's eligibility change?

(Example: Administrative hearing decision; additional information received, determination re-evaluated; Agency error, discovered by staff/supervisor; Agency error, discovered by Quality Control.)

SECTION D – FSD STAFF COMPLETE

Does the participant have a spend down for any month during the period shown on page 1? ☐ No. ☐ Yes.

If yes, enter the date that the participant met their spend down liability for each month.

JANUARY	FEBRUARY	MARCH
APRIL	MAY	JUNE
JULY	AUGUST	SEPTEMBER
OCTOBER	NOVEMBER	DECEMBER

If there were more than 12 months in the period shown on page 1, please provide additional spend down information below:

SECTION E – FSD STAFF COMPLETE

Were there any other members of the assistance group during the period shown?

NAME	DCN