HealthSystems of Mississippi
Medicaid Admission Review Form: Inpatient Medical / Surgical Services

Beneficiary Information	Provider Information
Beneficiary Name: ______ Medicaid #: ☐☐☐☐☐☐☐☐☐ K-Baby Name: ______ Date of Birth: ☐☐/☐☐/☐☐ Sex: ☐ Age: ☐☐☐ Beneficiary Account #: ______ *(if applicable)*	Facility #: ☐☐☐☐☐☐☐☐☐☐ Facility Name: ______ Physician Name: ______ Physician MS Medicaid #: ☐☐☐☐☐☐☐☐ Requested By: ☐ Facility ☐ Physician Requester Name: ______ Phone #: (☐☐☐) ☐☐☐-☐☐☐☐ Ext. ☐☐☐☐

Admission Information

Request Date: ☐☐/☐☐/☐☐	**OB: Delivered during stay:** Date of delivery: ☐☐/☐☐/☐☐ Time of Delivery: ☐☐:☐☐ ☐ **AM** ☐ **PM**
Service Dates: Outpatient Services Date: ☐☐/☐☐/☐☐ Emergency Department Services Date: ☐☐/☐☐/☐☐ Observation Admit Date: ☐☐/☐☐/☐☐ Actual/Proposed Admit Date: ☐☐/☐☐/☐☐ Proposed Discharge Date: ☐☐/☐☐/☐☐ Actual Discharge Date: ☐☐/☐☐/☐☐ Number of days requested: ☐☐☐ *(Requested days must include the earliest service date as identified above.)*	**NEWBORN** *Complete if this is the birth admission.* *List appropriate ICD-9-CM V30xx - V 37xx diagnosis code as admit diagnosis below under Medical Information.* Baby Birth Date: ☐☐/☐☐/☐☐ Transfer Date to any setting other than well baby: ☐☐/☐☐/☐☐ Mom's Discharge Date: ☐☐/☐☐/☐☐ Gram Weight at Birth: ☐☐☐☐ Gram Weight at time of review request: ☐☐☐☐ Nursery Level: ☐ I ☐ II ☐ III ☐ IV ☐ Other

Medical Information

Diagnosis and Procedures

(List the primary diagnosis first, and then list other diagnoses. Complete the primary diagnosis- specific information on page 3, if applicable.)

ICD-9-CM Code	Narrative Description
1. Primary Dx.:	
2.	
3.	
4.	

Date	ICD-9-CM Code	Procedure Description Date
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		

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Beneficiary Name: **Medicaid#:**

Treatment History: Did the patient receive related health care services prior to admit? ☐ Yes ☐ No ☐ Unknown

If **yes**, when:

List prior treatments:

Is / was this an urgent or emergent admission? ☐ Yes ☐ No

If **yes**, explain:

Can the beneficiary be managed in an outpatient or alterative level of care (if available)? ☐ Yes ☐ No

Clinical Signs and Symptoms*: (Clinical signs and symptoms must support the need for inpatient level of care.)*

Studies/labs/x-rays *(List any diagnostic studies, lab/x-ray tests and findings that are associated with the primary diagnosis.)*

Date	Study/Lab/X-Ray	Results/Findings
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		
☐☐/☐☐/☐☐		

Treatment Plan/Frequency *(Include treatment related to the primary diagnosis):*

List medications that are given by the IV/IM/SQ route *(Only list oral meds given for stat purposes, adjustments of oral cardiac meds, and chemotherapy drugs with number of days to be administered.)*

Date Ordered	Medication, Dosage, Frequency & Route	Date Discontinued *(if applicable)*
☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
☐☐/☐☐/☐☐		☐☐/☐☐/☐☐

If the patient is being admitted for surgery, provide the reason/medical indication for the surgery below.

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DISCHARGE PLANS

Will/can the beneficiary return to current living arrangement? ☐ Yes ☐ No

Anticipated Discharge Date: ☐☐/☐☐/☐☐

Anticipated Discharge to: *(Check one)*

- ☐ Acute Care — Facility: ____________
- ☐ Custody DHS — County: ____________
- ☐ Custody DYS
- ☐ Home with family
- ☐ Group home
- ☐ Foster home
- ☐ Shelter
- ☐ Independent living
- ☐ Left AMA
- ☐ Other: *(Specify.)*

____

____

Anticipated Follow-Up Care: *(Check all that apply)*

- ☐ Case Management
- ☐ Day Treatment - CMHC
- ☐ DME
- ☐ Family Therapy
- ☐ Follow-Up w/PCP /Specialist
- ☐ Follow-Up w/Pharmacy
- ☐ Group Therapy
- ☐ Med Management
- ☐ PDN
- ☐ OT/PT/ST Outpatient Therapy
- ☐ SNF/NH
- ☐ Substance Abuse Counseling
- ☐ Vocational Rehab
- ☐ Other: *(Specify.)*

____

____

Primary Diagnosis-Specific Information

ALCOHOL WITHDRAWAL/DETOXIFICATION

Is the beneficiary being admitted for medical stabilization for alcohol withdrawal/alcohol withdrawal syndrome? ☐ Yes ☐ No ☐ Unknown *If "yes", then provide information requested in the boxes to the right.*	Beneficiary's current blood alcohol level.	☐☐
	Has the beneficiary received detoxification within the last 30 days?	☐ Yes ☐ No ☐ Unknown
	Does the beneficiary have any of the conditions listed below? *(Check all that apply.)* ☐ Mental status changes ☐ Tachycardia	☐ Blood pressure above 150/80 ☐ Sweating /diaphoresis

ASTHMA: Did maximum outpatient/Emergency Department treatment fail? ☐ Yes ☐ No If **yes**, explain below:

____

____

Is the beneficiary compliant with medications? ☐ Yes ☐ No ☐ Unknown

If **no,** length of non-compliance: ☐ within in last month ☐ in past three months ☐ in past six months ☐ sporadically compliant

BURNS: % of total body surface area with 3rd degree burns: ☐☐☐ % of total body surface area with burns: ☐☐☐

SICKLE CELL CRISIS: Did maximum outpatient/Emergency Department treatment fail? ☐ Yes ☐ No If **yes**, explain below:

____

____

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