

**Instructions for Completing the HealthSystems of Mississippi Medicaid
Reconsideration Request Form**

Section I Beneficiary Information

1. **Beneficiary Medicaid #** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card
2. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card
3. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. (Use two-digit numbers)
4. **Sex** - Indicate the sex of the patient.
5. **Age** - Enter the age of the beneficiary at the time service is to be rendered.

Section II Provider Information

1. **Facility MS Medicaid Number** - Enter the facility's Mississippi Medicaid provider number.
2. **Facility Name** - Enter the name of the facility that will render the treatment.

Section III Request Information

1. **Request Date** - Record the date of the request.
2. **Time Telephone Request Received**: For HSM use to enter time telephone request received.
3. **Request Method** - Indicate whether request submitted by fax, mail or telephone
4. **Requested By** - Indicate whether the physician, facility, or beneficiary/representative made the request.
5. **Requester Name** - Enter the name of the individual requesting the review
6. **Requester Tel #** - Enter the telephone number of the requester including area code.
7. **Physician Name** - Enter the name of the physician rendering the service.
8. **Physician MS Medicaid #** - Enter the physician's Mississippi Medicaid provider number.

Section IV Reconsideration Information

1. **Date of Denial Notification** - Enter the date denial letter was issued.
2. **Date of Admission** - Enter the date the patient was admitted to the facility.
3. **Rationale for Request** - Enter the medical basis/rationale for disagreement.
4. **Additional information submitted** - Indicate whether additional information was submitted with the request.