HealthSystems of Mississippi Medicaid
Quality Re-review Request Form

BENEFICIARY INFORMATION	PROVIDER INFORMATION
Beneficiary Name: _____ Medicaid #: ☐☐☐☐☐☐☐☐☐ Date of Birth: ☐☐/☐☐/☐☐☐☐ Sex: ☐ Age: ☐☐☐	Provider's Name: _____ Medicaid #:☐☐☐☐☐☐☐☐☐☐ Physician's / Treating Clinician's Name: (last, first) _____ Medicaid #:☐☐☐☐☐☐☐☐☐☐ Phone #: (☐☐☐) ☐☐☐-☐☐☐☐
REQUESTER'S INFORMATION	**REQUEST AND NOTIFICATION DATES**
Requested By: ☐ Facility ☐ Physician/Clinician Requester's Name: _____ Phone #: (☐☐☐) ☐☐☐-☐☐☐☐ Ext. ☐☐☐☐☐	Request Date: ☐☐/☐☐/☐☐ Admission/Service Start Date: ☐☐/☐☐/☐☐ Date of quality issue notice: ☐☐/☐☐/☐☐

RATIONALE/MEDICAL REASON FOR DISAGREEMENT

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Additional information submitted: ☐ Yes ☐ No

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