

HealthSystems of Mississippi Medicaid Retrospective Certification Review Form

Beneficiary Information

Beneficiary Name: _____

Medicaid #:

Date of Birth: / /

Sex: Age:

Is this a K-baby review? Yes No

If yes, please complete the following:

Mother's Name: _____

Date of Birth: / /

Medicaid #:

Provider Information

Facility MS Medicaid #:

Facility Name: _____

Admission Information

Setting (Check one.)

Acute Inpatient Medical/Surgical Acute Inpatient Psychiatric Services

Admit Date: / /

Requested By: Facility Physician

Discharge Date: / /

Requester Name: _____

Request Date: / /

Phone #: () -

Inpatient Length of Stay (# of days):

Ext.

If service dates are greater than one year, provide TCN

Physician Name: _____

Number: _____

Physician MS Medicaid #:

Why is retrospective review being requested:

Patient's MS Medicaid eligibility became effective retroactively during admission or after discharge.

Facility/physician failed to certify the admission and continued stay.

The baby stayed longer than its mother. Mothers Discharge Date: / /

Other (describe): _____

NOTE: If this is a maternity admission with a length of stay of three days or less for a vaginal delivery or five days or less for a Cesarean delivery please submit a maternity report by Web or by phone at (888) 557-1923.

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