Missouri Department of
SOCIAL SERVICES
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MICHAEL L. PARSON, GOVERNOR • JENNIFER TIDBALL, ACTING DIRECTOR

MISSOURI MEDICAID AUDIT & COMPLIANCE UNIT
P.O. BOX 6500 • JEFFERSON CITY, MO 65102-6500
WWW.DSS.MO.GOV • 573-751-3399

MISSOURI MEDICAID AUDIT & COMPLIANCE UNIT
MEDICAL REFERRAL FORM OF RESTRICTED PARTICIPANTS

PARTICIPANT NAME:_____
(Last) (First) (Middle)

PARTICIPANT IDENTIFICATION NUMBER:_____

AUTHORIZED PROVIDER MAKING REFERRAL:_____

PROVIDER VENDOR NUMBER:_____

TAXONOMY CODE :_____
(If applicable)

AUTHORIZED PROVIDER'S SIGNATURE:_____

DATE OF SIGNATURE:_____

DATE OF SERVICE:_____

REASON FOR REFERRAL:_____

_____

_____

REFERRING TO:_____
(Provider's Name)

ADDRESS:_____ PHONE: _____

PROVIDER VENDOR NUMBER:_____

TAXONOMY CODE :_____
(If applicable)

This form is to be completed and signed by the authorized lock-in provider when a referral to another provider is medically necessary.

This referral form should NOT be attached to the claim form. You may either send it to Infocrossing Healthcare Services, Inc., P.O. Box 5900, Jefferson City, MO 65102 or submit via Internet. The website for these submissions is www.emomed.com. A referral form is needed for each claim in which services are rendered to a Missouri restricted participant in order for the provider performing the service to receive payment for his or her claim.

THIS REFERRAL IS GOOD ONLY FOR 30 DAYS FROM THE DATE OF SERVICE.

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