

HealthSystems of Mississippi

Medicaid Continued Stay Review Form: Inpatient Medical/Surgical Services

Beneficiary Information	Provider Information
Beneficiary Name: _____	Facility MS Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Facility Name: _____
K-Baby Name: _____	Physician Name: _____
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Physician MS Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Sex: <input type="text"/> Age: <input type="text"/> <input type="text"/> <input type="text"/>	Requested By: <input type="checkbox"/> Facility <input type="checkbox"/> Physician
Beneficiary Account #: _____ <i>(if applicable)</i>	Requester Name: _____
	Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Continued Stay Review Information	
Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Discharge Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Admit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Last Day Certified: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Treatment Authorization (TAN) #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Additional Days Requested: <input type="text"/> <input type="text"/> <input type="text"/>
If newborn : Current Gram Weight: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Nursery Level: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Other	

Medical Information		
New ICD-9-CM Codes	New Diagnosis Since Last Review	Date Identified
1.		
2.		
3.		
4.		

Date of Procedure	ICD-9-CM Codes	Procedure Description <i>(completed, planned, or cancelled)</i>	Check if cancelled
1. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>			<input type="checkbox"/>
2. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>			<input type="checkbox"/>
3. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>			<input type="checkbox"/>
4. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>			<input type="checkbox"/>

Clinical signs and symptoms that support continued stay *(Include progression or regression of admitting signs and symptoms.)*

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Beneficiary Name: _____ Medicaid #: _____

DISCHARGE PLANS

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

Anticipated Discharge Date: / / ---

Anticipated Discharge to: *(Check one)*

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Acute Care
<input type="checkbox"/> Custody DHS
<input type="checkbox"/> Custody DYS
<input type="checkbox"/> Home with family
<input type="checkbox"/> Group home
<input type="checkbox"/> Foster home
<input type="checkbox"/> Shelter
<input type="checkbox"/> Independent living
<input type="checkbox"/> Left AMA
<input type="checkbox"/> Other: <i>(Specify.)</i> | Facility: _____
County: _____

<input type="checkbox"/> Case Management
<input type="checkbox"/> Day Treatment - CMHC
<input type="checkbox"/> DME
<input type="checkbox"/> Family Therapy
<input type="checkbox"/> Follow-Up w/PCP /Specialist
<input type="checkbox"/> Follow-Up w/Pharmacy
<input type="checkbox"/> Group Therapy
<input type="checkbox"/> Home Health
<input type="checkbox"/> Other: <i>(Specify.)</i> | <input type="checkbox"/> Individual Therapy
<input type="checkbox"/> Med Management
<input type="checkbox"/> PDN
<input type="checkbox"/> OT/PT/ST Outpatient Therapy
<input type="checkbox"/> SNF/NH
<input type="checkbox"/> Substance Abuse Counseling
<input type="checkbox"/> Vocational Rehab |
|--|--|---|

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