

**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
P.O. Box 5900
Jefferson City, MO 65102**

or submit via Internet. The website for these submissions is www.emomed.com. **Please note, the PI 118 form cannot be faxed to us. It must be sent by one of the above methods.** 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.

PI 118 - Revised 07/22

AUXILIARY AIDS AND SERVICES ARE AVAILABLE UPON REQUEST TO INDIVIDUALS WITH DISABILITIES

TDD / TTY: 800-735-2966

RELAY MISSOURI: 711