

## Instructions for Completing the HealthSystems of Mississippi Medicaid Continued Stay (Concurrent) Review Form

### Section I Beneficiary Information

1. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
2. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card.
3. **K-Baby Name** - Enter the name of the baby born to the Medicaid eligible mother.
4. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. (Use two-digit numbers)
5. **Sex** - Indicate the sex of the beneficiary.
6. **Age** - Enter the age of the beneficiary at the time service is to be rendered. Enter in months if less than two (2) years of age.
7. **Beneficiary Account Number** - Enter the beneficiary's hospital account number. (*Optional field for hospital use only*).

### Section II Provider Information

1. **Facility MS Medicaid #** - Enter the facility's Mississippi Medicaid provider number.
2. **Facility Name** - Enter the name of the facility that will render the treatment.
3. **Physician Name** - Enter the name of the physician rendering the service, first and last name.
4. **Physician MS Medicaid #** - Enter the physician's Mississippi Medicaid provider number.
5. **Requested By** - Indicate whether the physician or facility made the request.
6. **Requester Name** - Enter the name of the individual requesting the review.
7. **Requester Tel #** - Enter the telephone number of the requester including area code and extension number.

### Section III Continued Stay Review Information

1. **Request Date** - Enter the date that you submit your request.
2. **Admit Date** - Enter the actual admission date.
3. **Discharge Date** - Enter the discharge date if the beneficiary has been discharged from the facility.
4. **Last Date Certified** - Enter the last date that was certified from the last review.
5. **Treatment Authorization Number** - Enter the certification number assigned by HSM for this admission.
6. **Number of Additional Days Requested** - Indicate the anticipated continued length of stay.
7. **For psychiatric admissions to general medical surgical hospitals**- Indicate bed type Acute Med/Surg, ICU, Geri-Psych, or other (specify type of bed if other is checked).

### Section IV Medical Information

1. **Current Diagnoses/ICD-9-CM Codes** - Enter the beneficiary's current diagnoses and enter the ICD-9-CM code(s) that correspond with the diagnoses.
2. **Date/Procedure/ICD-9-CM Codes** - Enter date and name of completed and planned procedures, and the ICD-9-CM code(s) that correspond with the procedure(s).
3. **Clinical Signs and Symptoms that Support Continued Stay** - List the present condition of the patient as it relates to the current diagnoses. Include progression or regression of admitting signs and symptoms.
4. **Labs/x-rays** - List the date, name and results/findings of diagnostic studies, lab and x-ray tests that are associated with the primary diagnoses, since admission.
5. **Treatment Plan** - List any treatment initiated since admission, not included in the initial plan.
6. **Medication Table** - List medications and frequency, the date ordered and date discontinued. Include PO cardiac medications. If the admission is for chemotherapy include the number of days for administration.
7. **Discharge Plans** - Indicate whether discharge plans have been started. If yes, state discharge plans.