

HealthSystems of Mississippi Medicaid Continued Stay Review Form

Beneficiary Information	Provider Information
Beneficiary Name: _____	Facility MS Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Facility Name: _____
K-Baby Name: _____	Physician Name: _____
Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Physician MS Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Sex: <input type="checkbox"/> Age: <input type="text"/> <input type="text"/> <input type="text"/>	Requested By: <input type="checkbox"/> Facility <input type="checkbox"/> Physician
Beneficiary Account #: _____ (if applicable)	Requester Name: _____
	Phone #: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Continued Stay Review Information	
Request Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Discharge Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Admit Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Last Day Certified: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Treatment Authorization (TAN) #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Additional Days Requested: _____
For psychiatric admissions to general med/surg hospitals, specify bed type:	
<input type="checkbox"/> Acute Med/Surg <input type="checkbox"/> ICU <input type="checkbox"/> Psych Unit <input type="checkbox"/> Geri-Psych <input type="checkbox"/> Other: _____	

Medical Information		
Current Diagnosis (Include new diagnosis)	ICD-9-CM Codes	
1.		
2.		
3.		
4.		
Date	Procedures (Completed and planned)	ICD-9-CM Codes
1. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
2. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
3. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
4. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

Clinical signs and symptoms that support continued stay (Include progression or regression of admitting signs and symptoms):

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Beneficiary Name: _____ Medicaid #: _____

Studies/labs/x-rays <i>(List any diagnostic studies, lab/x-ray tests and findings since last admission):</i>		
Date	Study/Lab/X-Ray	Results/Findings

Treatment Plan <i>(Include treatment related to the primary diagnosis):</i>

List medications that are given by the IV/IM/SQ route <i>(Only list PO meds given for stat purposes, adjustments of PO cardiac meds, and chemo drugs with number of days to be administered):</i>		
Date Ordered	Medication, Dosage & Frequency	Date Discontinued <i>(if applicable)</i>

Have discharge plans been started? Yes No If yes, state plans: _____

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