Opioid Prescription Intervention™ Program
Prescriber Feedback Response Form

The information in your OPI mailing packet is based on paid Medical Claims, including diagnosis and prescription drug claims submitted by pharmacies. IF you believe the information is in error, please indicate on this form and use the fax or e-mail information below to contact us. **You must also contact the pharmacy directly to correct this information, as we cannot resolve this issue for you.**

Please use this form to facilitate your response to information contained in your OPI mailing packet. We want to understand the patient-specific reasons for the drug therapy you have prescribed that is hitting the Quality Indicators™. You may alternately use the **Prescriber Summary Report** or a specific **Patient Profile Report** contained within the mailing to send comments, advise us of your follow-up actions, or inform us of some other opioid-responsive plan. You may also use this form to request a peer-to-peer consultation. Because of confidentiality considerations, you should use a separate feedback form for each patient response and send communication via secure e-mail, fax, or by US Mail. Make as many copies of the form as needed. A fillable version of this form is available at the following website link: https://dss.mo.gov/mhd/providers/files/provider-communication.pdf

Prescriber Name, NPI and address on record:

Primary Specialty:

Patient Name and MO HealthNet ID:

☐ Peer-to-Peer Consultation Requested

*Provider Contact # and preferred time of day for call: _____

Quality Indicator™ (QI) **use separate line for each*	Comments and/or Explanation *(use additional pages as necessary)*

Send ALL documentation via secure communication to:

Missouri Medicaid Audit and Compliance (MMAC) Unit
PO Box 6500
Jefferson City, MO 65102-6500
Fax: (573) 526-4375
E-Mail: MMAC.OPICompliance@dss.mo.gov