

**Instructions for Completing the HealthSystems of Mississippi  
School Health Related Services  
Physical/Occupational/Speech Therapy  
Precertification Request Form**

## **Section I            Beneficiary Information**

1. **Patient Name** - Enter the patient's last and first name as it appears on the Mississippi Medicaid ID card. If the beneficiary is a K baby, list baby's name.
2. **Medicaid #** - Enter the beneficiary's number that appears on the Mississippi Medicaid ID card.
3. **Date of Birth** – Enter the month, date, and year of the patient's birth.
4. **Age** - Enter the age of the patient at the time service is to be rendered.
5. **Sex** - Indicate the sex of the patient.
6. **Mother's Name** - Enter the full name of the K baby's mother.
7. **Mother's Date of Birth** - Enter the month, date, and year of the mother's birth.
8. **Therapy in other setting** – Indicate either yes or no if the patient is receiving therapy in any other setting.
9. **Place of Service Code** – If the patient is receiving therapy in another setting, indicate the place of service code.
10. **Last Physician, Nurse Practitioner, or Physician Assistant's Visit** – Enter the date of the last visit with the practitioner's. (Refer to Policy 47.10, 48.10 and 49.10 Continuing Medical Oversight)
11. **Next Scheduled Physician, Nurse Practitioner, or Physician Assistant's Appointment** – Enter the date of the next scheduled practitioner's appointment. (Refer to Policy 47.10, 48.10 and 49.10 Continuing Medical Oversight)

## **Section II            Provider Information**

1. **Request Date** – Record the date of the request.
2. **Medicaid #** - Enter the provider's Mississippi Medicaid Provider Number.
3. **Provider Name** - Enter the name of the provider that will provide the care.
4. **Contact /Requester** - Enter the name of the individual who is primary contact for this case.
5. **Telephone #** - Enter the contact person's telephone number, including area code and extension.
6. **Fax #** - Enter the provider's contact fax number, including area code.
7. **Intended Place of Service Code** – Indicate the intended place of service code.
8. **Ordering Physician, Nurse Practitioner, or Physician Assistant** – Indicate the name of the ordering MD/NP/PA.
9. **Telephone #** - Indicate the telephone number of the ordering MD/NP/PA.
10. **Services to be Provided By** – Indicate the type of provider that will provide therapy services.

## **Section III           Request Type**

1. **Precertification** - If the request is for precertification, insert the following:
  - A. **Date of Evaluation Visit** - Enter the date of initial evaluation visit provided to patient.
  - B. **Date of Next Planned Visit** - Enter date of the next scheduled visit to provide therapy service to patient.
  - C. **No Additional Visits Planned** – Indicate if patient does not qualify for or need additional therapy visits.

**NOTE: Attach a Copy of the Physician, Nurse Practitioner or Physician Assistant's Order (verbal or written), Initial Evaluation Visit notes and Plan Of Care.**

2. **Concurrent** - If the request is for concurrent review (certification for continuing services), complete the following:

- A. **Existing Certification #** - Enter existing certification number.
- B. **Date of Last Service Authorized** - Enter the date of last service authorized.
- C. **Date of Next Planned Visit** - Enter the date of the next scheduled therapy visit.

**NOTE: Current Physician, Nurse Practitioner, or Physician Assistant's orders, current plan of care, notes from therapist's last visit, and documentation of patient's progress toward achieving goals.**

3. **Retrospective** - Check box for retrospective review and complete the following, if applicable:

- A. **TCN** - Transaction Control Number

**NOTE: A copy of the patient's complete medical record must be attached to this request form.**

## **Section IV. Diagnoses and ICD-9-CM Codes**

1. **Medical Diagnoses/ICD-9-CM Codes** - Enter the patient's primary and secondary diagnoses for this admission (if applicable) and enter the ICD-9-CM codes that correspond to the diagnoses.
2. **Therapy Diagnoses/ICD9-CM Codes** - Enter the reason for school therapy and the patient's therapy diagnoses for this admission (if applicable) and enter the ICD-9-CM codes that correspond to the diagnoses.

## **Section V. Requested Therapy**

1. **Therapy Type** - Indicate if therapy type is physical (PT), occupational (OT) or speech therapy (ST).
2. **Narrative Description of Procedure** - Indicate a narrative description of the CPT<sup>®</sup> code procedure.
3. **CPT<sup>®</sup> Code** - Use a valid CPT<sup>®</sup> code.
4. **Frequency** - Indicate the number of times services are to be rendered per duration, such as 3 times per week for 4 weeks.
5. **Units** -
  - a. Record the number of units requested per visit for each CPT<sup>®</sup> code.
  - b. Record the total number of units requested for each CPT<sup>®</sup> code.
6. **Dates of Service** - Indicate date service will start and the date the service will end.
7. **Signature of Provider** - Indicates that the services listed in Section V of this form are those exact services ordered and certified as medically necessary by the ordering MD/NP/PA specified in Section II of this form for the beneficiary specified in Section I of this form.

**Section A: Beneficiary and Provider Information**

Patient Name: \_\_\_\_\_  
 Medicaid #:   
 Date of Birth: //  
 Age:  Sex:  (M or F)  
 Date of last visit: //

Ordering MD/NP/PA Name (First and Last): \_\_\_\_\_  
 Medicaid ID#:   
 Telephone #: -- Ext.

**Section B: Clinical Information**

*(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)*

Diagnoses	ICD-9-CM

**Clinical Summary:** Record relative history indicating patient's need for each requested therapy service by discipline, i.e., physical, occupational and/or speech therapy.

**Physician/Nurse Practitioner/Physician Assistant Order(s):**

**Section C: Physician//Nurse Practitioner/Physician Assistant Attestation, Signature and Date**

*A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed services, who knowingly or willfully makes, or causes to be made any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the prescribing physician/nurse practitioner/physician assistant identified in Section A and that I have prescribed the orders listed in Section B of this form. I certify that the medical necessity information in Section B is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.*

\_\_\_\_\_  
**Signature and Title of Prescribing Provider**

\_\_\_\_\_  
**Date**