HealthSystems of Mississippi
Additional Medical Information Form

BENEFICIARY INFORMATION	PROVIDER INFORMATION
Beneficiary Medicaid #: _____ Beneficiary Name: _____ Date This Information Submitted: ☐☐/☐☐/☐☐ Admit Date: ☐☐/☐☐/☐☐	Provider MS Medicaid #: ☐☐☐☐☐☐☐☐☐☐ Facility Name: _____ Requester Name: _____ Tel #: (☐☐☐) ☐☐☐-☐☐☐☐ Ext. ☐☐☐☐☐

If information was requested by HSM provide HSM's reviewer's name/number below:

_____

ADDITIONAL MEDICAL INFORMATION

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.