MISSOURI DEPARTMENT OF SOCIAL SERVICES

FAMILY SUPPORT DIVISION

**MEDICAID ELIGIBILITY AUTHORIZATION**



|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FROM** | | CASEWORKER | | | | | TELEPHONE NUMBER     -   - | | | | | | DATE  March 16, 2021 | | | | |
|  | | COUNTY OFFICE ADDRESS (STREET, CITY, STATE, ZIP CODE) | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | |
|  | | , MISSOURI | | | | | | | | | | | | | | | |
| **TO** | | NAME | | | | | | | | | |  | | | | | |
|  | | ADDRESS (STREET OR P.O. BOX NO.) | | | | | | | | | |  | | | | | |
|  | | CITY STATE ZIP       , | | | | | | | | | |  | | | | | |
| **RE** | | CASE NAME | | | | | | | | | | CASE NUMBER | | | | | |
| This is to certify that the following person(s) is receiving assistance benefits from our agency and is eligible  for Medicaid benefits.  This Form is Replacing a Lost Card/Letter:  Yes  No General Relief Case:  Yes  No  Lock-in Case:  Yes  No Hospice Case:  Yes  No | | | | | | | | | | | | | | | | | |
| QMB | NAME | | | | | | | | | | **MEDICAID NO.** | | | | PERIOD OF COVERAGE | | |
|  | (LAST) (FIRST) (MIDDLE) | | | | | | | | | |  | | | | FROM | | TO |
|  |  | | |  | | | |  | |  | | | |  | | |  |
|  |  | | |  | | | |  | |  | | | |  | | |  |
|  |  | | |  | | | |  | |  | | | |  | | |  |
|  |  | | |  | | | |  | |  | | | |  | | |  |
| **TO THE VENDOR:**  **QUALIFIED MEDICARE BENEFICIARIES:** Persons with a “Y” indicator in the QMB field are eligible for benefits in addition to regular Medicaid, which include Medicare covered services. Total Medicaid payment for Medicare covered services will consist of co-insurance and deductible amounts, as determined by the Medicare program.  **HOSPICE INFORMATION:** When hospice care is noted, providers are encouraged to contact the hospice indicated about who to bill for specific services. | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | **HOSPICE INFORMATION** | | | | | | | | |
|  | | | | | | | | | CLIENT NAME | | | | | | | | |
|  | | | | | | | | | HOSPICE NAME | | | | | | | | |
|  | | | | | | | | | ADDRESS | | | | | | | | |
|  | | | | | | | | | PHONE    -   - | | | | | | | | |
| **MEDICAID LOCK-IN PROGRAM** | | | | | | | | | **THIRD PARTY LIABILITY** | | | | | | | | |
| PHYSICIAN | | | PHARMACY | | OPTOMETRIST | | | | NAME | | | | | | |  | |
| DENTIST | | | PODIATRY | | O.P.-E.R. FACILITY | | | | INS. CO. | | | | | | | INS. CODE | |
| NAME | | | | | | | | | NAME | | | | | | |  | |
| ADDRESS | | | | | | | | | INS. CO. | | | | | | | INS. CODE | |
| NAME | | | | | | | | | NAME | | | | | | |  | |
| ADDRESS | | | | | | | | | INS. CO. | | | | | | | INS. CODE | |
| CASEWORKER SIGNATURE | | | | | | | | | NAME | | | | | | |  | |
|  | | | | | | | | | INS. CO. | | | | | | | INS. CODE | |
| MO 886-0697 (8-94)/E 04-2004 | | | | | | | **RETAIN 12 MONTHS** IM-29 (R8-94)/E 04-2004 | | | | | | | | | | | | |

        