HealthSystems of Mississippi
175 E. Capitol Street
Suite 250
Jackson, MS 39201

HealthSystems of Mississippi Medicaid School Health Related Services Physical/Occupational/Speech Therapy Precertification Request Form

I. Beneficiary Information

Patient's Information

Patient/Baby Name: ______________________________

Medicaid #: ☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

Age: ☐☐☐ Sex: ☐ (M or F)

Is patient also receiving therapy in any other setting? ☐Yes ☐ No

If yes, record *Place of Service Code:* ☐☐

Date of Last MD/NP/PA Appointment: ☐☐/☐☐/20☐☐

Date of next scheduled MD/NP/PA appointment: ☐☐/☐☐/20☐☐

II. Provider Information

Request Date: ☐☐/☐☐/20☐☐

MS Medicaid Provider #: ☐☐☐☐☐☐☐

Provider/Facility: ______________________________

Contact/Requestor: ______________________________

Telephone #:(_____) _________ -___________ Ext._________

Fax #: (_____) _________ -_________________

Record intended *Place of Service Code:* ☐☐

Referring MD/NP/PA Name: ________________________

MS Medicaid #: ☐☐☐☐☐☐☐

Telephone #: (____) ______-________ Ext. ___________

Services to be provided by:

☐ MD/NP/PA ☐ Licensed Therapist ☐ PTA/COTA

☐ Other (List)______________________________

III. Request Type - Select one

☐ **Precertification** – *Attach CMN, Initial Evaluation Form, and Plan of Care Form*

Evaluation Visit Date: ☐☐/☐☐/20☐☐

Next Planned Visit Date: ☐☐/☐☐/20☐☐

☐ **No Additional Visits Planned**

☐ **Concurrent** - *Attach a copy of current Plan of Care, Reevaluation (if applicable), notes from last visit and documentation of progress toward goals.*

Existing Certification #: ☐☐☐☐☐☐☐☐

Last Service Date Authorized: ☐☐/☐☐/20☐☐

Date of Next Planned Visit: ☐☐/☐☐/20☐☐

Please answer the following:

Yes	No	
☐	☐	Physical, occupational and/or speech services have been identified and documented as part of the beneficiary's IEP or IFSP.
☐	☐	The IEP, IFSP and Plan of Care for this service request have been discussed with the beneficiary's caregivers or legal guardians.

☐ **Retrospective Review**

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

Record TCN (If applicable): ______________________________

Reason for submitting retrospective review:

____

____

____

Complete this form and attach a copy of the complete medical record, including all therapy notes.

HealthSystems of Mississippi Medicaid School Health Related Services Physical/Occupational/Speech Therapy

Beneficiary Name: ______________________________________ **Medicaid #:** ☐☐☐☐☐☐☐☐☐

IV. Requested Therapy (Untimed codes are gray)

Type	CPT® Code	Units		Frequency (# per week, day, month)	Duration (# of weeks, days, months)	Dates of Service	
		Per Visit	Total			From	Thru
Speech/Language Therapy	92506						
Speech/Language Therapy	92507						
Physical Therapy	97001						
Physical Therapy	97002						
Physical Therapy	97112						
Physical Therapy	97116						
Physical Therapy	97530						
Occupational Therapy	97003						
Occupational Therapy	97004						
Occupational Therapy	97112						
Occupational Therapy	97116						
Occupational Therapy	97530						

What will be the total length/duration of therapy sessions? ☐ 1 hour ☐ 45 minutes ☐ 30 minutes ☐ 15 minutes

A therapy provider who knowingly or willfully makes, or causes to be made, false statement of representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that, as a therapy provider, a Certificate of Medical necessity for therapy services has been received from the prescribing provider (physician/nurse practitioner/physician assistant) for the above names beneficiary listed in Section I of this Pre-certification Request Form. I certify that the plan of care has been reviewed with and approved by the prescribing provider in Section II of this same form. I certify that the exact therapy services listed above by the prescribing provider. I understand that therapy services requested on this form are subject to review and approval through the Division of Medicaid's Utilization management and Quality Improvement Organization. I understand that any falsification, omission, or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution, or may automatically disqualify me as a provider of Medicaid services.

Signature of (Therapy) Provider: ____ **Date:** _________________

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.