

I. Beneficiary Information	
Patient's Information	K-Baby Checkbox and Complete Below:
Patient/Baby Name: _____ Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Age: <input type="text"/> <input type="text"/> <input type="text"/> Sex: <input type="text"/> (M or F)	<input type="checkbox"/> K-Baby - <i>Check Here and complete the following:</i> Mother's Name: _____ Mother's Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of Last MD/NP/PA <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/> Appointment: Date of next scheduled MD/NP/PA appointment: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/>
Is patient also receiving therapy in any other setting? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, record <i>Place of Service Code</i> : <input type="text"/> <input type="text"/>	Date of Last MD/NP/PA <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/> Appointment: Date of next scheduled MD/NP/PA appointment: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/>
II. Provider Information	
Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/> MS Medicaid Provider #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Provider/Facility: _____ Contact/Requestor: _____ Telephone #:(____) _____ - _____ Ext. _____ Fax #: (____) _____ - _____	Record intended <i>Place of Service Code</i> : <input type="text"/> <input type="text"/> Referring MD/NP/PA Name: _____ MS Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Telephone #: (____) _____ - _____ Ext. _____ Services to be provided by: <input type="checkbox"/> MD/NP/PA <input type="checkbox"/> Licensed Therapist <input type="checkbox"/> PTA/COTA <input type="checkbox"/> Other (List) _____
III. Request Type - Select one	
<input type="checkbox"/> Precertification – Attach CMN, Initial Evaluation Form, and Plan of Care Form Evaluation Visit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/> Next Planned Visit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/> <input type="checkbox"/> No Additional Visits Planned	<input type="checkbox"/> Concurrent - Attach a copy of current Plan of Care, Reevaluation (if applicable), notes from last visit and documentation of progress toward goals. Existing Certification #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Last Service Date Authorized: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/> Date of Next Planned Visit: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/>
<input type="checkbox"/> Urgent <input type="checkbox"/> Same Day/Non-Urgent Evaluation Visit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/> Next Planned Visit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /20 <input type="text"/> <input type="text"/> <input type="checkbox"/> No Additional Visits Planned If patient seen on "urgent" basis prior to precertification by HSM, also provide information about the urgent nature of the care. _____ _____ _____	<input type="checkbox"/> 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 Outpatient Physical/Occupational/Speech Therapy

Beneficiary Name: _____ **Medicaid #:**

IV. Requested Therapy								
Type	Procedure/ Modality	CPT® Code	Units		Frequency (# per week, day, month)	Duration (# of weeks, days, months)	Dates of Service	
			Per Visit	Total			From	Thru

A therapy provider who knowingly or willfully makes, or causes to be made, false statement or 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 named 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 are those approved 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.