

HEALTH PASSPORT COVER SHEET

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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

- Family Strengths and Needs Assessment (FSNA)
- Initial and Monthly Behavioral Health Assessment
- Biopsychosocial Assessment
- Psychological Evaluation
- Trauma Screening Questionnaire (TSQ) – Adults
- Child and Adolescent Trauma Screen (CATS) Caregiver Report (7-17)
- 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
- Involve People Care/Care Path - 2
- Birthing Center Report from 7484 - 1
- DME Certification and Receipt Form - 1
- Donor Human Milk Request Form - 1
- Federally Qualified Health Center Report Form 7484 - 1
- Labs
- Hearing Evaluation, Fitting, and Dispensing Report Form 3503-1
- Hospital Report HHSC Form 7484 - 1
- Notification of Pregnancy - 1
- Specimen Submission Form G-1C - 1
- Vision Care Eyeglass Patient Certification Form - 1
- Other (Discharge Summary, 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
- 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

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