

HealthSystems of Mississippi Medicaid Admission Review Form

Beneficiary Information	Provider Information
Beneficiary Name: _____	Facility #: <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"/> <input type="text"/>
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"/>	Facility Name: _____
K-Baby Name: _____	Physician Name: _____
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Physician #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Sex: <input type="text"/> Age: <input type="text"/> <input type="text"/> <input type="text"/>	Requested By: <input type="checkbox"/> Facility <input type="checkbox"/> Physician
Beneficiary Account #: _____ <i>(if applicable)</i>	Requester Name: _____
	Phone #: (<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"/> <input type="text"/>
	Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Admission Information	
Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Review Setting: <input type="checkbox"/> Acute Inpatient Hospital <input type="checkbox"/> Swing Bed
For psychiatric admissions to general med/surg hospitals, specify bed type:	
<input type="checkbox"/> Acute Med/Surg <input type="checkbox"/> ICU <input type="checkbox"/> Psych Unit <input type="checkbox"/> Geri-Psych <input type="checkbox"/> Other: _____	

<p>Service Dates:</p> <p>Outpatient Services Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Emergency Department Services Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Observation Admit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Actual/Proposed Admit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Discharge Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Number of days requested: <i>(Requested days must include the earliest service date as identified above.)</i> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>OB: Delivered during stay:</p> <p>Date of delivery: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Time: <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM</p> <hr/> <p style="text-align: center;">NEWBORN</p> <p style="text-align: center;"><i>Complete if this is the birth admission. List appropriate ICD-9-CM V30xx - V 37xx diagnosis code as admit diagnosis below under Medical Information.</i></p> <p>Baby Birth Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Transfer Date to any setting other than well baby: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>Mom's Discharge Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p>
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Medical Information		
Diagnosis <i>(List admit diagnosis first, then list other diagnoses)</i>	ICD-9-CM Codes	
1.		
2.		
3.		
4.		
Date	Procedures	ICD-9-CM Codes
1. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
2. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
3. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

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Beneficiary Name:	Medicaid#:
Did the patient receive outpatient treatment prior to admit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when:	
List treatment:	
Urgent or emergent admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Clinical signs and symptoms must support admission)</i>	

Clinical Signs and Symptoms:

Studies/labs/x-rays <i>(List any diagnostic studies, lab/x-ray tests and findings that are associated with the primary diagnosis)</i>		
Date	Study/Lab/X-Ray	Results/Findings

Treatment Plan/Frequency <i>(Include treatment related to the primary diagnosis):</i>

List medications that are given by the IV/IM/SQ route <i>(Only list PO meds given for stat purposes, adjustments of PO cardiac meds, and chemo drugs with number of days to be administered)</i>		
Date Ordered	Medication, Dosage & Frequency	Date Discontinued <i>(if applicable)</i>

If the patient is being admitted for surgery, provide the reason/criteria for the surgery:
Have discharge plans been started? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state plans:

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