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