



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE
MEDICAL REFERRAL OF RESTRICTED PARTICIPANT

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

This 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 their claim. **This referral form should NOT be attached to the claim form.**

This referral is only good for 30 days from the date of service.

Submit this form via [eMOMED](#) or by mail to:

**Wipro Infocrossing
PO Box 5900
Jefferson City, MO 65102**

This form cannot be faxed to MMAC; it must be sent in one of the two ways described above.

Participant Information

Participant Name (Last, First, Middle)	MO HealthNet Identification Number
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Authorized Provider Information

Name of Authorized Lock-In Provider Making the Referral

Provider NPI Number	Provider Taxonomy Code (if applicable)
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Authorized Provider Signature	Date
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Referral Information

Date of Service (Only one DOS can be listed)

Reason for Referral

Referred To Provider Information

Provider's Name Being Referred To	Telephone Number
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Street Address	City	State	Zip
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Provider NPI Number	Provider Taxonomy Code (if applicable)
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