

HealthSystems of Mississippi Medicaid Quality Re-review Request Form

BENEFICIARY INFORMATION	PROVIDER INFORMATION
Beneficiary Medicaid #: _____	Provider MS Medicaid #: _____
Beneficiary Name: _____	Provider Name : _____
Date of Birth: ___/___/___	
Sex: ___ (M or F) Age: _____	

REQUEST INFORMATION

Request Date: ___/___/___

Requested By: Provider Physician

Requester Name: _____

Requester Tel #: (____) _____ - _____ Ext. _____

Physician Name: _____ Physician MS Medicaid #: _____

(First) (Last)

QUALITY RE-REVIEW INFORMATION

Date of quality issue notification: ___/___/___ Date of Admission: ___/___/___

Rationale/medical reason for disagreement: _____

Is additional information being submitted? Yes No

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

HEALTHSYSTEMS OF MISSISSIPPI'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND

PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.