



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 DIVISION OF MEDICAL SERVICES  
**DIABETIC SUPPLIES PRIOR AUTHORIZATION**

RETURN TO: EDIT AUTHORIZATION  
 DIVISION OF MEDICAL SERVICES  
 PO BOX 4900  
 JEFFERSON CITY, MO 65102-4900

**PLEASE PRINT OR TYPE.**  
**ALL REQUIRED INFORMATION MUST BE SUPPLIED OR THE REQUEST CANNOT BE PROCESSED.**  
 1-800-392-8030 FAX: 573-636-6470

<input type="checkbox"/> INITIAL REQUEST <input type="checkbox"/> RENEWAL REQUEST		MEDICAID NUMBER	
RECIPIENT NAME		DATE OF BIRTH	
DIAGNOSIS			
REQUESTED PRODUCT	NDC NUMBER/HCPCS CODE	QUANTITY	
PRESCRIBING DIRECTIONS			
IS THE PATIENT CURRENTLY USING THE REQUESTED PRODUCT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
HOW LONG HAS THIS PRODUCT BEEN USED BY PATIENT?		DURATION OF NEED	
LIST ALL OTHER COVERED SUPPLIES PREVIOUSLY TRIED AND FAILED.			
PROVIDE DETAILED REASON REFERENCE PRODUCTS ARE NOT BEING UTILIZED.			
NAME OF <b>PRESCRIBING</b> PHYSICIAN OR APN		MEDICAID PROVIDER NUMBER (OR DEA NUMBER)	
ADDRESS	TELEPHONE NUMBER (    )	FAX NUMBER (    )	
NAME OF PHARMACY AND CONTACT PERSON		MEDICAID PROVIDER NUMBER	
ADDRESS	TELEPHONE NUMBER (    )	FAX NUMBER (    )	