HEALTH PASSPORT COVER SHEET

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PO Box 3003, Farmington, MO 63640-3803

superior healthplan

PROVIDER INFORMATION (*Required field)

TIN #*_____
NPI*_____
NAME_____
PHONE_____FAX_____
SERVICE DATE*_____# of PAGES_____

MEMBER INFORMATION(*Required field)

FIRST NAME*_____
LAST NAME*_____
DFPS ID*_____or MEDICAID ID*_____
DOB*_____

********Please check only **ONE** form type below. If you wish to submit multiple forms, please use a separate coversheet. ********

BEHAVIORAL HEALTH

DO NOT SEND INDIVIDUAL THERAPY NOTES

- ☐ Initial Behavioral Health Assessment - 4
- ☐ Behavioral Health Review (Monthly) - 3
- ☐ Biopsychosocial Assessment
- ☐ Psychological Evaluation
- ☐ Other (Discharge Summary, etc.)

DENTAL

- ☐ Dental Form - 1
- ☐ Other

EARLY CHILDHOOD INTERVENTION

- ☐ IFSP Form - 2
- ☐ Other

FORENSIC ASSESSMENT

- ☐ Forensic Assessment Form - 1
- ☐ Other

OTHER

- ☐ Non-Consent Emergency Notification - 1
- ☐ Other

PHYSICAL HEALTH

- ☐ 3-Day Exam
- ☐ 30-Day Exam
- ☐ Envolve People Care/Care Path - 2
- ☐ Birthing Center Report Form 7484 - 1
- ☐ DME Certification and Receipt Form - 1
- ☐ Donor Human Milk Request Form - 1
- ☐ Federally Qualified Health Center Report Form 7484 - 1
- ☐ Labs
- ☐ HearingEvaluation,Fitting,andDispensingReportForm3503-1
- ☐ Hospital Report HHS Form 7484 - 1
- ☐ Notification of Pregnancy - 1
- ☐ Specimen Submission Form G-1C - 1
- ☐ Vision Care Eyeglass Patient Certification Form - 1
- ☐ Other(DischargeSummary,etc.)

TEXAS HEALTH STEPS

- ☐ Discharge to 5 Day Visit - 2
- ☐ 2 Week Visit - 2
- ☐ 2 Month Visit - 2
- ☐ 4 Month Visit - 2
- ☐ 6 Month Visit - 2
- ☐ 9 Month Visit - 2
- ☐ 12 Month Visit - 2
- ☐ 15 Month Visit - 2
- ☐ 18 Month Visit - 2
- ☐ 24 Month Visit - 2
- ☐ 30 Month Visit - 2
- ☐ 3 Year Visit - 2
- ☐ 4 Year Visit - 2
- ☐ 5 Year Visit - 2
- ☐ 6 Year Visit - 2
- ☐ 7 Year Visit - 2
- ☐ 8 Year Visit - 2
- ☐ 9 Year Visit - 2
- ☐ 10 Year Visit - 2
- ☐ 11 Year Visit - 2
- ☐ 12 Year Visit - 2
- ☐ 13 Year Visit - 2
- ☐ 14 Year Visit - 2
- ☐ 15 Year Visit - 2
- ☐ 16 Year Visit - 2
- ☐ 17 Year Visit - 2
- ☐ 18 Year Visit - 2
- ☐ 19 Year Visit - 2
- ☐ 20 Year Visit - 2
- ☐ Child Health History - 2
- ☐ CCP ECI Request for Initial/Renewal Outpatient Therapy - 1
- ☐ CCP Prior Authorization Private Duty Nursing - 1 CCP
- ☐ Prior Authorization Request Form - 1
- ☐ CRAFFT
- ☐ Dental Mandatory Prior Authorization Request - 1
- ☐ Dental Criteria for Dental Therapy Under Anesthesia -
- ☐ 2 Hearing Checklist for Parents - 1
- ☐ HEEADSSS
- ☐ Lead Poisoning/Parent Questionnaire - 2
- ☐ Mental Health Interview Tool 0-2 Years - 1
- ☐ Mental Health Interview Tool 3-9 Years - 1
- ☐ Mental Health Interview Tool 10-12 Years - 1
- ☐ Mental Health Interview Tool 13-20 Years - 1
- ☐ Nursing Addendum to Plan of Care - 3
- ☐ Pediatric Symptom Checklist (PSC-35)
- ☐ PSC-Y
- ☐ Referral Form - 1
- ☐ TB Questionnaire - 1
- ☐ Other

INTERNAL USE ONLY: TEMPLATE NAME _____