



**Missouri Care**  
HEALTH PLAN

**Missed Appointment Notification Form**

Member Name:	Date of Birth:
DCN:	SSN:
Address:	
Any working phone number(s):	
Name of Parent or Guardian (if child):	
PCP name:	Clinic Name:
Name of person completing form:	Clinic phone number:

**Please indicate the problem. Check all that apply:**

- Member missed one or more **well-child checkup** (EPSDT/HCY) appointments.  
Date of missed appointment(s): \_\_\_\_\_
- Member missed one or more **immunization** appointment(s).  
Date of missed appointment(s): \_\_\_\_\_
- Member missed one or more **well-woman checkup** appointment(s).  
Date of missed appointment(s): \_\_\_\_\_
- Other \_\_\_\_\_

**Please indicate actions already taken by your office. Check all that apply:**

- Made reminder call to member before appointment.
- Called member to reschedule. How many times? \_\_\_\_\_
- Mailed letter to member to reschedule.
- Other \_\_\_\_\_

**Additional Comments:**

Please fax to 866-946-1125  
Attn: Quality Management  
or mail to Missouri Care Health Plan  
2404 Forum Blvd  
Columbia, MO 65203