**Instructions for Completing the HealthSystems of Mississippi Medicaid**
**Quality Re-review 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. ***Requested By*** - Indicate whether the physician or facility made the request.
3. ***Requester Name*** - Enter the name of the individual requesting the review
4. ***Requester Tel #*** - Enter the telephone number of the requester including area code.
5. ***Physician Name*** - Enter the name of the physician rendering the service.
6. ***Physician MS Medicaid #*** - Enter the physician's Mississippi Medicaid provider number.

## Section IV Quality Re-review Information

1. ***Date of Quality Issue Notification*** - Enter the date quality 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.