

Instructions for Completing the HealthSystems of Mississippi Medicaid Admission Review Form

Section I Beneficiary Information

1. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
2. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card.
3. **K-Baby Name** - Enter the name of the baby born to the Medicaid eligible mother.
4. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. (Use two-digit numbers)
5. **Sex** - Indicate the sex of the beneficiary.
6. **Age** - Enter the age of the beneficiary at the time service is to be rendered. Enter in months if less than two (2) years of age.
7. **Beneficiary Account Number** - Enter the beneficiary's hospital account number. *(Optional field for hospital use only)*

Section II Provider Information

1. **Facility Medicaid #** - Enter the facility's Mississippi Medicaid provider number.
2. **Facility Name** - Enter the name of the facility that will render the treatment.
3. **Physician Name** - Enter the name of the physician rendering the service, first and last name.
4. **Physician MS Medicaid #** - Enter the physician's Mississippi Medicaid provider number.
5. **Requested By** - Indicate whether the physician or facility made the request.
6. **Requester Name** - Enter the name of the individual requesting the review.
7. **Requester Tel #** - Enter the telephone number of the requester including area code and extension number.

Section III Admission Information

1. **Request Date** - Enter the date that you submit your request
2. **Review Setting** - Indicate whether the review setting is an Acute Inpatient Hospital or Swing Bed. For psychiatric admissions to general medical surgical hospitals, indicate bed type Acute Med/Surg, ICU, Geri-Psych, or other (specify type of bed if other is checked).
3. **Outpatient Services Date** - Enter the date the beneficiary received outpatient services (of any type) when the beneficiary never left the hospital and was admitted to inpatient services (if applicable).
4. **Emergency Department Services Date** - Enter the date the beneficiary received emergency department services when the beneficiary never left the hospital and was admitted to inpatient services (if applicable).
5. **Observation Admit Date** - Enter the date the beneficiary was admitted to observation status if applicable.
6. **Actual/ Proposed Admit Date** - Enter the actual or proposed admission date. For newborn birth admissions, enter the baby's date of birth in this area.
7. **Discharge Date** - Enter the discharge date if the beneficiary has been discharged from the facility.
8. **OB delivered during stay** - **APPLIES ONLY WHEN CERTIFICATION IS REQUIRED.** Enter the delivery date and time.
9. **Number of Days Requested** - Enter the days you are requesting to be certified. Requested days must include the earliest service date i.e. outpatient services, emergency department service or observation admit date, if applicable.
10. **Baby Birth Date** - Enter the date of birth of the baby if the review is for the birth admission of a newborn baby.
11. **Baby Transfer Date** - Enter the date the newborn baby was transferred within the hospital (during the birth admission) to any other setting other than well-baby nursery.
12. **Mother's Discharge Date** - Enter the mother's discharge date, if the mother has been discharged and the certification is for the birth admission of a newborn baby.

Section IV Medical Information

1. **Diagnoses/ICD-9-CM Codes** - Enter the beneficiary's primary diagnosis and any secondary diagnoses, if applicable and enter the ICD-9-CM codes that correspond with the diagnoses.
2. **Date/Procedure/ICD-9-CM Codes** - Enter date of planned procedures, procedure name and the ICD-9-CM codes that corresponds with the procedure(s).
3. **Did the beneficiary receive outpatient treatment?** - Indicate whether the beneficiary received outpatient treatment prior to this admission. If yes, indicate date the patient was treated outpatient.
4. **List outpatient Treatment.** - Give brief description of outpatient treatment received by the patient.
5. **Urgent or Emergent Admission** - Indicate whether the admission was determined to be an urgent admission or an emergency admission. Support the determination with clinical signs and symptoms that are documented in the patient's medical record.
6. **Clinical Signs and Symptoms** - List the clinical signs and symptoms that were present at admission.
7. **Studies/labs/x-rays** - List the date, name and results/findings of diagnostic studies, lab and x-ray tests that are associated with the primary diagnoses.
8. **Treatment Plan** - List all planned treatment beginning with those related to the primary diagnosis.
9. **Medication List** - List medications given, its dosage and frequency, the date it was ordered, and date discontinued. Include PO cardiac meds. *(If admission is for chemotherapy include the number of days to be administered).*
10. **Is the beneficiary admitted for surgery?** - If yes, indicate the reason/criteria for surgery.
11. **Have discharge plans been started?** - Indicate whether discharge planning has been initiated. If yes, state the plans.