

# HealthSystems of Mississippi Medicaid Retrospective Certification Review Form

## Beneficiary Information

Beneficiary Name: \_\_\_\_\_

Medicaid #:

Date of Birth:   /   /

Sex:  Age:

Is this a K-baby review?  Yes  No

If yes, please complete the following:

Mother's Name: \_\_\_\_\_

Date of Birth:   /   /

Medicaid #:

## Provider Information

Facility MS Medicaid #:

Facility Name: \_\_\_\_\_

## Admission Information

Review Setting:  Acute Inpatient Hospital  Swing Bed

For psychiatric admissions to general med/surg hospitals, specify bed type:

Acute Med/Surg  ICU  Psych Unit  Geri-Psych  Other: \_\_\_\_\_

Admit Date:   /   /

Requested By:  Facility  Physician

Discharge Date:   /   /

Requester Name: \_\_\_\_\_

Request Date:   /   /

Phone #: (  )    -

Length of Stay (# of days):

Ext.

If service dates are greater than one year, provide TCN

Physician Name: \_\_\_\_\_

Number: \_\_\_\_\_

Physician MS Medicaid #:

Why is retrospective review being requested:

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

Facility/physician failed to certify the admission and continued stay.

The baby stayed longer than its mother. Mothers Discharge Date:   /   /

Other (describe): \_\_\_\_\_

NOTE: If this is a maternity admission with a length of stay of two days or less for a vaginal delivery or four days or less for a Cesarean delivery please contact maternity reporting at (888) 557-1923.

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